

**AN ANALYSIS OF HEALTHCARE AND MALPRACTICE LIABILITY
REFORM: ALIGNING PROPOSALS TO IMPROVE QUALITY OF
CARE AND PATIENT SAFETY**

by

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SUMMARY

The South African health system faces numerous challenges. A large majority of the population are dependent and have to contend with a dysfunctional public sector. The quality of care patients receive is severely compromised. Systemic factors, that are particularly prevalent in state facilities, exacerbate the problem. As a result, patient safety is endangered and many avoidable adverse events occur. These adverse events bring about grave consequences for the practitioner involved, the healthcare system with regard to the detrimental impact on resources and, most importantly, the patient.

It must be acknowledged that many of the problems and institutional weaknesses that prevail in the public sector have been inherited. Recognising this, however, does not absolve the current administration, as many of the challenges are compounded by poor policy decisions and failures in crucial areas. This necessitates the need for a critical evaluation of proposed reforms. This dissertation conducts such an evaluation to investigate whether the National Health Insurance will adequately address the deficiencies of the existing system and ensure that South Africans have access to affordable, quality healthcare services. It is argued that there are many unanswered questions in the proposal as set out in the Green Paper. An insufficient case is made for the complete reform of the healthcare system. The adequacy and effectiveness of the NHI, as the preferred mechanism with which to achieve positive health outcomes, have not been established. There are also serious concerns about the affordability thereof as well as the transparency of the process.

Medical malpractice is also investigated. The dissertation provides an overview of the current regulatory and civil liability framework, before evaluating the current malpractice situation. The increasing costs and frequency of claims have been identified as a threat to the existing healthcare system and the successful implementation of the NHI. The dissertation assesses the problem, by considering the extent, effects and causes of increased malpractice litigation. It is argued that the existing malpractice system may be inadequate at promoting and ensuring quality care and patient safety. Reforms that align the objectives of the health system with those of the medical malpractice system should be implemented. Conventional reforms that would merely alter the current system will be insufficient. Fundamental reforms should thus be considered. A patient-orientated approach will be crucial in this regard. Patients are the most severely affected by malpractice and will have to contend with the consequences of malpractice litigation as well. Reforms, seeking to ensure that patients receive compensation whilst making healthcare safer, should be central to any discussion.

Concrete research is necessary. Information on South Africa's health system as it relates to the burden of iatrogenic injury and the causes and avoidability thereof should be studied. The malpractice system should also be scrutinised. Reliable data is required on the number of malpractice claims filed, the causes, costs involved and the difficulties experienced in obtaining compensation. Policy decisions that would ensure that quality care is provided and that patient safety is emphasised must be informed by the necessary inquiries.

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Introduction

1. Introduction

The South African health system faces numerous challenges. A large majority of the population are dependent and have to contend with a dysfunctional public sector.¹ These already vulnerable patients are exposed to conditions that, rather than promote well-being, may in actual fact be detrimental thereto. The quality of care patients receive is severely compromised. Systemic factors, that are particularly prevalent in state facilities, exacerbate the problem. As a result, patient safety is endangered and many avoidable adverse events occur.² These adverse events bring about grave consequences for the practitioner involved, the healthcare system with regard to the detrimental impact on resources and, most importantly, the patient.³

Most of these challenges that contribute to poor quality health services and the resultant adverse events have their roots in policies of the past.⁴ The health system has not escaped the devastating effects of South Africa's history that continue to

¹ National Planning Commission (2012) National Development Plan 2030: Our Future - Make It Work 51, 331.

² Wilson *et al* "Patient safety in developing countries: retrospective estimation of scale and nature of harm to patients in hospital" (2012) 344 *BMJ*.

³ Charles *et al* "Sued and nonsued physicians' self-reported reactions to malpractice litigation" (1985) 142 *American Journal of Psychiatry*. 438; Bates *et al* "The costs of adverse drug events in hospitalized patients" (1997) 277 *JAMA: The Journal of the American Medical Association* 307; Vincent, Neale & Woloshynowych "Adverse events in British hospitals: preliminary retrospective record review" (2001) *BMJ* 519; Vincent "Understanding and responding to adverse events" (2003) 348 *The New England Journal of Medicine* 1054; Studdert *et al* "Defensive medicine among high-risk specialist physicians in a volatile malpractice environment" (2005) 293 *JAMA* 2609.

⁴ Ngwenya "The historical development of the modern South African health-care system: from privilege to egalitarianism" (2004) 2 *De Jure* 290; Coovadia *et al* "The health and health system of South Africa: historical roots of current public health challenges" (2009) 374 *The Lancet* 817.

haunt us in many respects. Racial and income inequality, gender discrimination, migrant labour, forced displacements, the absence of basic services and high rates of violence are all repercussions that have added to the burden placed upon the health system. It is important to recognise this fact. However, it is equally important to recognise that many of the problems we currently face are due to poor policy decisions and the failure to implement adequate measures to address the dire situation.⁵ It is therefore important to be critical of reforms, such as the National Health Insurance, that may not necessarily be beneficial to patients and the population as a whole.⁶ Reforms that seek to fundamentally change the health system should be extensively scrutinised. The financial consequences alone will be immense.⁷ This necessitates an investigation into the potential effectiveness of such a proposed reform, as South Africans cannot afford to spend colossal amounts of money on a system that will not ensure that existing problems are resolved or that access to quality healthcare will be improved. The National Health Insurance will thus be critically evaluated in order to establish whether it would in fact be the best mechanism with which to ensure that the population receives quality care.

2. Purpose and Problem Statement

It should be emphasised that the focus of this research is into the quality of care patients receive, by recognising that the health system and the malpractice liability system both have a role to play in ensuring patient safety. The existing liability system is critically evaluated in this light. It is argued that a divide exists between the current liability system and the health system. Recent developments suggest that there may be an opportunity to reconsider both and align the objectives of the malpractice system with that of the healthcare system. Major reforms such as the

⁵ Development Bank of South Africa (2008) A Roadmap for the Reform of the South African Health System.

⁶ Department of Health (2011) Policy on National Health Insurance in South Africa. GN 657 in GG 34523 of 12 August 2011.

⁷ Matsoso & Fryatt "National Health Insurance: the first 18 months: legislation and financing" (2012) *South African Health Review* 29.

NHI and the establishment of a Medico Legal Task Team seem to indicate that a policy environment conducive to change exists.⁸ Any proposed changes must however be informed by substantive data and be guided by patients' interests.

This dissertation assesses whether that holds true. An evaluation is conducted in light of the proposed reforms as set out in the Green Paper on NHI. The changes proposed thereby and how they relate to liability, quality of care and patient safety are considered. The existing malpractice liability system is also set out and critically evaluated in order to determine whether it achieves its objectives with regard to the deterrence of future errors, compensation of injured patients and its role in effecting corrective justice.

3. Overview of Chapters

The dissertation is divided into two sections. In the first section, an overview of the regulatory and civil liability system is provided. It consists of chapters on the Health Professions Council of South Africa and the law of obligations, which is divided into two separate chapters, covering contractual liability and delictual liability.

The first chapter on the Health Professions Council of South Africa examines its function as the main regulatory body of the health profession and its powers with regard to unprofessional conduct. The chapter extensively examines professional conduct inquiries, disciplinary proceedings and the disciplinary powers of the professional boards.

The contractual relationship between the patient and doctor is considered in the following chapter. The nature, commencement and terms of the agreement are discussed. The rights and duties of the practitioner as a party to the agreement are also examined. The chapter concludes by considering the legal consequences that flow from a breach of contract.

⁸ Parliamentary Question 2013/25A Question Number 627. Also see "Medical litigation: A national health crisis requiring urgent solutions" Medical Chronicle 7 November 2011.

In the next chapter, delictual liability as it pertains to the doctor is considered. This chapter discusses the remedies available to the patient and the elements that must be present in order to prove liability stemming from delict.

In the second section, the NHI as proposed in the Green Paper and the developments since are critically evaluated. The medical malpractice problem is also thoroughly examined.

The chapter on the NHI is analysed according to the structure of sections as set out in the policy document. The problems identified by the drafters of the Green Paper are scrutinised, especially the claim that many of the current problems are caused by the existence of the private sector. The NHI, as mechanism with which to fix the health system, is also called into question. As there is no indication why this mechanism would be preferable to other alternatives or why other alternatives have not been considered. The case made for its implementation is also often based on inaccurate information. Several instances are identified where statistics are inappropriately utilised to support a certain predetermined agenda. It is indicated that there is not enough evidence to support the notion that the NHI as proposed would be the best possible mechanism to address South Africa's health problems. The tremendous costs involved in implementing an inadequate system may actually exacerbate the problems faced. A large part of the chapter is also dedicated to the newly established Office of Health Standards Compliance. The Office will seek to monitor and enforce norms and standards for healthcare establishments. The provisions enacted by the National Health Amendment Act are set out and discussed. It is submitted that such a body is much needed, but that the functioning thereof may be negatively affected by its lack of independence. Along with massive investments in the health system and resources, the Office is the main entity responsible for the protection and promotion of health and safety of patients.

The provision of quality care and patient safety is also the focus of the chapter on malpractice liability. In this chapter, conventional legal liability as discussed in the first section is evaluated in terms of its contribution towards the health system's objectives of ensuring quality care and patient safety. The effect of the Consumer Protection Act on healthcare is also examined. Thereafter, the medical malpractice problem is assessed as it relates to the increase in the frequency of claims and the

amounts awarded to injured patients. The extent thereof with regard to the private as well as the public sector is considered. The chapter also reflects on the effects of increased medical malpractice litigation and the possible causes that have led to such an increase. As quality of care and patient safety is at the core of the discussion, the patients' perspective is addressed. As they are the ones who have to directly contend with medical malpractice and also the effects thereof, their interests should be central to any discussion on the matter.

As such, the effect of the malpractice system on patient safety is evaluated in the final chapter and the reforms that are often proposed are discussed. These reforms are subdivided into two categories; the first includes conventional reforms that only seek to alter the existing malpractice system to reduce claims and the resultant costs, the second category includes fundamental reforms that may be more aligned with the provision of quality care and the promotion of patient safety. The chapter concludes with an evaluation of the NHI's response to some of the concerns raised. Indicating that measures such as the Office of Health Standards Compliance is a step in the right direction, but that the malpractice system also has a role to play in ensuring patient safety and that it might be failing in that regard. It is argued that fundamental reforms should be considered and that patient safety and patients' interests should be decisive in this regard. Conventional reforms that are often proposed will not align the objectives of the health system with that of the malpractice system. It is however submitted that in order to make informed policy decisions, more research will be essential.

4. Research Methodology and Limitations

As the dissertation is divided into two sections a different approach is taken in respect to each. In the first section with its focus on the existing sphere of liability, both primary and secondary sources of law are consulted. Primary sources of law that are canvassed include the Constitution, the common law, case law, national legislation and regulations promulgated thereunder, as it pertains to healthcare and liability incurred in such a setting. Authoritative textbooks and academic articles are also consulted as secondary sources of law.

In the second section primary sources are still referred to, however the nature of the topic demands that the discussion be dominated by governmental policy documents and several reports. Secondary sources are also relied on more readily in this section. Writings of international authors and numerous studies are also examined to draw attention to potential inefficiencies of the existing malpractice system.

Some limitations were encountered, mostly due to progress made since the introduction of the Green Paper, the dissertation attempts to accurately reflect recent developments in the implementation of the NHI. It is however an on-going process and new information will inevitably arise. For this reason the Green Paper forms the basis of the discussion in the chapter on the NHI. Limitations also arose in the evaluation of the malpractice liability system. Very little concrete evidence or statistics are available on adverse events, claims and costs in South Africa. One of the recommendations of this dissertation is that more research be conducted to ensure that informed policy decisions are made. Arguments for reforms that focus on patient safety are thus largely based on studies conducted in other countries.

Section One: The Existing Regulatory and Civil Liability System

Chapter One: The Health Professions Council of South Africa (HPCSA)

Overview

In this chapter the Health Professions Council of South Africa will be examined. The HPCSA replaced the South African Medical and Dental Council as the supreme statutory body responsible for the regulation of the medical profession. It was established in terms of the Health Professions Act, which serves as the principal piece of legislation in matters concerning the health professions. The objectives of the HPCSA will be considered, with specific reference to the Council's dual role as protector of the public and guardian of the medical profession. The chapter will also examine the powers of the HPCSA that allow it to meet the objectives of the Act. The Minister must, on the recommendation of the HPCSA, establish Professional Boards. There are currently twelve such Boards. This chapter will, however, concentrate on the Medical and Dental Professions Board. The disciplinary powers of the Board will be central to the discussion. Professional Boards are authorised to institute inquiries into complaints, charges or allegations of unprofessional conduct and may establish committees for that purpose. Professional Conduct Inquiries

will be addressed in this chapter. The latest regulations concerning the disciplinary procedures of the HPCSA and Professional Boards make provision for the lodging of complaints, mediation by an ombudsman, preliminary inquiries and disciplinary inquiries. These matters and the procedures involved will be set out and examined.

1. Introduction

The Health Professions Council of South Africa (HPCSA) was established by the Health Professions Act and replaced the old South African Medical and Dental Council and the Interim National Medical and Dental Council of South Africa.⁹ It has been said that the council is the *custos morum* of the medical profession and placed in a position to be the guardian of the prestige, status and dignity of the profession and public interest.¹⁰

In *Preddy and Another v Health Professions Council of South Africa*¹¹ the court reiterated that the predecessors of the council were each the repository of power to make findings on what was ethical and unethical in medical practice.¹² The court also acknowledged that the council sets the standard of honour to which its members

⁹ Health Professions Act 56 of 1974; For a general discussion of the role and powers of the regulatory body and its predecessors see Strauss & Strydom (1967) *Die Suid-Afrikaanse Geneeskundige Reg* 10; Taitz "The disciplinary powers of the South African Medical and Dental Council" (1988) *Acta Juridica* 40; Taitz "Review of the disciplinary proceedings of the Medical and Dental Council" (1988) 105 *South African Law Journal* 25; Verschoor & Alberts (1990) *Verdicts of the Medical Council*; Verschoor & Oosthuizen (1990) *Handbook of the Rules and Regulations for Medical Practitioners and Dentists*; Strauss (1991) *Doctor, Patient and the Law: A Selection of Practical Issues* 369; Van Rensburg (2004) *Health and Health Care in South Africa* 324; Carstens & Pearmain (2007) *Foundational Principles of South African Medical Law* 250; Dhali & McQuoid-Mason (2011) *Bioethics, Human Rights and Health Law: Principles and Practice* 30; Slabbert (2011) 'South Africa' in *International Encyclopaedia of Laws: Medical Law* 51.

¹⁰ *Veriava v President, SA Medical and Dental Council, and Others* 1985 (2) SA 293 (T).

¹¹ *Preddy and Another v Health Professions Council of South Africa* 2008 (4) SA 434 (SCA).

¹² *Meyer v SA Medical and Dental Council and Others* 1982 (4) SA 450 (T) at 455.

should conform.¹³ This is still the position under the HPCSA and Courts take cognisance of decisions taken by the council, being mindful not to usurp the functions of the professional body or interfere with findings of the council.¹⁴

2. Objects of the HPCSA

In Section 3 of the Act the objects and functions of the HPCSA are set out.¹⁵ The objects and functions of the council are to:

- (a) co-ordinate the activities of the professional boards established in terms of the Act, the council also acts as an advisory and communicatory body for such professional boards;
- (b) promote and regulate inter-professional liaison between health professions in the interest of the public;
- (c) determine strategic policy with regard to the professional boards and the health professions, for matters such as finance, education, training, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, inter-professional matters and maintenance of professional competence;
- (d) consult and liaise with relevant authorities on matters affecting the professional boards in general;
- (e) assist in the promotion of the health of the population of the Republic;
- (f) subject to legislation regulating health care providers and consistency with national policy determined by the Minister, to control and to exercise authority in respect of all matters affecting the education and training of persons in, and the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in human kind;

¹³ *De La Rouviere v SA Medical and Dental Council* 1977 (1) SA 85 (N) at 97.

¹⁴ *Preddy and Another v Health Professions Council of South Africa*.

¹⁵ S 3(a)-(q).

- (g) promote liaison in the field of education and training referred to in paragraph (f), both in the Republic and elsewhere, and to promote the standards of such education and training in the Republic;
- (h) advise the Minister on any matter falling within the scope of this Act in order to support the universal norms and values of health professions, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement;
- (i) communicate to the Minister information of public importance acquired by the council in the course of the performance of its functions under this Act;
- (j) serve and protect the public in matters involving the rendering of health services by persons practising a health profession;
- (k) exercise its powers and discharge its responsibilities in the best interest of the public and in accordance with national health policy determined by the Minister;
- (l) be transparent and accountable to the public in achieving its objectives and when performing its functions and exercising its powers;
- (m) uphold and maintain professional and ethical standards within the health professions;
- (n) ensure the investigation of complaints concerning persons registered in terms of this Act and to ensure that appropriate disciplinary action is taken against such persons in accordance with this Act in order to protect the interest of the public;
- (o) ensure that persons registered in terms of this Act behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to act accordingly;
- (p) submit to the Minister a five-year strategic plan within six months of the council coming into office which includes details as to how the council plans to fulfil its objectives under this Act; every six months a report on the status of health professions and on matters of public importance that have come to the attention of the council in the course of the performance of its functions under this Act and an annual report within six months of the end of the financial year; and

(q) ensure that an annual budget for the council and the professional boards is drawn up and that the council and the professional boards operate within the parameters of such budget.

The HPCSA as the supreme statutory body regulating the medical profession is responsible for the safeguarding of quality health standards.¹⁶ It functions in a value-driven framework underpinned by the provisions and principles of the South African Constitution.¹⁷ The Act specifically states that any person registered with the HPCSA must behave in a manner that respects the constitutional rights to human dignity, bodily and psychological integrity and equality of health care users. Failure to do so will result in disciplinary action being taken against such persons.¹⁸

The HPCSA seeks to protect the public in their relationship with members of the profession, while the HPCSA also strives to protect and guide the medical profession.¹⁹ The HPCSA endeavours to promote the health of the population of South Africa, through proper education and training. It aims to maintain health care standards through the enforcement of ethical and professional conduct. The HPCSA also seeks to be transparent and accountable to the public in performing its functions and exercising its powers under the Act.

3. General Powers of the HPCSA

There are extensive powers conferred upon the HPCSA enabling the council to achieve the objects of the Act.²⁰ The HPCSA has the power to: Render financial assistance to professional boards enabling them to perform their functions; consider any matter affecting the health professions registered under the Act and make representations or take such action in connection therewith as the council deems

¹⁶ Carstens & Pearmain (2007) 250.

¹⁷ Carstens & Pearmain (2007) 251.

¹⁸ S 3(o).

¹⁹ Carstens & Pearmain (2007) 251; Mcquoid-Mason (2008) 'Medical Professions and Practice' in *The Law of South Africa* 2.

²⁰ S 4(a)-(f).

necessary; make rules on all matters, consistent with national health policy, which the council considers necessary or expedient to achieve the objects of the Act; delegate powers to professional boards or committees and perform other functions and do such things the council deems necessary to achieve the objects of the act within the framework of national health policy.

3.1 Establishment of Committees

The HPCSA is specifically empowered to establish committees as it may deem necessary, including disciplinary committees.²¹ These committees must consist of a number of persons as determined by the council and must include at least one member of the council, who will act as the chairperson of the established committee (except in the case of an *ad hoc* appeal committee).²²

The council may delegate some of its powers as it may from time to time determine to an established committee or to any person, however the council will not be divested of any power so delegated.²³ *Ad hoc* appeal committees, each consisting of a chairperson, who must be a person with knowledge of the law and at least ten years' relevant experience; not more than two registered persons drawn from the relevant profession of the registered person in respect of whose conduct a professional conduct committee of a professional board had held an inquiry; and a member of the council appointed to represent the community, must be established by the HPCSA.²⁴

An appeal committee has the power to vary, confirm or set aside a finding of a professional conduct committee with instructions as it may deem fit.²⁵

²¹ S 10; Carstens & Pearmain (2007) 252; Slabbert (2011) 61.

²² S 10(1)(a).

²³ S 10(1)(b).

²⁴ S 10(2).

²⁵ S 10(3).

3.2 The Functions and Duties of the Registrar

The Minister must, after consultation with the council, appoint a registrar and the council may delegate to the registrar the power to appoint such persons as the registrar may deem necessary for carrying out the functions specified in the Act, and the council may also delegate to the registrar the power to dismiss such other persons.²⁶

The registrar is the accounting officer and the secretary of the council and of each of the professional boards. The registrar must perform the functions and carry out the duties assigned to or imposed upon him or her in terms of the Act as well as such functions and duties as may from time to time be assigned to or imposed upon him or her by the council or a professional board or a committee established in terms of section 10.²⁷

The HPCSA is essentially funded by the registration, examination, annual and other fees payable in terms of the Act. The Act makes provision for a list of financial duties and responsibilities of the registrar, these include: The keeping of financial records; ensuring that the resources of the council are used in an effective, efficient, economical and transparent manner; preparing and submitting financial statements and the general financial management of the HPCSA.²⁸

4. The Professional Boards

4.1 Establishment of Professional Boards

The Minister must, on the recommendation of the HPCSA, establish a professional board with regard to any health profession in respect of which a register in terms of

²⁶ S 12(1).

²⁷ S 12(2).

²⁸ S 13(3).

the Act is kept, or with regard to two or more such health professions.²⁹ The professional boards operate under the jurisdiction of the HPCSA.

On the recommendation of the HPCSA, the Minister may make regulations relating to the constitution, functions and functioning of a professional board.³⁰ These regulations must provide for the appointment of members of a professional board on the basis of nominations made by the members of the health profession or professions involved.³¹

Provision must also be made for persons representing the community to comprise not less than 20% of the membership of a professional board, with a minimum of one such unregistered representative for each professional board.³² The representation of relevant educational institutions and health authorities, as well as the appointment of one or more persons versed in law, where appropriate, must be set out in the regulations.³³

The regulations must also provide for the establishment of professional conduct committees, each consisting of so many persons as may be prescribed, but including at least three board members or members of the relevant profession, and at least two public representatives one of whom shall be the chairperson of such committee.³⁴

There are currently twelve professional boards that function under the jurisdiction of the HPCSA.³⁵ Professional boards have been established for speech, language and hearing professions; dental therapy and oral hygiene; psychology; occupational therapy and medical orthotics/prosthetics; physiotherapy, podiatry and biokinetics; radiography and clinical technology; medical technology; environmental health

²⁹ S 15(1).

³⁰ S 15(4).

³¹ S 15(5)(a).

³² S 15(5)(b).

³³ S 15(5)(c)-(e).

³⁴ S 15(5)(fA).

³⁵ Professional boards have been established in terms of GN 75 in GG 18608 of 16 January 1998. Regulations governing the functioning of professional boards are contained in GN 979 in GG 20371 of 13 August 1999.

officers; emergency care personnel; optometry and dispensing opticians; dietetics; and medical and dental professions.

The Medical and Dental Professions Board is exclusively responsible for dealing with all registered medical and dental practitioners, as well as the training of medical and dental students in South Africa.³⁶ The focus will thus be placed on this particular professional board for purposes of the current discussion.

4.2 Objects of the Professional Boards

The objects of professional boards are generally in line with those of the HPCSA.³⁷ The professional boards assist in the promotion of health of the population of South Africa on a national basis and exercise authority while maintaining standards in respect of all matters affecting the education and training of persons in any health profession falling within the ambit of the professional board.³⁸

The professional boards may make recommendations to the Minister of Health on matters falling within the scope of the Act as it relates to any health profession falling within the ambit of the professional board, in order to support the universal norms and values of the profession, with emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement.³⁹ The Minister of Health must also be advised on matters of public importance acquired by the professional board in the course of the performance of its functions under the Act.⁴⁰ The professional boards are responsible to maintain and enhance the dignity of the professions and the integrity of the persons practising such profession.⁴¹ The professional boards must guide the professions and protect the public.⁴²

³⁶ Carstens & Pearmain (2007) 253.

³⁷ S 15A; Carstens & Pearmain (2007) 253; Slabbert (2011) 62.

³⁸ S 15A(b)-(c).

³⁹ S 15A(e).

⁴⁰ S 15A(f).

⁴¹ S 15A(g).

⁴² S 15A(h).

A significant overlap and similarity can be noted when comparing the objects of the HPCSA with those of the professional boards.⁴³ Carstens and Pearmain state that the professional boards are an extension of the HPCSA and that they operate as the bureaucratic arm that seeks to regulate the professions registered with the HPCSA, while the HPCSA can be considered the executive, over-arching regulatory body.⁴⁴ As such the role and function of the professional boards must always be measured in conjunction with the HPCSA.⁴⁵

4.3 General Powers of the Professional Boards

The professional boards have extensive powers under the Act. A professional board may remove and restore names from and to a register, and suspend a registered person from practising his or her profession pending the institution of a formal inquiry.⁴⁶ Examiners and moderators may be appointed, who may then conduct examinations and grant certificates as may be prescribed.⁴⁷ The professional boards may subject to prescribed conditions, approve training schools.⁴⁸ Matters affecting the professions may be considered and action, as the professional board deems advisable in connection therewith, may be taken.⁴⁹

The professional boards may also recognise local and foreign qualifications, either wholly or in part.⁵⁰ Additionally, the professional boards may perform such functions as may be prescribed and do all such things as the professional board deems necessary or expedient to achieve the objects of the Act in relation to a profession falling within the ambit of the professional board.⁵¹

⁴³ Carstens & Pearmain (2007) 253.

⁴⁴ *Id* 254.

⁴⁵ *Ibid*.

⁴⁶ S 15B(1)(a).

⁴⁷ S 15B(1)(b).

⁴⁸ S 15B(1)(c).

⁴⁹ S 15B(1)(d).

⁵⁰ S 15B(1)(e).

⁵¹ S 15B(1)(g).

It is important to note that any decision of a professional board relating to a matter falling entirely within its ambit will not be subject to ratification by the HPCSA, and the HPCSA must, for this purpose, determine whether a matter falls entirely within the ambit of a professional board.⁵²

5. Disciplinary Powers of Professional Boards

Professional boards have the power to institute an inquiry into any complaint, charge or allegation of unprofessional conduct against practitioners registered under the Act.⁵³ This is the case irrespective of where such person resided, practised or where the misconduct occurred.⁵⁴

In practice the professional boards appoint a professional conduct committee to conduct the enquiries, rather than conducting the enquiries themselves.⁵⁵

If a practitioner is found guilty of unprofessional conduct the relevant professional board has the power to impose the prescribed penalties as specified in section 42(1) of the Act.⁵⁶ A practitioner found guilty of improper or disgraceful conduct, or conduct

⁵² S 15B(2).

⁵³ S 41.

⁵⁴ *Phathela v Chairman, Disciplinary Committee, SA Medical & Dental Council* 1995 (3) SA 179 (T). It was argued that the disciplinary committee had no jurisdiction to adjudicate upon the charges of misconduct as the misconduct took place outside of the Republic of South Africa in a foreign country. It was held that the council, being the *custos morum* of the medical profession, should exercise control and authority over all registered persons without qualification. The council was not exercising power or authority in a foreign country, but it was exercising power over a medical practitioner registered in the Republic of South Africa.

⁵⁵ Slabbert (2011) 63. The power to appoint a professional conduct committee is conferred upon the professional boards under section 15(5)(fA) of the Act read with the regulations published in GN 979 in GG 20371 of 13 August 1999.

⁵⁶ 'Unprofessional conduct' is defined in the Act as 'improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy'. See Carstens & Pearmain (2007) 262-264 for a discussion on the concept of unprofessional conduct. Also note the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, drawn up by

which, when regard is had to such person's profession, is improper or disgraceful shall be liable to one or more of the penalties: (a) a caution or a reprimand or a reprimand and a caution; (b) suspension for a specified period from practising or performing acts specially pertaining to his or her profession; (c) removal of his or her name from the register; (d) a prescribed fine; (e) a compulsory period of professional service as may be determined by the professional board; or (f) the payment of the costs of the proceedings or a restitution or both.

Where an appeal is lodged against a penalty of erasure or suspension from practice, the penalty remains effective until the appeal is finalised.⁵⁷ A penalty imposed will have the effect of a civil judgement of the magistrate's court of the district in which the inquiry took place.⁵⁸

Where there is doubt as to whether an inquiry should be held in connection with the complaint, charge or allegation, a professional board may consult with or seek information from any person, including the person against whom the complaint, charge or allegation was made.⁵⁹

5.1 Manner in which Certain Investigations may be instituted

For the purpose of investigations an officer of the professional board or any other suitable person may be appointed as an investigating officer in order to establish more facts.⁶⁰ Investigating officers carrying out investigations may request any

the HPCSA, in consultation with the professional boards and published with the approval of the Minister of Health under GN 717 in GG 29079 of 4 August 2006. The rules will be decisive in ascertaining whether the conduct of the practitioner had been unprofessional. Whilst courts are not bound by these codes when determining legal liability, the Ethical Rules of Conduct and the prevailing practices of the profession at the time will nonetheless be an important consideration in determining whether conduct constitutes medical malpractice.

⁵⁷ S 42(1A).

⁵⁸ S 42(10)(b).

⁵⁹ S 41(2).

⁶⁰ S 41A(1)-(2).

person to produce books, documents, electronic data or other things and may request explanations in relation to the above-mentioned articles.⁶¹

Provision is also made for obtaining search warrants.⁶² It is significant to note that under certain circumstances an investigating officer may continue his investigation without a warrant. This would be the case where the person concerned consents to the search and seizure or where the investigating officer, on reasonable grounds believes that a search warrant will be issued, but a delay in obtaining the warrant would defeat the object of the search.⁶³

Powers conferred upon investigating officers under the Act regarding search and seizure of books, documents or other things are to be interpreted strictly in order to prevent the unnecessary violation of a person's constitutional right to personal privacy.⁶⁴

5.1.1 Report of the Investigation

A report of the investigation shall be compiled and submitted to the registrar.⁶⁵ If such a report reveals *prima facie* evidence of unprofessional conduct and no complaint or charge has been lodged or laid, or allegation regarding the conduct in question has been made for the purpose of an inquiry in terms of section 41, such report shall be deemed to be a complaint made for that purpose and a copy thereof must be served on the registered person concerned.⁶⁶ A copy of the report shall be submitted to the health committee to further investigate and deal with the matter if the report reveals *prima facie* evidence which would make it desirable for an investigation in terms of section 51 to be instituted.⁶⁷ If a report does not however

⁶¹ S 41A(6)(a).

⁶² S 41A(6)(b)-(g).

⁶³ S 41A(6)(h).

⁶⁴ *Mistry v Interim National Medical and Dental Council of South Africa* 1998 (4) SA 1127 (CC).

⁶⁵ S 41A(8)(a).

⁶⁶ S 41A(8)(b)(i).

⁶⁷ S 41A(8)(b)(ii).

reveal *prima facie* evidence of unprofessional conduct, the registrar shall serve a copy thereof on the registered person concerned.⁶⁸

5.1.2 Admission of Guilt Fine

If a registered person is alleged to be guilty of unprofessional conduct and the professional board on reasonable grounds is of the opinion that it shall impose a fine on conviction after an inquiry under section 41, the professional board may issue a summons as prescribed on which an endorsement is made by the professional board or the registrar that the registered person may admit that he or she is guilty of the said conduct and that he or she may pay the fine stipulated without appearing at the inquiry.⁶⁹

An admission of guilt may have serious consequences for a practitioner if a civil suit for damages is brought against him or her by the patient. Such an admission will strengthen the case against the practitioner if it is used by the patient's legal representatives.⁷⁰

6. Professional Conduct Inquiries

The Act provides for the investigation of complaints of alleged unprofessional conduct against registered practitioners. The position is summarised in a concise manner by Mhlantla JA in *Roux v Health Professions Council of South Africa and Another*:

“...section 3(n) empowers a council to investigate complaints against health practitioners and to ensure that appropriate disciplinary action is taken against such persons in terms of the Act. Section 41(1) confers on the professional board the

⁶⁸ S 41A(8)(b)(iii).

⁶⁹ S 42(8)-(9).

⁷⁰ Strauss (1991) 371.

power to institute inquiries into complaints, charges or allegations of unprofessional conduct. A board may in terms of section 15(5)(f) establish committees comprising such persons as the board may deem fit, and shall include at least one member of the board. It may delegate to such committee such of its powers as it may determine.

In terms of section 61(h)(i) of the Act, the Minister is empowered, after consultation with the council, to make regulations relating to the manner in which complaints, charges or allegations brought against a registered person shall be lodged”.⁷¹

The regulations concerning the disciplinary procedures of the HPCSA and professional boards make provision for the lodging of complaints, mediation by an ombudsman, a preliminary inquiry and a disciplinary inquiry.⁷²

6.1 Lodging of Complaints

Complaints must be lodged in writing and are submitted to the registrar, who then has to: Peruse and analyse the complaints received; categorise the complaints according to their significance and seriousness; record each complaint against the name of the respondent concerned as it appears in the register; and refer complaints of minor transgressions to the ombudsman for mediation.⁷³

6.2 Mediation by Ombudsman

Cases of minor transgressions referred to the ombudsman must be mediated with the view of resolving such matters.⁷⁴ If the matter cannot be resolved through mediation it has to be referred to the registrar for preliminary investigation. Matters

⁷¹ *Roux v Health Professions Council of South Africa and Another* [2012] 1 All SA 49 (SCA) at 55.

⁷² Health Professions Council of South Africa: Regulations relating to the conduct of inquiries into alleged unprofessional conduct GN 102 in GG 31859 of 6 February 2009.

⁷³ Reg 2.

⁷⁴ An ‘ombudsman’ is a person appointed by the council to mediate in the case of minor transgressions referred to him or her by the registrar for mediation.

falling outside of the jurisdiction of the council are referred to the appropriate bodies or tribunals and the complainant is informed thereof.⁷⁵

After receiving a complaint for mediation an ombudsman may call for further information in any manner he or she deems appropriate, from any person who may be able to assist in the mediation to resolve the matter.⁷⁶ Once the information has been received the ombudsman must consider the matter and mediate between the parties.

The ombudsman must then make a determination on the matter and require the parties to indicate whether or not they will abide by the determination.⁷⁷ If the parties agree to abide by the determination, it will then be confirmed in writing and be binding on both parties as a final resolution of the matter.⁷⁸

If either party does not agree to abide by the determination, the matter must be referred to the registrar for preliminary investigation.⁷⁹ It must be noted that all information obtained by the ombudsman is confidential and privileged and may not be considered by the preliminary committee of inquiry if a matter is referred for preliminary investigation.⁸⁰

6.3 Preliminary Inquiry

After receiving and registering a complaint, the registrar must notify the respondent thereof.⁸¹ Copies of the complaint and further information or affidavits need to be forwarded to the respondent. The registrar must also request a written response

⁷⁵ Reg 3(1).

⁷⁶ Reg 3(2).

⁷⁷ Reg 3(3).

⁷⁸ Reg 3(4).

⁷⁹ Reg 3(5).

⁸⁰ Reg 3(6).

⁸¹ A 'complaint' means any information in writing regarding alleged unprofessional conduct by a person registered under the Act that comes to the attention of the registrar or the council or a professional board or an ombudsman, or a complaint, charge or allegation of unprofessional conduct against such person.

from the respondent, which must be submitted within 40 working days after receiving notification.⁸²

The respondent has to be warned that the written response may be used as or in evidence against him or her. If the respondent fails to submit a written response the complaint and further information or affidavits will be submitted to the preliminary committee of the inquiry, without the respondent's written response.⁸³

The registrar must advise the respondent that failure to respond will constitute contempt of council and that a response may also just consist of a written communication that he or she wishes to invoke his or her right to remain silent.⁸⁴

The registrar may refer the complaint directly to the preliminary committee of inquiry or the chairperson of such committee for instructions on the information required to complete a full investigation of the matter, or direct that an investigation in terms of section 41A be conducted.⁸⁵

After gathering further information and the written response as prescribed, the registrar must submit the complaint along with the above-mentioned particulars to the preliminary committee of inquiry.⁸⁶ The preliminary committee of inquiry may after due consideration of the complaint, any further information and the respondent's explanation, decide that there are no grounds for taking further action

⁸² Strauss (1991) 370. The written response is known as a 'please explain' letter in medical circles and Strauss advises practitioners to obtain legal advice when confronted with a complaint of this nature.

⁸³ The preliminary committee of inquiry may after due consideration of the matter in terms of regulation 4(3), direct the registrar to issue a notice in writing to the respondent, instructing him or her to appear in person with his or her legal representative before the preliminary committee of inquiry to inquire why he or she did not respond to the council correspondence and to give his or her response to the complaint or exercise his or her right to remain silent. The respondent may be found guilty contempt of council and a penalty may be imposed. See in this regard regulation 4(4)-(6).

⁸⁴ Reg 4(1)(b).

⁸⁵ Reg 4(1)(c)-(d).

⁸⁶ Reg 4(2).

on the matter.⁸⁷ The preliminary committee of inquiry must then note and accept the respondent's explanation, and give its reasons for so noting and accepting the explanation, and direct the registrar to communicate its decision in writing to the complainant and the respondent stating the reason for the decision.⁸⁸ The complainant may, however, still approach the Court for an order to compel the institution of a professional conduct inquiry. It must be noted that the courts would only interfere with a decision of the council in exceptional circumstances.⁸⁹

If the preliminary committee decides that there are grounds for a professional conduct inquiry into the conduct of the respondent, it must direct that an inquiry be held. The registrar must then communicate the decision in writing to the parties and arrange for the holding of such inquiry, or allow the respondent to pay an admission of guilt fine in terms of section 42(8) and (9) of the Act.⁹⁰ A preliminary committee of enquiry is not concerned with establishing whether the charge will actually be proved eventually. It is only concerned with the question of whether there ought to be an enquiry at all.⁹¹

In the instances where the preliminary committee of inquiry finds that the respondent acted unprofessionally, but the conduct was found to constitute only a minor transgression, the preliminary committee of inquiry must determine a suitable penalty to be imposed.⁹²

The registrar must communicate the charges and the decision in writing to the respondent, stipulating that the penalty must be accepted or rejected within 14 days from the date of receipt of the communication. If the penalty is accepted by the respondent, proof of compliance must accompany the notice of acceptance and the

⁸⁷ Strauss (1991) 371. In many cases a doctor's explanation will be the end of the matter as the committee considers it along with the other information obtained and then come to the conclusion that the complaint would not constitute unprofessional conduct.

⁸⁸ Reg 4(7).

⁸⁹ Strauss (1991) 372, citing *Veriava and Others v President, SA Medical and Dental Council and Others*.

⁹⁰ Reg 4(8).

⁹¹ *Tucker and Another v SA Medical and Dental Council and Others* [1980] 3 All SA 632 (T) at 638.

⁹² Reg 4(9). A suitable penalty in this instance would be one or more of the penalties provided for in section 42(1)(a) and (d).

matter will be regarded as finalised.⁹³ If no response is received by the due date an inquiry into the professional conduct of the respondent must be arranged and the formulated charges and penalty may no longer be applied to the matter.⁹⁴

A committee of preliminary inquiry ensures that only suitable complaints are proceeded with, it has been described as fulfilling a sifting function. The committee consists of health professionals who possess the necessary skills to decide whether complaints before it are warranted and if there are grounds on which to conduct an inquiry into unprofessional conduct. It is the committee's function to specify the conduct which must be subject to the inquiry.⁹⁵

6.4 Arranging an Inquiry

After the receipt of a directive in terms of regulation 4(8) or a notice of rejection of penalty or if no response is received by the due date as contemplated in regulation 4(9)(b), the registrar must issue a notice to the respondent stating the date and time when and the place where the inquiry will be held and enclose a charge sheet as formulated by the *pro forma* complainant.⁹⁶

The formulation of a charge sheet constitutes administrative action as defined in section 1 of the Promotion of Administrative Justice Act⁹⁷ and can be subject to review.⁹⁸ Even if that was not the case, the committee and the *pro forma* complainant exercise public power and the principle of legality applies to every exercise of public power, thus providing a safeguard even when an action does not qualify as administrative action. Administrative authorities cannot act in a manner which is not in accordance with their statutory powers. The *pro forma* complainant has a duty to act in accordance with the instructions of the committee and will act

⁹³ Reg 4(9)(a).

⁹⁴ Reg 4(9)(b).

⁹⁵ *Roux v Health Professions Council of South Africa and Another* at 56.

⁹⁶ Reg 5(1). For an example of a charge sheet in case law, see *Health Professions Council of SA v De Bruin* [2004] 4 All SA 392 (SCA) at [11].

⁹⁷ Promotion of Administrative Justice Act 3 of 2000.

⁹⁸ *Roux v Health Professions Council of South Africa and Another* at 58-59.

outside of his authority if he adds a further charge to the charge sheet on his own accord, without reference to the committee.⁹⁹

The notice and charge sheet must be served or posted to the respondent at least 60 days prior to the date of the inquiry and a copy of the notice and charge sheet must be served or posted to the respondent's legal representative, if one was appointed at the time.¹⁰⁰

Further particulars about the charges may be requested by the respondent or his or her legal representative; such a request must be received by the *pro forma* complainant, at least 30 days before the date of the inquiry.¹⁰¹ A written reply to the request for further particulars must be furnished to the respondent or his or her legal representative within 14 days from the date of the receipt of the request.¹⁰²

It would be unwise for a practitioner to conduct his own defence as the charges may be of a serious nature and the facts may be complex.¹⁰³

6.5 Constitution of the Professional Conduct Committee

A professional conduct committee is composed of at least: Two public representatives, one of whom must be the chairperson; two persons registered in the profession in which the respondent is registered, at least one of whom must be registered in the same discipline as the respondent; one member of the board; and one legal assessor.¹⁰⁴

⁹⁹ *Ibid.*

¹⁰⁰ Reg 5(2).

¹⁰¹ Reg 7(1). The *pro forma* complainant does not need to respond to any request if it is received less than 30 days before the inquiry. See regulation 7(3) in this regard.

¹⁰² Reg 7(2).

¹⁰³ Strauss (1991) 371.

¹⁰⁴ Reg 6.

6.6 Pre-Inquiry Conference

A pre-inquiry conference must be arranged by the *pro forma* complainant in order to determine the issues in the dispute. Both parties and their legal representatives must attend the conference, which must be arranged on any date at least seven days before the date of the inquiry.¹⁰⁵

At the pre-inquiry conference the respondent must indicate the exceptions, objections or points *in limine* he or she intends to raise.¹⁰⁶ The respondent must also indicate how he or she intends to plead to the charge or charges.¹⁰⁷

The parties are required to exchange copies of all documents, reports, notes, X-rays and other exhibits which they intend to use at the inquiry, the originals may also be perused.¹⁰⁸ The parties may make admissions with regard to allegations or exhibits.¹⁰⁹

A summary of the opinion of an expert witness that a party intends to call at the inquiry must also be furnished to the other party and any other matter concerning the inquiry must be resolved.¹¹⁰

6.7 Procedure at an Inquiry

A professional conduct committee is constituted to hear proceedings at an inquiry and is for all intents and purposes a court.¹¹¹ Although not as formal, and the rules of admissibility of evidence are not applied as rigidly, the procedure at an inquiry is very similar to that of a trial.¹¹² Carstens and Pearmain state that a professional conduct

¹⁰⁵ Reg 8(1).

¹⁰⁶ Reg 8(1)(a).

¹⁰⁷ Reg 8(1)(b).

¹⁰⁸ Reg 8(1)(c)-(d).

¹⁰⁹ Reg 8(1)(e).

¹¹⁰ Reg 8(1)(f)-(g).

¹¹¹ Strauss (1991) 373.

¹¹² *Ibid.*

committee functions as an administrative body which is *quasi-judicial* in nature and as such is bound by the Constitution and the Promotion of Administrative Justice Act.¹¹³ All respondent practitioners are thus afforded a right to fair administrative action that is lawful, reasonable and procedurally fair.¹¹⁴ The procedure to be followed at such an inquiry is set out in the regulations.¹¹⁵

The chairperson of the professional conduct committee must ask the respondent or his or her legal representative to plead to the charge(s) and then record the plea.¹¹⁶

If the respondent pleads guilty to the charge(s), the professional conduct committee must ask the respondent or his or her legal representative questions so as to ascertain whether all the elements of the charge(s) are admitted.¹¹⁷ If that is the case, the *pro forma* complainant must address the professional conduct committee and indicate whether the plea of guilty is accepted, after which the chairperson must make a finding of guilty and allow the parties to address the committee.¹¹⁸

If the respondent pleads not guilty to the charge(s), or a plea of not guilty is entered or if a plea of guilty is not accepted by the *pro forma* complainant, the chairman must allow the complainant to: Address the professional conduct committee; lead evidence in support of his or her case; re-examine witnesses after cross-examination by the respondent or his or her legal representative; and thereafter close his or her case.¹¹⁹

The onus of proof lies with the *pro forma* complainant, who must prove on a preponderance of probabilities that the conduct of the respondent was of an unprofessional nature. The proven facts therefore need to *prima facie* support a finding of disgraceful or improper conduct.¹²⁰

¹¹³ Carstens & Pearmain (2007) 274.

¹¹⁴ *Ibid.*

¹¹⁵ Reg 9.

¹¹⁶ Reg 9(1).

¹¹⁷ Reg 9(3).

¹¹⁸ Reg 9(4)-(5). The parties are allowed to address the committee in accordance with regulation 9(22).

¹¹⁹ Reg 9(6).

¹²⁰ Carstens & Pearmain (2007) 275.

After the *pro forma* complainant has closed his or her case the respondent or his or her legal representative may apply for his or her discharge.¹²¹ The *pro forma* complainant must be given the opportunity to reply to such an application.¹²² If the application for discharge is dismissed, the respondent or his or her legal representative may address the professional conduct committee and lead evidence in support of his or her case, re-examine witnesses after cross-examination by the complainant and thereafter close his or her case.¹²³

Witnesses may be questioned by the professional conduct committee to clarify issues arising from their evidence and the parties are then allowed to further cross-examine or re-examine the witness on those clarified issues.¹²⁴

After all the evidence has been adduced the *pro forma* complainant and respondent or his or her legal representative may address the professional conduct committee on the evidence and the legal position.¹²⁵ At the conclusion of the hearing the professional conduct committee must deliberate *in camera* and then, within a period as may be determined, inform the parties of its findings.¹²⁶

6.7.1 A Finding of Poor Performance

The findings of the professional conduct committee may include a finding of poor performance on the part of the respondent.¹²⁷ The committee may then be

¹²¹ Reg 9(7).

¹²² Reg 9(8).

¹²³ Reg 9(10).

¹²⁴ Reg 9(12)-(13).

¹²⁵ Reg 9(14).

¹²⁶ Reg 9(20). For an example of a finding by the committee and reasons for the finding in case law, see *Health Professions Council of SA v De Bruin* at [12] and [13].

¹²⁷ 'Poor performance' means negligence and conduct on the part of a practitioner which falls short of the required standards or generally acceptable norms in health care and which is found to be due to a lack of clinical or related skills or adequate knowledge of the management of patients or a particular health condition.

addressed on the appropriateness of a full or partial referral of the matter to a performance assessment committee.

The performance assessment committee can then inquire into the performance of the respondent and make a determination on the appropriate management thereof.¹²⁸ In the instances where the evidence also points to unprofessional conduct, practice restrictions may be imposed along with a referral to a performance assessment committee. The performance assessment committee may direct the registrar to arrange a performance assessment.¹²⁹

6.7.2 A Finding of Guilt

If the respondent is found guilty of unprofessional conduct the *pro forma* complainant must address the committee and furnish details of previous convictions of the respondent on unprofessional conduct under the Act.¹³⁰ The *pro forma* complainant may also address the professional conduct committee on a suitable penalty and lead evidence in support of imposing such penalty.¹³¹

After the *pro forma* complainant has addressed the professional conduct committee, the respondent or his or her legal representative may address the committee on the personal circumstances of the respondent. The committee may also be addressed on a suitable penalty to be imposed and evidence may be lead in support of such penalty and in mitigation of the penalty recommended by the *pro forma* complainant. The *pro forma* complainant is then given an opportunity to reply in aggravation of the penalty.¹³²

The professional conduct committee deliberates *in camera* on the appropriate penalty to impose and the chairperson must inform the parties of the penalty decided

¹²⁸ Reg 9(21).

¹²⁹ Reg 9(23)

¹³⁰ Reg 9(22)(a).

¹³¹ Reg 9(22)(b).

¹³² Reg 9(22)(c).

on.¹³³ The finding made and penalty imposed shall be of force and effect from the date determined by the committee.¹³⁴

6.8 Performance Assessment

A performance assessment is held by the performance assessment committee to assess the areas of poor performance as identified by the professional conduct committee.¹³⁵

A performance assessment committee is composed of three registered practitioners from the same discipline as the respondent.¹³⁶ The manner in which the performance assessment is to be conducted must be determined by the performance assessment committee.¹³⁷

At the conclusion of the assessment the committee must make a determination on the appropriate management of the respondent's poor performance and give directives, which must be adhered to by the respondent to improve on his or her performance. If the respondent fails to adhere to the directives the committee may direct the registrar to suspend the respondent from practicing his or her profession until the directives have been complied with.¹³⁸ The respondent is required to submit reports as determined by the committee, to enable it to make a final determination on the performance of the respondent.¹³⁹

If the performance assessment committee is satisfied that the respondent has acquired the required skills to enable him or her to perform optimally in practicing his

¹³³ Reg 9(22)(d).

¹³⁴ Reg 9(22)(e).

¹³⁵ A 'performance assessment' means an assessment conducted by a performance assessment committee to inquire into and make a determination on the clinical or related performance of a practitioner against whom a professional conduct committee found evidence of poor clinical or related performance, or of a pattern of such performance, at an inquiry.

¹³⁶ Reg 10(1).

¹³⁷ Reg 10(3).

¹³⁸ Reg 10(5).

¹³⁹ Reg 10(4).

or her profession, it may lift the practice restrictions imposed by the professional conduct committee.¹⁴⁰ If the performance assessment committee is not satisfied that the respondent has acquired the required skills, the committee must determine the skills the respondent requires to be able to practice his or her profession with reasonable skill.¹⁴¹

6.9 Presentation of Evidence at a Disciplinary Hearing

All oral evidence is taken under oath or on affirmation administered by the chairperson of the professional conduct committee.¹⁴² Evidence on affidavit is admissible; the opposing party may require the deponent of such affidavit to be present for purposes of cross-examination.¹⁴³ Witnesses may be subpoenaed to appear before a professional conduct committee to give oral evidence or to produce any book, record, document or thing.¹⁴⁴

The record or any portion thereof, of a lawfully constituted court, inquest court or disciplinary tribunal from any jurisdiction is acceptable as *prima facie* evidence if it has been certified to be a true copy by that court or disciplinary tribunal. On application by either party and for the purposes of cross-examination, a witness whose evidence appears in a record of a court or disciplinary tribunal and which is presented as *prima facie* evidence may be ordered to attend the inquiry.¹⁴⁵

6.10 Continuation of Disciplinary Inquiries

If a member of the professional conduct committee is unable to serve at any time after a plea has been entered, the inquiry will proceed, provided that not less than

¹⁴⁰ Reg 10(7).

¹⁴¹ Reg 10(8).

¹⁴² Reg 9(17).

¹⁴³ Reg 9(18).

¹⁴⁴ Reg 15.

¹⁴⁵ Reg 9(19).

four of the original members are available to continue with the inquiry.¹⁴⁶ Where the chairperson is unable to serve after a plea has been entered, the inquiry will proceed with the remaining public representative as the new chairperson.¹⁴⁷

6.11 Accessibility of an Inquiry

The proceedings at an inquiry are open to the public, however there are certain exceptions.¹⁴⁸ If there is good cause shown or at the discretion of the committee evidence may be heard *in camera*.¹⁴⁹ An order can be made prohibiting the publishing of information which is likely to reveal the identity of a particular person other than the respondent.¹⁵⁰ Any person who contravenes or fails to comply with such an order is guilty of an offence and liable on conviction to a fine or imprisonment.¹⁵¹

The council must keep recordings of all inquiries and a copy of the transcription of such a recording must, on written request, be made available to the complainant, the respondent or any other party who has a substantial interest in the matter.¹⁵²

6.12 Publication in the Gazette

The name of the respondent, the charge(s) on which he or she has been found guilty and the penalty imposed is published in the *Gazette*.¹⁵³

¹⁴⁶ Reg 12(1).

¹⁴⁷ Reg 12(2).

¹⁴⁸ Reg 13(1).

¹⁴⁹ Reg 13(2)(b).

¹⁵⁰ Reg 13(2)(c).

¹⁵¹ Reg 13(3).

¹⁵² Reg 13(4).

¹⁵³ Reg 14.

6.13 Rights of Practitioners and Powers of Professional Boards regarding Disciplinary Enquiries

A practitioner will be afforded the opportunity of answering the charge and being heard in his or her defence if his or her conduct is subjected to a disciplinary inquiry.¹⁵⁴ Professional boards may take evidence, summon witnesses and require the production of any book, record, document or thing for the purposes of an inquiry.

A person summoned to appear before a professional board or to produce certain materials is bound to obey such a summons and may be found guilty of a criminal offense if he or she refuses. Every person summoned shall be entitled to all privileges which a witness in a court of law is entitled.¹⁵⁵

A person with adequate experience in the administration of justice may be appointed as an assessor to advise on matters of law, procedure or evidence at an inquiry.¹⁵⁶

A disciplinary committee and the HPCSA should see that a charged practitioner is treated in a just and fair manner and is given a proper hearing. Only after misconduct has been proven does the council fulfil its function of protecting the public, preventing and discouraging future misconduct and guarding the dignity of the profession by imposing a penalty.¹⁵⁷

6.14 Postponement and Suspension of Penalties

A professional board that has found a person guilty of unprofessional conduct may postpone the imposition of the penalty or order that the execution of certain imposed penalties be suspended for a period and on conditions as it may determine.¹⁵⁸ The

¹⁵⁴ S 42(2).

¹⁵⁵ S 42(4).

¹⁵⁶ S 42(5).

¹⁵⁷ *Marais v Interim Nasionale Mediese en Tandheelkundige Raad van Suid-Afrika en 'n Ander* [1997] 4 All SA 260 (O) at 268.

¹⁵⁸ S 43(1).

professional board may inform the person concerned that a penalty will not be imposed, if at the end of the period of postponement, the person concerned has complied with all the relevant conditions.¹⁵⁹ The same applies where a penalty has been suspended, the penalty will not be executed if the person concerned observed all the relevant conditions.¹⁶⁰ If the person concerned fails to observe any of the conditions of suspension, the professional board must bring the penalty into operation, unless the person concerned can satisfy the board that the non-observance of the condition was due to circumstances beyond his or her control.¹⁶¹

6.15 Appeal to the Appeal Committee

The respondent or the *pro forma* complainant may appeal to the appeal committee against the findings or penalty of the professional conduct committee.¹⁶²

The appellant must within 21 days from the date of the decision of the professional conduct committee, submit to the registrar a written notice of his or her intention to appeal.¹⁶³ A copy of the transcript of the proceedings of the inquiry must be provided to the appellant within 60 days after reception of the written notice to appeal.¹⁶⁴

The appellant must deliver six copies of his or her papers, setting out the grounds of the appeal and a summary of argument to the registrar and one copy to the other party within 30 days from the date on which he or she received the copy of the transcript.¹⁶⁵ The other party must then deliver six copies of his or her reply to the appellant's papers, containing his or her summary of arguments to the registrar.¹⁶⁶ Within 14 days from the date on which the other party submitted his or her reply, the

¹⁵⁹ S 43(2)(a).

¹⁶⁰ S 43(2)(b).

¹⁶¹ S 43(2)(c).

¹⁶² Reg 11(1).

¹⁶³ Reg 11(2).

¹⁶⁴ Reg 11(3).

¹⁶⁵ Reg 11(4).

¹⁶⁶ Reg 11(5). Provision is made for an application for indulgence for late submissions in regulation 11(6).

respondent must also deliver his or her reply to the registrar and the other party.¹⁶⁷ If no reply is submitted by the appellant, the registrar must advise the parties in writing thereof and of the date on which the matter will be heard by the appeal committee.¹⁶⁸

The appeal committee considers the appeal on the papers submitted to it and allows representations and arguments from both parties and their legal representatives. After deliberation on the matter *in camera* the appeal committee advises the parties of its findings, which must be confirmed by the registrar in writing.¹⁶⁹

The decision of the appeal committee is of force and effect from a date as determined by the committee and may be set aside by a High Court if approached in terms of section 20 of the Act.¹⁷⁰

6.16 Appeal to Court

Any person who is aggrieved by any decision of the council, a professional board or a disciplinary appeal committee, may appeal to the appropriate High Court against such decision.¹⁷¹ Notice of appeal must be given within one month from the date on which such decision was given.¹⁷²

The appeal created in section 20 of the Act is an appeal in the ordinary sense. It constitutes a rehearing on the merits, but it is limited to the information and evidence on which the original decision was made. The only determination is whether the decision was right or wrong. The council is the statutory *custos morum* of the medical profession and is composed of members of the profession who appreciate the standards demanded of it. As such the council has considerable advantages

¹⁶⁷ Reg 11(7).

¹⁶⁸ Reg 11(8).

¹⁶⁹ Reg 11(9).

¹⁷⁰ Reg 11(11).

¹⁷¹ S 20(1).

¹⁷² S 20(2).

over a court in the consideration and evaluation of the standards sought to be maintained.¹⁷³

When the council declares that professional misconduct by a practitioner is serious, it is emphatically accepted, unless there are compelling reasons to the contrary. The courts are mindful not to usurp the function of the HPCSA in determining what is or is not improper or disgraceful conduct.¹⁷⁴ The courts act with restraint and are very cautious when interfering with findings of the committee.¹⁷⁵

Chapter One: Conclusion

This chapter examined the powers of the Health Professions Council of South Africa, more specifically the disciplinary powers thereof. In this regard Section 3(n) of the Health Professions Act empowers the Council to investigate complaints against registered health practitioners in order to ensure that appropriate disciplinary action is taken against such individuals to protect the interest of the public. Section 41(1) confers on the Professional Board, the power to institute inquiries into any complaint, charge or allegation of unprofessional conduct against registered practitioners. In accordance with section 15(5)(f) a Professional Board may establish committees as it deems necessary and delegate its powers to it. Section 61(1)(h)(i) of the Act empowers the

¹⁷³ *Health Professions Council of SA v De Bruin* at 403.

¹⁷⁴ Where the conduct of a medical practitioner falls outside of the scope or context of the doctor/patient relationship, a court would not be as hesitant to interfere, with a decision of the council to impose severe penalties. See the *De Bruin*-case in this regard. Dr De Bruin's conduct was indeed reprehensible. However, it was found that the conduct did not take place in the context of a usual doctor-patient relationship.

¹⁷⁵ *De Beer v Health Professions Council of South Africa* 2005 (1) SA 332 (T) at 343; *Preddy and Another v Health Professions Council of SA* at 87.

Minister, after consultation with the council, to make regulations relating to the manner in which complaints, charges or allegations brought against a registered person shall be lodged.

The chapter examined the latest published regulations pertaining to Professional Conduct Inquiries. Provision is now made for the mediation of minor transgressions by an ombudsman. The ombudsman must refer cases that could not be resolved through mediation to the registrar for preliminary investigation.

The chairperson of the professional board must, at the request of the registrar, appoint a professional conduct committee. The professional conduct committee must now be composed of certain specified members as well. It must include at least two persons registered in the same profession of the respondent, one of whom must be registered in the same discipline. A legal assessor must also form part of the professional conduct committee.

Pre-inquiry conferences are now mandatory and any party that fails to attend may be ordered to do so and pay the costs as determined by the registrar in respect of the day wasted because the hearing could not proceed. Minutes must also now be kept at such a conference and be signed by both parties.

A finding of poor performance is also a new addition to the regulations; such a finding may require the referral of the matter to a performance assessment committee. A performance assessment will then be arranged.

In terms of the latest regulations, the registrar must now also publish the name of the respondent, the charge(s) on which he or she has been found guilty and the penalty that has been imposed in the *Gazette*.

This chapter has provided an overview of the HPCSA in its regulatory capacity and has demonstrated what sanctions may be imposed upon practitioners found guilty of unprofessional conduct or poor performance. In the following two chapters the law of obligations as it relates to the doctor will be considered.

HPCSA Diagram:

This diagram was created by the author and was used during a lecture on the subject.

Health Professions Act

[Key Act governing the health profession]

HPCSA

[Statutory body, main regulator of the health profession]

Professional Boards

- Promote health
- Education and training
- Maintain standards

Medical and Dental Professional Board + others

Objects: Maintain dignity and integrity

Protect the public
Powers: Remove names from register
Suspend practitioners
Recognise qualifications

Custos morum of the medical profession
Guardian of prestige, status and dignity
Power to establish Committees
No person may practice unless registered – criminal offence

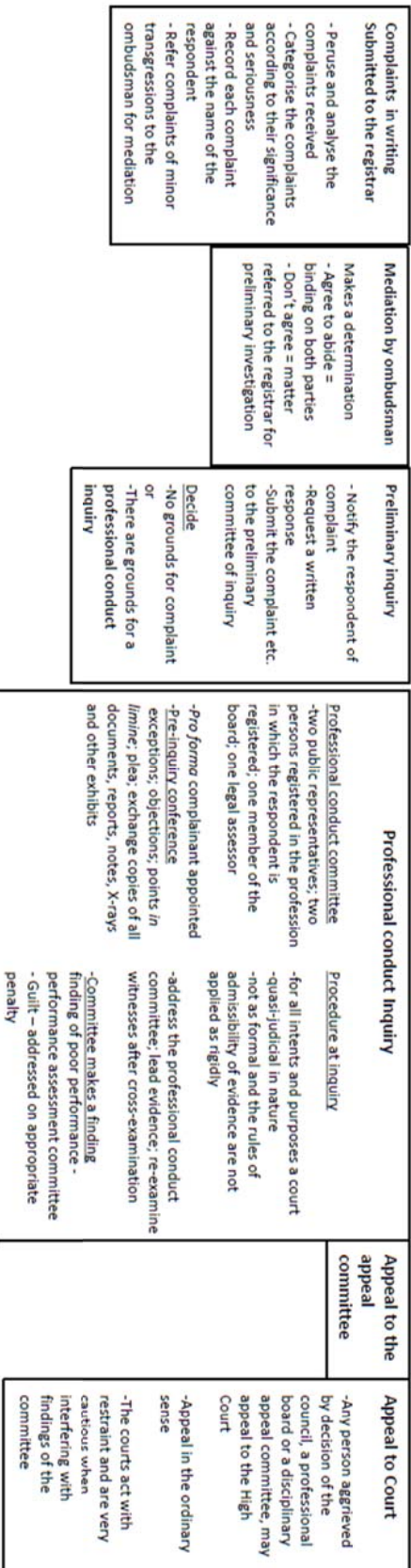
Disciplinary Proceedings

- "unprofessional conduct" -improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy

- Code of Ethical Rules and Rulings of the HPCSA and Professional guidelines

Onus of proof – Complainant - Prove on a preponderance of probabilities

Penalties:
(a) a caution or a reprimand or a reprimand and a caution;
(b) suspension for a specified period from practising or performing acts specially pertaining to his or her profession;
(c) removal of his or her name from the register;
(d) a prescribed fine;
(e) a compulsory period of professional service as may be determined by the professional board; or
(f) the payment of the costs of the proceedings or a restitution or both.



Chapter Two: The Law of Obligations (Contractual Liability)

Overview

In this chapter the contractual relationship between the doctor and patient will be examined. The nature of the agreement, the commencement thereof and the terms typically applicable to such a contract will be scrutinised. The rights and duties of the practitioner as a party to the agreement will be addressed. A doctor who enters into a contractual relationship with a patient incurs a number of different obligations. These include the duty to treat the patient and to attend to the patient once treatment has begun. The doctor would also need to obtain the patient's consent. The duty to obtain legally valid informed consent will be examined in this regard. Other related matters such as patient autonomy, information presented regarding the diagnosis, and the nature and scope of the disclosure will also form part of the discussion. Practitioners are expected to treat patients with the due care and skill that can be reasonably expected from a practitioner in the particular doctor's branch of the profession. This duty to exercise due care and skill will also be accordingly examined. Thereafter the inquiry will shift to the legal consequences of a breach of contract.

1. Introduction

The relationship between the patient and a doctor or hospital is generally governed by the law of obligations, meaning the law of contract and the law of delict.¹⁷⁶ A contractual relationship is entered into when a patient consults a doctor in private practice or presents for medical treatment at a hospital.¹⁷⁷ The contract is established when both parties reach consensus.¹⁷⁸ However, in practice a patient is usually required to sign a hospital admission form and consent in writing to surgery. A doctor who fails to adhere to the agreement entered into between him or her and the patient, could be held liable for such breach of contract and may incur damages.¹⁷⁹ The doctor typically undertakes to treat or operate upon the patient with the due competence, care and skill which may be expected from a medical practitioner in the particular branch of the profession.¹⁸⁰ As a duty of care may underlie both contract and delict, liability for both may arise from the same act or omission by a doctor or hospital.¹⁸¹ If there is no contract in place between the patient and a doctor or hospital, the relationship will be governed by the law of delict.¹⁸²

With the introduction of the Constitution, national legislation and the fact that the majority of South African citizens are dependent on the public health sector for their health services, there has been a definite shift to public law considerations as opposed to private law considerations, which have traditionally governed the relationship between doctor and patient.¹⁸³ The legal basis of the traditional

¹⁷⁶ Strauss & Strydom (1967) 104; Claassen & Verschoor (1992) *Medical Negligence in South Africa* 115; Dada & McQuoid-Mason (eds) (2001) *Introduction to Medico-Legal Practice* 5; Carstens & Pearmain (2007) 283; Mcquoid-Mason (2008) LAWSA 30; Slabbert (2011) 69.

¹⁷⁷ Slabbert (2011) 69; Mcquoid-Mason (2008) LAWSA 30.

¹⁷⁸ Claassen & Verschoor (1992) 115.

¹⁷⁹ Mcquoid-Mason (2008) LAWSA 30.

¹⁸⁰ Slabbert (2011) 71.

¹⁸¹ *Id* 69.

¹⁸² *Ibid*.

¹⁸³ Carstens & Pearmain (2007) 283; Slabbert (2011) 69.

relationship is now permeated by constitutional values and subject to purposive interpretation.¹⁸⁴

2. The Contractual Relationship between Doctor and Patient

2.1 Nature of the Agreement

The agreement between a patient and a doctor is ordinarily considered to be that of letting and hiring of work, in some circumstances however, the agreement may be that of letting and hiring of services.¹⁸⁵ A contract of sale could also be entered into between the parties, as in the case where a dentist supplies a patient with a denture or where a hospital supplies and fits a patient with prosthesis.¹⁸⁶

2.2 Commencement of the Agreement

As mentioned above, a contract between the parties comes into existence by mere consensus and requires no legal formalities.¹⁸⁷ Generally an agreement will be entered into verbally or even tacitly.¹⁸⁸ In private practice patients and doctors normally enter into tacit agreement, which is initiated by the patient consulting the

¹⁸⁴ *Ibid.*

¹⁸⁵ Strauss (1991) 69; Slabbert (2011) 70 (citing *Myers v Abramson* 1951 (3) SA 438 (C), in which the contract between the parties was held to be one of letting and hiring of services).

¹⁸⁶ *Tulloch v Marsh* 1910 TPD 453 at 455 “When the client or customer supplies the material, and the other party the work, then it is letting and hiring. When the workman provides an article manufactured by himself out of his own material, which he supplies to the customer, then the contract is one not of letting and hiring, but sale.”; *Sutherland v White* 1911 EDL 407; *Oates v Niland* 1914 CPD 976; *Shiels v Minister of Health* [1974] 3 All SA 116 (RA); Strauss (1991) 69; Carstens & Pearmain (2007) 420; Slabbert (2011) 70.

¹⁸⁷ Claassen & Verschoor (1992) 115.

¹⁸⁸ Strauss & Strydom (1967) 105.

doctor and the doctor attending to the patient.¹⁸⁹ The implied terms of such a tacit contract will depend upon the specific circumstances of the case.¹⁹⁰ Where more serious procedures or operations are performed a patient is usually required to enter into a written agreement, wherein the particulars of the intervention as well as matters incidental thereto are specified.¹⁹¹ A written agreement sets out the scope of the doctor's competencies and seeks to capture the patient's consent with regard to the procedure.¹⁹² Such an agreement could also be relevant in determining delictual liability.¹⁹³

Establishing whether a contractual relationship has been entered into between a patient and a doctor is of utmost importance, as proof of the existence of such a relationship would have considerable implications during civil litigation. If a patient is unable to prove the existence of a contractual relationship, his or her chances of a claim succeeding would be greatly diminished.¹⁹⁴

The commencement of a contractual relationship between the patient and doctor will be apparent where an express agreement is entered into. Determining whether a contractual relationship has been entered into in the case of a tacit agreement is less evident. Express contracts, either written or oral, are usually of a more formal nature and would set out the specifics of the diagnosis or treatment.

A doctor generally informs the patient of the treatment and the expected results thereof, this disclosure must consist of sufficient information to enable a patient to make an informed decision.¹⁹⁵ Strauss states that the procedure should be explained in simple terms and in such a manner that would make it possible for the patient to apply his or her mind intelligently.¹⁹⁶ A patient's acceptance would constitute informed consent if the required knowledge, appreciation and acquiescence exist on

¹⁸⁹ Strauss & Strydom (1967) 105; Claassen & Verschoor (1992) 115; Slabbert (2011) 70.

¹⁹⁰ Slabbert (2011) 70.

¹⁹¹ Strauss & Strydom (1967) 105.

¹⁹² *Ibid.*

¹⁹³ *Ibid.*

¹⁹⁴ Strauss & Strydom (1967) 105.

¹⁹⁵ Strauss & Strydom (1967) 104-110; Strauss (1991) 8-10; Slabbert (2011) 70.

¹⁹⁶ Strauss (1991) 9; Carstens & Pearmain (2007) 875.

the part of the patient.¹⁹⁷ The doctrine of informed consent ensures that the patient's right to self-determination and freedom of choice is respected. It also encourages rational decision-making by allowing the patient to consider the benefits and risks involved in order to come to an informed decision.¹⁹⁸

Agreements between healthcare providers and patients are also sometimes reduced to writing.¹⁹⁹ Patients are usually required to sign a pre-printed admission form when being admitted to hospital. This admission form contains a number of provisions relating to, amongst other matters, the payment for costs incurred while in hospital, conditions relating to treatment and most hospitals also include an exemption clause which seeks to restrict their liability. There is very little room for negotiation, the provisions and essential terms all form part of a standard contract and patients seeking to be admitted to hospital are required to sign the agreement.²⁰⁰

Written contracts are also usually entered into before a patient submits to an intervention or undergoes an operation. Such an agreement will include terms relating to the proposed intervention or operation, the procedure to be followed by the doctor, the staff who will assist the doctor during the proposed intervention or operation and the facilities that will be used.²⁰¹

Establishing whether a tacit agreement was entered into is more difficult. A contract between a patient and doctor generally takes the form of a tacit agreement, whereby the doctor undertakes to examine and treat the patient.²⁰² The commencement of such a tacit agreement would be inferred from the conduct of the parties and depends on the specific circumstances of each case.²⁰³ Probably the most obvious situation, in which a tacit contract will arise, will be where a patient consults with the

¹⁹⁷ Carstens & Pearmain (2007) 878; Mcquoid-Mason (2008) LAWSA 32.

¹⁹⁸ Van Oosten *The Doctrine of Informed Consent in Medical Law* (Unpublished LLD Thesis, 1989 UNISA) 446; Carstens & Pearmain (2007) 883; Slabbert (2011) 82.

¹⁹⁹ Carstens & Pearmain (2007) 413.

²⁰⁰ Strauss (1991) 305; Claassen & Verschoor 102-103; Carstens & Pearmain (2007) 413.

²⁰¹ Strauss & Strydom (1967) 104-110; Strauss (1991) 8-10; Mcquoid-Mason (2008) LAWSA 30; Slabbert (2011) 70.

²⁰² Strauss & Strydom (1967) 105; Strauss (1991) 3; Claassen & Verschoor (1992) 115.

²⁰³ Carstens & Pearmain (2007) 345.

doctor and the doctor, as part of the consultation, examines the patient.²⁰⁴ In many cases, however, the existence of a tacit contract will not be as obvious.

2.3 Terms of the Agreement

Where the patient and doctor have entered into a tacit agreement, the nature of the examination, treatment or operation will be determined by the specific surrounding circumstances on a case by case basis.²⁰⁵ A doctor generally agrees to examine, diagnose and treat a patient with the professional expertise, care and judgement reasonably expected from the average or ordinary medical practitioner in the particular branch of the profession, to which the doctor belongs.²⁰⁶ The doctor's conduct must be in accordance with recognised, accepted, customary or usual practices of medicine.²⁰⁷ Any unusual interventions or procedures should be brought to the attention of the patient.²⁰⁸ It is not wise to keep the patient uninformed about his or her condition or the treatment contemplated, as any agreement between the parties could be considered invalid and the absence of consent could result in delictual liability for the doctor.²⁰⁹

A doctor who merely agrees to treat a patient, does not guarantee that such treatment will cure the patient or relieve all ails.²¹⁰ A doctor would normally only

²⁰⁴ *Id* 343.

²⁰⁵ *Ibid.*

²⁰⁶ Strauss & Strydom (1967) 106; Claassen & Verschoor (1992) 116; Carstens & Pearmain (2007) 362. Carstens & Pearmain identified a number of tacit terms, especially relevant in the public health sector context, which may be inferred in health care contracts on the grounds of public policy, fairness and reasonableness.

²⁰⁷ *Van Wyk v Lewis* 1924 AD 438 at 448, 469-470; *Allot v Paterson & Jackson* 1936 SR 221 at 224; *cf. Kovalsky v Krige* (1910) 20 CTR 822 at 823; *Coppen v Impey* 1916 CPD 309 at 314; *Buls v Tsatsarolakis* 1976 (2) SA 891 (T) at 893; *Applicant v Administrator, Transvaal* 1993 (4) SA 733 (W) at 738; *Collins v Administrator, Cape* 1995 (4) SA 73 (C) at 81-82; *Clinton-Parker v Administrator, Transvaal* 1996 (2) SA 37 (W) at 56, 58; Slabbert (2011) 71.

²⁰⁸ Strauss & Strydom (1967) 106.

²⁰⁹ *Ibid.*

²¹⁰ Strauss & Strydom (1967) 106; Dada & McQuoid-Mason (eds) (2001) 5.

undertake to treat a patient with the manner of skill and competence which is reasonably expected from a doctor in his or her particular branch of the profession.²¹¹ Although a doctor may guarantee the success of a procedure or to cure a patient, such an undertaking could have severe adverse consequences on the doctor's liability. A failure to fulfil such a guarantee would expose the doctor to a claim for damages based on breach of contract.²¹² When determining whether a statement amounts to a guarantee in the particular circumstances, it is important to consider that mere words of encouragement by the doctor regarding a patient's situation and prospects of recovery will not constitute a guarantee.²¹³

A doctor in private practice is generally under no obligation to consult with or treat a patient and may accept or refuse patients at will.²¹⁴ The doctor has a duty to refer a patient or to call in a specialist where the diagnosis or treatment falls outside the doctor's range of training or specialisation.²¹⁵ An independent contract, encompassing diagnoses and possibly treatment, is entered into between the patient and the specialist. This is a separate agreement to the one entered into between the patient and the referring doctor.²¹⁶ Likewise, where a doctor requests a colleague to collaborate on a particular case, a separate and independent agreement would have to be entered into between the patient and the colleague.²¹⁷

²¹¹ *Ibid.*

²¹² Strauss & Strydom (1967) 107; Claassen & Verschoor (1992) 116; Slabbert (2011) 72.

²¹³ Strauss & Strydom (1967) 107; Claassen & Verschoor (1992) 116.

²¹⁴ Strauss & Strydom (1967) 104; Strauss (1991) 3.

²¹⁵ Slabbert (2011) 71; Strauss (1991) 280, where the case of *S v Nel* 1987 TPD (unreported) is discussed. Dr Nel, a general practitioner, was attending to a woman during and after the birth of her third child, when complications arising from the removal of the placenta from the patient's uterus, caused massive blood loss. Numerous attempts to remove the placenta by hand were made, all of which were unsuccessful. The patient's husband, being aware of the problems, informed the doctor that there was a specialist on the premises. The doctor however, continued without the help of the specialist, only calling for his help at a much later stage. Unfortunately the doctor had left it too late and the patient died. Dr Nel was found to be negligent in several respects, including his failure to call in a specialist, and was convicted of culpable homicide.

²¹⁶ Strauss & Strydom (1967) 109; Slabbert (2011) 71.

²¹⁷ *Ibid.*

Where the patient and the doctor reach agreement on the course or manner of treatment and the doctor then deviates from the agreed upon intervention or performs an entirely different procedure, the doctor could be held liable for damages as it could constitute a breach of contract.²¹⁸

A doctor may not ethically refuse to treat a patient in a situation where the patient's life or health would be threatened if the patient does not receive immediate medical attention, except where compelling circumstances exist which prevent the doctor from aiding the patient.²¹⁹ A legal duty to act in terms of the common law and the Constitution may also exist depending on the situation.²²⁰

The fact that a doctor agrees to diagnose, treat or operate on a patient does not entitle the patient to radiographs, photographs, films, scans, reports or records taken and compiled by the doctor, unless the agreement between the parties makes provision therefore.²²¹ However, in practice X-ray negatives, scans and reports are often supplied to patients.²²²

A patient, who consults with a doctor, tacitly or expressly agrees to compensate the doctor for services rendered.²²³ In certain circumstances a third party may be expected, in terms of common law, a statutory obligation or an agreed upon term included in the contract between the patient and doctor, to pay the fees incurred by the patient.²²⁴

²¹⁸ Strauss & Strydom (1967) 107.

²¹⁹ Mcquoid-Mason (2008) LAWSA 30.

²²⁰ Strauss (1991) 90; Mcquoid-Mason (2008) LAWSA 30; *Minister van Polisie v Ewels* [1975] 3 All SA 599 (A) at 602-603; *Magware v Minister of Health NO* [1981] 4 All SA 531 (Z) at 534-535; S 27(3) of the Constitution of the Republic of South Africa, 1996.

²²¹ Strauss & Strydom (1967) 108; Slabbert (2011) 72.

²²² Slabbert (2011) 72. S 32 of the Constitution read with the Promotion of Access to Information Act 2 of 2000, gives a patient the right, subject to certain limitations, to receive copies of his or her medical records.

²²³ Strauss & Strydom (1967) 108.

²²⁴ Slabbert (2011) 71; *Behr v Minister of Health* 1961 (1) SA 629 (SR) in which a husband was found to be liable for the medical costs of his wife; S 36(1), 36A and 77 of the Occupational Diseases in Mines and Works Act 78 of 1973; S 42(2) of the Compensation for Occupational Injuries and Diseases Act 130 of 1993; S 18(2) of the Children's Act 38 of 2005.

An agreement between a patient and a doctor, like any other contract, must be legal. An illegal agreement will not create any obligations and will be null and void.²²⁵

3. The Doctor's Rights and Duties

3.1 General

A doctor that undertakes to examine or treat a patient must do so in a manner fitting of the unique relationship that comes into being between physician and patient. Certain distinct rights and duties emanate from the agreement between the parties. A doctor should treat the patient and execute his mandate honestly, faithfully and with care.²²⁶ Claassen and Verschoor rightfully point out that a doctor finds himself in a relationship of significant trust due to the specialised expert knowledge he or she possesses and the fact that services rendered are of a confidential nature.²²⁷ A doctor's visit is almost always a very private and intimate occurrence, one where the patient is in a particularly vulnerable position considering that the average patient is generally ill-informed in medical and related health matters. A patient relies heavily on the doctor's obligation to exercise reasonable care and skill during consultations and treatment.²²⁸

A doctor may be held liable for breach of contract if he or she fails to treat a patient who requires treatment or treats the patient in a negligent manner.²²⁹ Negligent treatment on the part of the doctor may also result in a claim based on delict.²³⁰ In actual fact, in practice most cases dealing with negligent treatment on the part of the

²²⁵ Strauss & Strydom (1967) 110; *Edouard v Administrator, Natal* 1989 (2) SA 368 (D) at 376 and 379.

²²⁶ Strauss & Strydom (1967) 111; Claassen & Verschoor (1992) 116.

²²⁷ Claassen & Verschoor (1992) 116.

²²⁸ Claassen & Verschoor (1992) 116; *Mitchell v Dixon* 1914 AD 519; *Van Wyk v Lewis* 1924 (AD) 438; *Castell v De Greef* [1994] 4 All SA 63 (C) at 81.

²²⁹ Strauss & Strydom (1967) 111; Claassen & Verschoor (1992) 116.

²³⁰ Strauss & Strydom (1967) 111.

doctor are decided on the basis of delict, this however does not preclude the patient from founding his or her claim on either contract or delict, or both.²³¹

3.2 The Duty to Treat the Patient

Whether a duty to treat a patient exists, depends on a number of factors, including whether the patient consults with a doctor in private practice or if the patient consults with a doctor in the public sector.

A doctor in private practice is generally not required to treat any person who seeks to obtain his or her services.²³² In terms of the fundamental principle of freedom of contract a doctor in private practice is considered a free agent and he or she can consequently decide whether or not to enter into a contractual relationship and with whom to enter into such a relationship.²³³

There are, however, exceptions to this rule and a doctor's freedom is qualified in certain circumstances.²³⁴ This will be the case where a doctor has accepted a patient and commenced with a particular treatment. The doctor may not abandon such patient unilaterally, if doing so will result in harm being caused to the patient. The doctor must either continue with the treatment, or with the patient's consent, transfer him or her to a different practitioner.²³⁵ In some emergency cases there may be an ethical duty on the doctor to attend to a patient.²³⁶

²³¹ *Ibid.*

²³² Strauss (1991) 3; Dada & McQuoid-Mason (eds) (2001) 6.

²³³ Slabbert (2011) 73.

²³⁴ Dada & McQuoid-Mason (eds) (2001) 7.

²³⁵ Strauss (1991) 3.

²³⁶ *Id* 25. Strauss refers to a ruling of the SAMDC where it was held: "A medical practitioner is free to decide whomever he will serve. A practitioner may, however, be required to justify his actions should unnecessary suffering or death result from his refusal to attend a patient; in cases of emergency, a practitioner is obliged to render assistance under all circumstances."; Slabbert (2011) 74; *Stoffberg v Elliot* 1923 CPD 148; *Ex Parte Dixie* 1950 (4) SA 748 (W) at 751; *Esterhuizen v Administrator Transvaal* 1957 (3) SA 710 (T) at 718 and 720; *Castell v De Greef* 1994 (4) SA 408 (C) at 420, 421 and 426.

A doctor may also be held liable for damages if he or she unreasonably refuses to treat a patient, if such patient is seriously ill or injured.²³⁷ The Supreme Court of Appeal has held that an omission to act could under certain circumstances result in delictual liability if the omission is considered to be wrongful, as determined with regard to the juristic convictions of society.²³⁸

Contract is regarded as the general legal basis through which a patient receives services from a healthcare provider in the private sector.²³⁹ The position in the public sector is less clear.

There are several characteristics of the relationship between public healthcare providers and patients that seem to indicate that the basis of such relationship is contractual.²⁴⁰ A few examples that lend credence to the notion that the relationship is indeed contractual should be noted. The fact that a patient's informed consent is required is akin to many general principles of the law of contract, such as, consensus, meeting of the minds, contractual capacity and involuntary reliance.²⁴¹

An intention to contract can also potentially be inferred from the classification of patients into different categories and the requirement that such patients must pay a determined amount for services received at a state facility. The obligation to pay for health services may thus also, be indicative of a contractual relationship.²⁴²

A situation, as in *Edouard*, where a patient elects to undergo a specific procedure, which is not essential to the patient's health or well-being may also be relevant when considering what the nature of the relationship between the public healthcare provider and patient is. Whether a contractual relationship exists will for the most part depend on the circumstances of each case and public policy considerations.²⁴³

²³⁷ *Ibid.*

²³⁸ *Minister van Polisie v Ewels* 1975 (3) SA 590 (A).

²³⁹ Carstens & Pearmain (2007) 413.

²⁴⁰ *Id* 404.

²⁴¹ *Ibid.*

²⁴² *Ibid.*

²⁴³ Carstens & Pearmain (2007) 405. For arguments against a contractual relationship, see authors at 406.

Carstens and Pearmain conclude that a contractual relationship most likely does not exist between public healthcare providers and patients, and that patients receive health care services from the state in terms of the relevant empowering statutes. Thus a contractual relationship would not be necessary as the legislation sufficiently governs the situation. Regulations determine payment of fees and patients are entitled to health care services in terms of the Constitution and other relevant national and provincial legislation. A patient, who suffers damages as a result of medical malpractice, can institute a claim under the law of delict. The authors, however state that a contractual fiction in the public health sector, remains useful and serves a purpose, as demonstrated in *Edouard*.²⁴⁴

Doctors who are employed by the state are required to treat all patients who are admitted to the hospital or other health-care facility. They are bound by the terms in their employment contracts, statutory and constitutional obligations which determine that they must attend to all admitted patients in state facilities.²⁴⁵ With regard to the duty to treat patients in the public health sector, the Constitutional Court has held that courts will be slow to interfere with rational decisions taken in good faith by political organs and medical authorities and that as there are limited resources a holistic approach is favoured which would benefit the larger needs of society rather than the specific needs of individuals.²⁴⁶

3.3 Duty to Attend to the Patient Once Treatment has begun

A doctor is under no obligation to take on a case, however if he or she decides to do so and treatment commences, he or she must continue to attend to the patient unless²⁴⁷:

- i) The doctor can hand the case over to another competent medical practitioner;

²⁴⁴ Carstens & Pearmain (2007) 411.

²⁴⁵ *Ibid.*

²⁴⁶ *Soobramoney v Minister of Health, KwaZulu-Natal* [1998] 1 All SA 268 (CC).

²⁴⁷ Mcquoid-Mason (2008) LAWSA 31.

- ii) The doctor issues adequate directions or instructions for additional treatment;
- iii) The patient is cured or there is no need for further treatment;²⁴⁸
- iv) The patient declines further treatment or on own accord insists on being discharged from hospital; or
- v) The doctor informs the patient, by way of reasonable notice, of an intention to discontinue his or her attendance, in which case the doctor should ensure that other facilities are available.

With regard to the doctor who gives the patient reasonable notice of his or her intention to discontinue his or her attendance, the doctor must issue full instructions for further treatment and indicate that he or she is prepared to consult with the medical practitioner who takes over the case and the responsibility of treating the patient.²⁴⁹

3.4 The Duty to Obtain the Patient's Consent

²⁴⁸ *Kovalsky v Krige*. In this case the doctor treated an infant patient of nine months for haemorrhage, which resulted from a circumcision procedure. After treatment the patient contracted gangrene and permanent damage was caused. A claim based on negligence was brought against the doctor. The plaintiff alleged that the defendant was negligent in that he withdrew from the case before the bleeding stopped and that the defendant did not return within a reasonable time. The court, however, did not find that to be the case. In dismissing the plaintiff's claim the court held: "He remedied the evil which he had been called in to remedy. The next allegation is that he did not return within a reasonable time, not until he had been called upon to do so. I cannot see that there was any necessity for him to return; he had been called in to stop the haemorrhage, and he had done so. As a rule, doctors do not pay visits after they have done their work unless they are especially asked to do so on behalf of the patients."; Strauss & Strydom (1967) 113. Claassen & Verschoor (1992) 117. The authors state that a doctor may not withdraw from treatment, where the treatment takes the form of a therapeutic series. The whole process would need to be completed and if the doctor withdraws before completion of the treatment, the doctor may be held delictually responsible if the patient suffers personal injuries, as a result of the treatment being interrupted in a negligent manner.

²⁴⁹ Gordon, Turner & Price (1953) *Medical Jurisprudence* 123.

Under normal circumstances a doctor will not be able to treat a patient unless the patient consents to the proposed treatment.²⁵⁰ As the relationship between healthcare providers and patients are usually contractual, and because a contract presupposes *consensus ad idem* between the parties, for a lawful medical intervention to take place a patient's effective consent is needed and considered essential.²⁵¹

There are exceptions where the lack of effective consent on the part of the patient will not result in the medical intervention being wrongful or unlawful. These exceptions include emergency situations, statutory authority and court authorisation. As a general rule, however, a doctor who treats a patient, without obtaining effective consent from the patient or a person acting on behalf of a patient, will be engaging treatment in an unlawful or wrongful manner.²⁵²

The defence of *volenti non fit iniuria* in medical cases will apply if the patient has knowledge and an appreciation of the nature or extent of the harm or risk involved in the intervention and then consents to the harm or assumed risk. This consent must be comprehensive, meaning that it should extend to the entire transaction, inclusive of its consequences.²⁵³

It is clear then that as a legal concept consent consists of three elements: Knowledge, appreciation and acquiescence. The patient must be willing to submit to the proposed conduct or intervention.²⁵⁴ If the patient, or the person who consents on behalf of the patient, has not been sufficiently informed of the nature and potential

²⁵⁰ See generally Gordon, Turner & Price (1953) 153 ff.; Strauss & Strydom (1967) 175 ff.; Strauss (1991) 3 ff., 267 ff., 289; Claassen & Verschoor (1992) 55 ff.; Dada & McQuoid-Mason (eds) (2001) 8ff.; Mcquoid-Mason (2008) LAWSA 32 ff.; Slabbert (2011) 81 ff.; National Health Act 61 of 2003 sections 6, 7, 8, 9, 11.

²⁵¹ Slabbert (2011) 81.

²⁵² Van Oosten "*Castell v De Greef and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy*" (1995) *De Jure* 166.

²⁵³ *Castell v De Greef* [1994] 4 All SA 63 (C) at 80; Van Oosten (Unpublished Thesis, 1989) 13-25; Van der Walt & Midgley (2005) *Principles of Delict* 140.

²⁵⁴ Strauss (1991) 4 ff.; Van Oosten (Unpublished Thesis, 1989) 15 ff.; Claassen & Verschoor (1992) 59 ff.

consequences of the proposed treatment or the other possible alternatives to the proposed treatment, there can be no possibility of true consent.²⁵⁵

Consent will not be recognised by law if it does not conform to the *boni mores*. Certain procedures such as criminal abortions, unlawful organ transplantations, illegal artificial procreation, unauthorised experimentation and human cloning will invalidate factual consent as the procedures are *contra bonos mores*.²⁵⁶

Similarly to the contract between the doctor and patient, consent is generally implied by the patient's conduct.²⁵⁷ Consent can also be granted expressly, either in writing or orally.²⁵⁸ A person's written consent may also be required by statute.²⁵⁹ Whether the necessary consent was present or if there was an absence of consent will depend on the circumstances of each particular case.²⁶⁰ The doctor who treats the

²⁵⁵ Slabbert (2011) 82.

²⁵⁶ Strauss (1991) 286 Where the author gives the example of plastic surgery being performed on a fugitive with the exclusive purpose of shielding him or her from prosecution.; Slabbert (2011) 83 citing the case of *S v V* 1972 (3) SA 611 (A) at 621-622 The court stated that brain surgery that would seek to destroy or dampen the sexual drive of a rapist, could not remove the many legal, moral and practical difficulties involved, even if the person consents to such an operation.

²⁵⁷ Strauss (1991) 12; Slabbert (2011) 82.

²⁵⁸ Strauss & Strydom (1967) 187. The authors state that where a patient orally consents to a procedure, such apparent consent must be taken as real consent, even if there are undisclosed mental reservations about the treatment. If the patient verbally refuses an intervention, out of fear of pain or injury, while still subjecting him- or herself to the intervention, tacit consent must also be taken to have been granted.

²⁵⁹ See for example the National Health Act 61 of 2003. S 55 of the Act that deals with the removal of tissue, blood, blood products or gametes from living persons makes it clear that such removal requires written consent. S 71 which provides for the research on or experimentation with human subjects also requires the written consent of the person who participates in the research or experimentation. Also see the Sterilisation Act 44 of 1998. S 4 of the Act requires that the person signs a prescribed consent form.

²⁶⁰ In *Stoffberg v Elliott* at 149 the court dealt with the issue of implied consent: "Now, the declaration in this case alleges an unjustified, unexcused, and unconsented to interference; the plea admits an interference, but it says there was consent to the operation, but not an express consent, a consent implied by the fact that the man went into the hospital; it says the plaintiff was admitted for treatment, and thereby consented to undergo such surgical and medical treatment as was immediately necessary, and here we come really to the first issue between the parties. It is a question partly of fact and a question partly of law whether there was an implied consent to undergo such surgical treatment

patient has the primary responsibility to ensure that appropriate consent is acquired; if the doctor fails to obtain the patient's consent he or she could be found guilty of assault.²⁶¹ The patient who gives his or her consent to the intervention must also have the legal capacity to be able to do so.²⁶²

A doctor who performs a procedure or treats a patient without having obtained the required effective consent may incur liability for breach of contract.²⁶³ Liability for civil

as was considered reasonable and necessary by the doctor. Now, in so far as the question of law is concerned, I must direct you that a man, by entering a hospital, does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary; he may submit himself for medical treatment, but I am not going into that; I am not going to attempt to define the exact limits of medical treatment, because they do not seem to me to be material in this case, but he does not consent to such surgical treatment as the doctor may consider necessary. By going into hospital, he does not waive or give up his right of absolute security of the person; he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purposes of vivisection; he remains a human being, and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to, and, unless his consent to an operation is expressly obtained, any operation performed upon him without his consent is an unlawful interference with his right of security and control of his own body, and is a wrong entitling him to damages if he suffers any." In the more recent case of *Castell v De Greef* [1994] 4 All SA 63 (C) at 74 the issue of consent was again discussed "It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination. A woman may be informed by her physician that the only way of avoiding death by cancer is to undergo a radical mastectomy. This advice may reflect universal medical opinion and may be, in addition, factually correct. Yet, to the knowledge of her physician, the patient is, and has consistently been, implacably opposed to the mutilation of her body and would choose death before the mastectomy. I cannot conceive how the 'best interests of the patient' (as seen through the eyes of her physician or the entire medical profession, for that matter) could justify a mastectomy or any other life-saving procedure which entailed a high risk of the patient losing a breast. Even if the risk of breast-loss were insignificant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would refuse consent if informed of the risk. It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would, in my view, be equally irrelevant that the medical profession was of the unanimous view that, under these circumstances, it was the duty of the surgeon to refrain from bringing the risk to his patient's attention".

²⁶¹ McQuoid-Mason (2008) LAWSA 32.

²⁶² Slabbert (2011) 83.

²⁶³ *Castell v De Greef* [1994] 4 All SA 63 (C).

or criminal assault may be incurred on the basis that the procedure or treatment violates the patient's bodily integrity.²⁶⁴ Carstens and Pearmain argue that the lack of informed consent amounts to an assault and that the concept of assault should not be viewed to literally, but rather be regarded as a violation of the patient's right to bodily, physical or mental integrity as protected by section 12(2) of the Constitution.²⁶⁵

The doctor may also be held liable for civil or criminal *injuria*²⁶⁶, the violation of *dignitas* or privacy, as well as negligence²⁶⁷. Depending on the circumstances of the particular case, a doctor may incur liability for one or more of the abovementioned and additionally the doctor may have to forfeit the professional fee.²⁶⁸

Even if the procedure or treatment was carried out with the due care and skill, or turns out to have been to the patients eventual benefit, a doctor may still incur liability if effective consent had not been obtained from the patient.²⁶⁹

3.5 The Duty to Inform the Patient

²⁶⁴ *Stoffberg v Elliot, Layton and Layton v Wilcox and Higginson* 1944 SR 48; *Lampert v Hefer* 1955 (2) SA 507 (A); *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) at 718; *S v Sikunyana* 1961 (3) SA 549 (E) at 551; *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C) at 232; *Burger v Administrator, Kaap* 1990 (1) SA 483 (C) at 489; *Castell v De Greef* 1993 (3) SA 501 (C) at 425; *S v Binta* 1993 (2) SACR 553 (C) at 561; *Fowlie v Wilson* 1993 (N) (unreported); *S v Kiti* 1994 (1) SACR 14 (E) at 18; *Pop v Revelas* 1999 W (unreported); *Broude v McIntosh* 1998 (3) SA 60 (SCA) at 61; *Oldwage v Louwrens* [2004] 1 All SA 532 (C); *McDonald v Wroe* [2006] 3 All SA 565 (C); *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at 174.

²⁶⁵ Carstens & Pearmain (2007) 687; S 12(2)(b) of the Constitution of the Republic of South Africa, 1996.

²⁶⁶ *Stoffberg v Elliot* at 152.

²⁶⁷ *Lymbery v Jefferies* 1925 AD 236; *Prowse v Kaplan* 1933 EDL 257; *Allott v Patterson & Jackson* 221-222, 224; *Layton and Layton v Wilcox and Higginson* at 50; *Dube v Administrator Transvaal* 1963 (4) SA 260 (W) at 269; *Richter and Another v Estate Hammann* at 232; *Louwrens v Oldwage* at 174.

²⁶⁸ Slabbert (2011) 81.

²⁶⁹ *Ibid* stating that: "The violation perpetrated by the doctor who performs the wrongful or unlawful intervention being one against the patient's physical integrity or *dignitas*/privacy rather than one against his or her health."

3.5.1 Informed Consent

Legally valid consent will only be obtained if the patient is informed in a manner which ensures that the patient has substantial knowledge about the nature and effect of the proposed intervention.²⁷⁰ Consent is only considered lawful if the patient who consents has knowledge about the proposed intervention and appreciates what he or she is consenting to.²⁷¹ For a patient to have the necessary knowledge and appreciation, a doctor needs to consider what the patient in actual fact understands and not what the patient is presumed to have understood.²⁷² Informed consent is thus required. As most medical procedures and treatments are very technical a doctor has a duty to adequately inform the patient of the nature and possible consequences of the proposed procedure or treatment.²⁷³ The doctor is not obliged to inform the patient of all the potential complications that may arise during treatment

²⁷⁰ Dada & McQuoid-Mason (eds) (2001) 13; Mcquoid-Mason (2008) LAWSA 40.

²⁷¹ *Botha v Rompel* 1955 TPD 719 (unreported), discussed in *Esterhuizen v Administrator, Transvaal* “There is no doubt that a surgeon who intends operating on a patient must obtain the consent of the patient. In such cases where it is frequently a matter of life and death I do not intend to express any opinion as to whether it is the surgeon’s duty to point out to the patient all the possible injuries which might result from the operation, but in a case of this nature which may have serious results to which I have referred, in order to effect a possible cure for a neurotic condition, I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent - it is consent without knowledge of the possible injuries. On the evidence defendant did not notify plaintiff of the possible dangers, and even if plaintiff did consent to shock treatment he consented without knowledge of injuries which might be caused to him. I find accordingly that plaintiff did not consent to the shock treatment.”; *Esterhuizen v Administrator, Transvaal* at 719 where Bekker J states that “a therapist, not called upon to act in an emergency involving a matter of life or death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and a risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient – no matter how laudable his motives might be - and should he act without having done so and without having secured the patient’s consent, he does so at his own peril.”; *Castell v De Greef* [1994] 4 All SA 63 (C) at 69; *Louwrens v Oldwage*; *McDonald v Wroe*.

²⁷² *Lymbery v Jefferies* 1925 AD 236 at 240; Strauss & Strydom (1967) 214; Slabbert (2011) 88.

²⁷³ Mcquoid-Mason (2008) LAWSA 40.

or the procedure.²⁷⁴ The doctor must however point out and warn the patient of the material risks which may potentially be encountered if the proposed intervention is performed or the material risks inherent to the proposed intervention.²⁷⁵ The technical nature of medical treatments and procedures need to be explained to patients who usually possess little or no understanding about health related matters, as such knowledge and appreciation on the part of the patient can only be achieved if appropriate and sufficient information is conveyed during consultations. Sufficient information is thus required in order to achieve knowledge and appreciation, and therefore, also a requisite for obtaining lawful consent.²⁷⁶

If a patient is not given adequate information about the proposed treatment or intervention proper consent will be absent. The legal duty to inform the patient of the necessary information that will allow the patient to have knowledge about the treatment or intervention, and appreciate the potential consequences of his or her decision, rests on the doctor. Proper consent must therefore be obtained by the doctor.²⁷⁷

The doctor is obliged to inform the patient, as the duty to obtain consent arises in the contractual context. The obligation is distinct from the duty of care owed to the patient; however the same policy considerations are involved when assessing both.²⁷⁸

3.5.2 The Duty to Inform Patients of their Diagnosis

²⁷⁴ *Lymbery v Jefferies*; *Castell v De Greef* [1994] 4 All SA 63 (C) at 70; *Louwrens v Oldwage* at 174.

²⁷⁵ *Castell v De Greef* [1994] 4 All SA 63 (C) at 81.

²⁷⁶ Van Oosten (Unpublished Thesis, 1989) 20; Slabbert (2011) 88.

²⁷⁷ *Edouard v Administrator, Natal* at 383 where Thirion J remarks "Considering the ease with which doctors would be able to protect themselves against liability by warning the woman of the danger that the operation might not result in sterility, there seems to be no reason why the Court should extend to them a special protection against their own negligence; be it in a delictual or contractual context."; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W) at 384, 393, 397; *Administrator, Natal v Edouard* at 374.

²⁷⁸ *Castell v De Greef* [1994] 4 All SA 63 (C) at 79; Slabbert (2011) 88.

Doctors are ordinarily required to inform patients of their diagnosis. If there is substantial evidence that the disclosure of the patient's health status would not be in the best interest of the patient, a doctor is not required to inform the patient thereof.²⁷⁹ This will be the case where the information regarding the diagnosis or the potential consequences of the intervention may have a detrimental effect or harmful influence on the patient. Disclosing certain information about the patient's health status may hinder or impede the success of the treatment. In these cases a doctor may rely on the so-called therapeutic privilege to withhold information.²⁸⁰ Disclosure is compulsory for the necessary consent to be obtained, where the patient makes his or her consent dependent on being made aware of the diagnosis.²⁸¹ If information regarding the diagnosis is material to the patient's decision to undergo or refuse treatment, the diagnosis must be disclosed to the patient, if the patient is not informed proper consent will not be obtained.²⁸²

3.5.3 Patient Autonomy

When medical matters are concerned the accepted opinion is that the consent obtained from patients must satisfy the requirements of informed consent. This view is in line with the so-called 'doctrine of informed consent', which has been acknowledged and accepted in recent judicial pronouncements.²⁸³ Informed consent

²⁷⁹ S 6(1)(a) of the National Health Act 61 of 2003. Also see S 8(3) of the Act.

²⁸⁰ *South African Medical and Dental Council v McLoughlin* 1948 (2) SA 355 (A) at 366 Watermeyer CJ observed that "it may sometimes be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him"; *Castell v De Greef* [1994] 4 All SA 63 (C) at 80 Ackermann J concludes "that, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment... This obligation is subject to the therapeutic privilege, whatever the ambit of the so-called 'privilege' may today still be."; Van Oosten (Unpublished LLD Thesis, 1989) 428; Strauss (1991) 18; Welz "The boundaries of medical-therapeutic privilege" (1999) *SALJ* 299; Carstens & Pearmain (2007) 314, 910; Mcquoid-Mason (2008) *LAWSA* 40.

²⁸¹ Mcquoid-Mason (2008) *LAWSA* 40.

²⁸² Van Oosten (Unpublished Thesis, 1989) 433.

²⁸³ *Castell v De Greef* [1994] 4 All SA 63 (C) at 80.

recognises and endorses the patient's fundamental right of individual autonomy and self-determination. In following this approach medical paternalism is thus rejected and a patient-orientated approach is introduced.²⁸⁴ Patient autonomy has been further strengthened by the provisions in the National Health Act. Patients must be informed of matters pertaining to their health, so that they may have full knowledge thereof.²⁸⁵ No health service may be provided to a patient without the patient's informed consent.²⁸⁶ Patients also have the right to participate in any decisions that affect their personal health or treatment.²⁸⁷

The decision to undergo or refuse medical treatment ultimately rests with the patient; it is not for the doctor to decide.²⁸⁸ The patient's rights of bodily integrity and autonomous moral agency entitle the patient to refuse medical interventions, even in cases where the refusal may lead to the death of the patient, or appears to be grossly unreasonable if considered from the point of view of the medical profession. It would also be irrelevant in such circumstances if the medical profession was of the opinion that the doctor should not disclose the risks or complications, as the patient should be informed of all the matters in order to make his or her decision, regardless of what the eventual consequences of such decision will be.²⁸⁹

Failing to obtain a patient's informed consent, will not be excused by claiming that it was in the patient's best interest. Such a medical paternalistic view in treating the patient will be unable to justify the violation of a patient's autonomy.²⁹⁰

²⁸⁴ *Castell v De Greef* [1994] 4 All SA 63 (C) at 74, 75, 79, 80 Ackermann J states that the formulation of informed consent "is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away."

²⁸⁵ S 6 of the National Health Act 61 of 2003.

²⁸⁶ S 7 of the National Health Act 61 of 2003.

²⁸⁷ S 8 of the National Health Act 61 of 2003.

²⁸⁸ *Stoffberg v Elliott, Castell v De Greef* [1994] 4 All SA 63 (C) at 74 "It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination." ; *Phillips v De Klerk* 1983 TPD (unreported); See also Strauss (1991) 29.

²⁸⁹ *Castell v De Greef* [1994] 4 All SA 63 (C) at 74; *Phillips v De Klerk*.

²⁹⁰ *Stoffberg v Elliott* at 149; *Ex Parte Dixie* 1950 (4) SA 748 (W) at 751; *Esterhuizen v Administrator, Transvaal* at 718, 720; *Castell v De Greef* [1994] 4 All SA 63 (C) at 74.

3.5.4 The Nature and Scope of the Disclosure

When determining the nature and scope of the information which the doctor should disclose to the patient cognisance should be taken of the legislative requirements contained in section 6 of the National Health Act. In terms of this section:

“Every health care provider must inform a user of –

- (a) the user’s health status except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user;
- (b) the range of diagnostic procedures and treatment options generally available to the user;
- (c) the benefits, risks, costs and consequences generally associated with each option; and
- (d) the user’s right to refuse health services and explain the implications, risks, obligations of such refusal.”²⁹¹

This section also obligates a doctor to inform the patient, where possible, in a language that the patient understands and in a manner which takes the patient’s level of literacy into account.²⁹²

Carstens and Pearmain opine that ordinarily the nature and scope of information which must be disclosed by the doctor should give the patient a general idea in broad terms and in normal understandable language of the nature²⁹³, scope²⁹⁴, the

²⁹¹ S 6 of the National Health Act 61 of 2003 must be read in context with sections 7, 8 and 9 of the Act.

²⁹² S 6(2).

²⁹³ See *Stoffberg v Elliot*, in which a patient, who was operated on to treat his penile cancer, regained consciousness to find that his penis had been amputated. In *Jacobson v Carpenter-Kling* 1998 TPD (unreported), the patient instituted a claim against an ear-nose and throat specialist for damages arising from the lack of informed consent. The court found that the doctor only needed to indicate the body parts on which the operation will be performed and indicate “danger areas” which might be

possible consequences²⁹⁵ or risks involved, dangers or complications²⁹⁶ that may arise and the benefits a patient may reasonably expect to see as a result of the treatment or procedure. Possible alternative interventions and their disadvantages and prognosis must be discussed. The doctor should also be sure to inform the patient of his or her right to refuse treatment.²⁹⁷

A doctor need not inform the patient of unusual or remote risks and dangers, unless the patient specifically enquires about them or if they are serious and typically found to occur during the proposed intervention.²⁹⁸

affected. In this case, a leakage of cerebrospinal fluid in the course of endoscopic sinus surgery required further corrective surgery. In *Louwrens v Oldwage* the patient alleged that he did not consent to an iliac bi-femoral bypass. The doctor however, claimed that he did explain the procedure to the patient in detail and that the consent form the patient signed, which referred to a 'fem-fem bypass', was just another term generally used for the previously explained operation.

²⁹⁴ See *Esterhuizen v Administrator, Transvaal*, in which the doctor failed to inform the patient that the proposed treatment, differed from previous treatments which consisted of superficial radiotherapy, as it involved radical radiotherapy. In the absence of consent a doctor's conduct amounts to assault.

²⁹⁵ Doctors have been held liable for their failure to disclose harm caused to patients in taking remedial action while attempting to address negligent conduct that had taken place. In *Prowse v Kaplan* the defendant was held to be negligent for not informing the patient of the injuries he had caused her and for the failure to treat the jaw dislocation and subsequent injuries caused during the tooth extraction. See also *Allott v Patterson & Jackson* concerning an arm injury during a tooth extraction.

²⁹⁶ Doctors are required to warn patients of the potential risks, dangers and complications involved in treatment and can be held liable if they fail to do so. See in this regard *Lymbery v Jefferies* concerning sterility and burns as a result of radiotherapy.; *Rompel v Botha* 1953 TPD (unreported) with regard to a bone fracture as a consequence of electro-convulsive shock treatment.; *Esterhuizen v Administrator, Transvaal* concerning severe irradiation and ulceration of tissues, disfigurement, necrosis, cosmetic changes and amputation of limbs.; *Richter and Another v Estate Hammann* with reference to loss of control of the bladder and bowel, loss of sexual feeling and loss of power in the right leg and foot.; *Castell v De Greef* regarding discolouration of the areolae, necrosis of the tissues, a discharge with an offensive odour, a *staphylococcus aureus* infection, pain, embarrassment and trauma and further required surgeries to repair damage.; *McDonald v Wroe* concerning a risk of permanent nerve damage following surgical extraction of wisdom teeth.

²⁹⁷ Carstens & Pearmain (2007) 884.

²⁹⁸ *Id* 885.

A doctor is obliged to disclose information to a patient where a material risk inherent to the proposed treatment exists.²⁹⁹ A risk is considered material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would likely attach significance to it; or where the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would likely attach significance to it.³⁰⁰

What needs to be disclosed would of course depend upon the circumstances. A number of factors need to be taken into account when disclosing information, thus the nature of the intervention, the patient's health and understanding and the patient's requests all need to be considered.³⁰¹ The amount of potential anxiety or distress a disclosure may cause if an unnecessary disclosure was made to a patient should also be evaluated.³⁰²

Carstens and Pearmain correctly state that a subjective patient-centred approach, as opposed to the reasonable doctor-approach, should be followed when disclosures are made.³⁰³ This was understood to be the general position after the decision in *Castell v De Greef*; however the Supreme Court of Appeal in *Louwrens v Oldwage*³⁰⁴

²⁹⁹ *Castell v De Greef* [1994] 4 All SA 63 (C) at 81; *Oldwage v Louwrens*. In this case the court had to determine whether the plaintiff consented to the procedure. The doctrine of informed consent was applied. A patient needs to consent, not only to the injury or intervention proposed, but also the risks and possible consequences thereof. The Court applied the test in *Castell* and found that the necessary disclosure was not present, as alternative options were not discussed and the patient was not informed of the material risks involved in such an operation. The court held that informed consent was not obtained and as such the conduct amounted to assault; *McDonald v Wroe*. In this case the plaintiff was experiencing problems with her wisdom teeth and consulted the defendant, a dental practitioner. The extraction of the teeth resulted in nerve damage. The plaintiff claimed damages, alleging that the defendant negligently breached his duty of care by not referring the plaintiff to a specialist surgeon and not informing her of the possible complications and risks of the proposed procedure. The court found that there was a failure to warn the plaintiff of the risks and complications involved and that the defendant was guilty of violating the plaintiff's constitutional right to bodily integrity. The defendant was held liable for the damages suffered by the plaintiff.

³⁰⁰ *Castell v De Greef* [1994] 4 All SA 63 (C) at 81.

³⁰¹ Van Oosten (Unpublished Thesis, 1989) 450, 455.

³⁰² Carstens & Pearmain (2007) 886.

³⁰³ *Ibid.*

³⁰⁴ [2006] 1 All SA 197 (SCA).

has unfortunately muddled the previous clear understanding.³⁰⁵ Nonetheless, the Supreme Court of Appeal did not overrule the subjective patient-centred approach, and as there is not yet a binding judgement on the matter, courts are still free to follow the subjective patient-centred approach as argued in *Castell v De Greef*.³⁰⁶

3.6 The Doctor's Duty to Exercise Due Care and Skill

The duty to exercise due care and skill is one of the most important duties a doctor has towards a patient. When a doctor agrees to examine or treat a patient the doctor does not, by mere agreement, undertake to cure such patient.³⁰⁷ The doctor is however expected to treat the patient with the due care and skill which can be reasonably expected from a practitioner in the particular doctor's branch of the profession.³⁰⁸ The duty to exercise due care and skill may be found as an express term in an agreement between the parties, normally included in a consent form. Where no express agreement exists between the doctor and the patient, the duty subsists as an implied term of the tacit contract between the parties.³⁰⁹

The duty to exercise due care and skill has received attention from the courts who have interpreted the meaning thereof in order to give substance thereto.³¹⁰ The

³⁰⁵ Carstens & Pearmain (2007) 886.

³⁰⁶ Wilson "When is a risk of medical treatment material?" (2006) *De Rebus* 22.

³⁰⁷ See Strauss (1991) 40 the author explains a doctor's duty to treat, which does not include a guarantee of a cure, "where a patient consults a doctor who undertakes to treat him, the doctor assumes no greater duty than to treat the patient with due care and skill, unless the doctor has expressly guaranteed that the patient will be healed by his treatment – something which the prudent doctor will generally not do".

³⁰⁸ *Mitchell v Dixon* at 525; *Richter and Another v Estate Hammann* at 323; *Blyth v Van der Heever* 1980 (1) SA 191 (A) at 221; *Correia v Berwind* 1986 (4) SA 60 (ZH) at 66; *Friedman v Glicksman* 1996 (1) SA 1134 (W); Strauss & Strydom (1967) 106; Strauss (1991) 40; Claassen & Verschoor (1992) 116; Mcquoid-Mason (2008) LAWSA 30; Slabbert (2011) 70.

³⁰⁹ Mcquoid-Mason (2008) LAWSA 30; Slabbert (2011) 70. See Carstens & Pearmain (2007) 362 for a discussion on the terms which may be inferred in health care contracts.

³¹⁰ The duty to exercise due care and skill has received attention in *Van Wyk v Lewis* at 444 where Innes C.J discusses the position: "It was pointed out by this Court, in *Mitchell v Dixon* (1914, A.D., at p. 525), that 'a medical practitioner is not expected to bring to bear upon the case entrusted to him the

criteria used in determining whether a doctor exercised the due care and skill is that of the reasonable doctor or reasonable specialist, depending on the applicable branch of the medical profession. A doctor's conduct is measured against that of an average or ordinary medical practitioner belonging to the same field of medicine, taking into account the recognised, accepted or usual practices of medicine.³¹¹ If the doctor is a specialist, the doctor's conduct will be measured against that of the reasonable specialist in that field of practice.³¹² The specialist would thus need to exercise a higher degree of care and skill concerning matters within his or her field of speciality.³¹³ Claassen and Verschoor indicate that the objective "reasonable physician test" is subjectified to the particular branch of medicine to which the specialist belongs.³¹⁴

4. The Legal Consequences of a Breach of Contract

highest possible degree of professional skill, but he is bound to employ reasonable skill and care.' And in deciding what is reasonable the Court will have regard 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 the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level." The same court again at 641: "We cannot determine in the abstract whether a surgeon has or has not exhibited reasonable skill and care. We must place ourselves as nearly as possible in the exact position in which the surgeon found himself when he conducted the particular operation and we must then determine from all the circumstances whether he acted with reasonable care or negligently. Did he act as an average surgeon placed in similar circumstances would have acted, or did he manifestly fall short of the skill, care and judgment of the average surgeon in similar circumstances? If he falls short he is negligent."

³¹¹ *Van Wyk v Lewis; Allott v Patterson & Jackson; Kovalsky v Krige; Coppen v Impey; Buls and Another v Tsatsarolakis; Applicant v Administrator, Transvaal, and Others; Collins v Administrator, Cape; Clinton-Parker v Administrator, Transvaal; Strauss & Strydom* (1967) 106; Claassen & Verschoor (1992) 22, 116; Carstens & Pearmain (2007) 642; Slabbert (2011) 71.

³¹² *R v Van der Merwe* 1953 (2) PH H 124 (W); *Esterhuizen v Administrator, Transvaal*; Claassen & Verschoor (1992) 15.

³¹³ Strauss & Strydom (1967) 268.

³¹⁴ Claassen & Verschoor (1992) 15.

If a doctor fails to perform or deviates from the express or implied terms of the contract³¹⁵, he or she may be held liable for breach of contract and may have to compensate the patient for damages incurred. A doctor can only be held liable for patrimonial loss suffered as a result of a breach of contract, non-pecuniary damages cannot be recovered.³¹⁶ As a consequence of the breach of contract, a patient is

³¹⁵ Strauss & Strydom (1967) 107 It will constitute a breach of contract if a doctor undertakes to treat a patient in a certain way, or if he or she agrees to perform a specific operation and then fails to treat or operate on the patient in the agreed upon manner. See *Recsei's Estate v Meine* 1943 EDL 277 at 284 where the court held that “[i]n the face of these admissions by the plaintiff it is quite impossible for us to hold otherwise than that the plaintiff was well aware of, and fully accepted, the fact that before operating personally upon the deceased he required the consent and authority, not only of the deceased, but of the defendant, as well. Nor on the evidence is it possible for us to interfere with the finding of the magistrate that the defendant did not in fact consent to the operation being performed by the plaintiff, but that on the contrary he insisted that it should be performed by Dr. Ziervogel with the collaboration of Dr. Phillips.”; In *Burger v Administrateur, Kaap* the patient was under the impression that the operation was performed by a certain doctor, when in actual fact it was performed by a different doctor. The patient was not aware thereof and only later realised that an unlawful operation was performed on him. The court found that his claim had not yet prescribed as he could not have been reasonably aware of the cause of action on the earlier date.; See also, *Verhoef v Meyer* 1976 A (unreported), discussed in Strauss (1991) 35, where the patient alleged that the doctor failed to inform her of the consequences of the intervention, left the operation to another ophthalmologist and interfered with her left eye without her consent. The court ruled that the patient’s evidence failed to establish a case on a preponderance of probabilities.

³¹⁶ *Edouard v Administrator, Natal* at 385 ff. “If there is a need to extend the rules of our law relating to the recoverability of non-pecuniary loss flowing from the breach of contract, such need can best be accommodated in the law of delict where the concepts of wrongfulness and fault (in the form of culpa and dolus) and the defences germane to delict can be used to define the limits of the relief. In my judgment plaintiff is not entitled on his claim, which is based solely on contract, to be awarded damages in respect of the discomfort, pain and suffering and loss of amenities suffered by Andrae.”; *Administrator, Natal v Edouard* at 384 ff. “I cannot agree with the submission that there are compelling reasons why damages for pain and suffering should be recoverable in an action for breach of contract. I say so for mainly the following reasons: 1) Ex delicto such damages may only be claimed if the tortfeasor acted intentionally or negligently. By contrast fault is not a requirement for a claim for damages based upon a breach of contract. The proposed extension of liability would therefore result in the anomalous situation that damages may be recovered ex contractu under circumstances where no action ex delicto would lie. 2) A contractual action for damages is always actively transmissible. By contrast, a delictual claim for pain and suffering is not. An extension of liability as contended for by counsel for the respondent would therefore result in the further incongruous consequence that a contractual claim for damages for pain and suffering would be transmissible under circumstances

exempted from his or her obligation to remunerate the doctor and a doctor will be unable to recover a fee for the services rendered.³¹⁷ It is also conceivable for a patient to claim damages from a doctor, if his or her breach of contract led to the patient incurring extra costs in seeing another practitioner.³¹⁸ As the courts are unwilling to order specific performance in cases where a doctor renders a personal service to the patient, a patient will probably not be able to compel the doctor to specific performance if the doctor breaches the contract.³¹⁹ If the doctor and patient come to an agreement, in advance, that the contractual relationship will be freely terminable, the doctor will not be liable for breach of contract if he terminates the relationship.³²⁰ A doctor should also always be aware that irrespective of the contractual relationship, negligent treatment of a patient may lead to him or her incurring delictual liability.³²¹

where such a delictual claim cannot survive the death of the victim. It may be that for reasons of convenience it is desirable that in some cases some form of intangible loss may be recovered in contract. That, however, is an extension of the law which has to be effected by the legislature and not by a court of law.”; *Jansen van Vuuren and Another NNO v Kruger* 1993 (4) SA 842 (A) at 848.

³¹⁷ *Sutherland v White* 1911 EDL 407; *McCallum v Hallen* 1916 EDL 74; *Hewat v Rendel* 1925 TPD 679; *Recsei's Estate v Meine*; cf. *Oates v Niland* 1914 CPD 976; *Shiels v Minister of Health* 1974 (3) SA 276 (RA); See Strauss & Strydom (1967) 114.

³¹⁸ See Strauss & Strydom (1967) 114 where the authors give the example of a patient having to travel to another town or city for treatment.

³¹⁹ *Myers v Abramson* [1951] 3 All SA 82 (C); Strauss & Strydom (1967) 114.

³²⁰ Strauss & Strydom (1967) 114.

³²¹ *Id* (1967) 115.

Chapter Two: Conclusion

The relationship between the doctor and patient is generally governed by the law of obligations. In this chapter the emphasis was on the contractual relationship and the rights and duties imposed thereby. Once the parties reach consensus an agreement will commence, this ordinarily occurs tacitly, however when more serious procedures or operations are envisioned the agreement will be express and reduced to writing. The commencement of a tacit agreement would be more difficult to establish as it would be inferred from the conduct of the parties and depends upon the specific circumstances of each case. It would be important in civil litigation to prove that a contract was actually entered into, in that if a patient is unable to prove the existence of a contractual relationship his or her chances of a claim succeeding would be greatly diminished.

The terms of the agreement will also vary on a case by case basis. However, a practitioner generally agrees to examine, diagnose and treat a patient with the professional expertise, care and judgement reasonably expected from the average or ordinary medical practitioner in the particular branch of the profession to which the doctor belongs. It would be particularly unwise for a doctor to guarantee that treatment would cure the patient or alleviate all ails, as the failure to do so would constitute a breach of contract. A breach of contract could also occur if a practitioner deviates from an agreed upon intervention. Other matters pertaining to the terms of agreement were also discussed.

Certain distinct rights and duties emanate from the agreement between a doctor and patient. A doctor should treat the patient and execute his mandate honestly, faithfully and with care. Due to the unique relationship between the parties and

the vulnerable position of the patient, there is a substantial reliance on the doctor's obligation to exercise reasonable care and skill during consultations and subsequent treatment.

The chapter also examined the practitioner's duty to treat the patient. This duty is influenced according to where the doctor practices, be it in the public or private sector. A doctor in the private sector generally has freedom to contract with whoever he or she chooses, but this freedom may be qualified in certain circumstances. The duty in the public sector is less clear, as a contractual relationship most likely does not exist between public healthcare providers and patients. Patients at these public facilities receive health care services from the state in terms of the relevant empowering statutes, although a contractual fiction in the public health sector would remain useful.

It was also indicated that a doctor who agrees to treat a patient must continue to attend to such patient and may only be absolved of his or her duty under certain circumstances.

Doctors are only able to treat patients if they consent to the proposed treatment. For a lawful medical intervention to take place a patient's effective consent is needed and considered essential. The doctor who treats the patient has the primary responsibility to ensure that appropriate consent is acquired. If a procedure is performed or a patient treated without having obtained the required effective consent, the doctor may incur liability for breach of contract. Liability for civil or criminal assault may also be incurred on the basis that the procedure or treatment violates the patient's bodily integrity.

Along similar lines, the doctor's duty to inform the patient was scrutinised. The requirements for obtaining informed consent were discussed. Consent is only considered lawful if

the patient who consents has knowledge about the proposed intervention and appreciates what he or she is consenting to. For a patient to have the necessary knowledge and appreciation, a doctor needs to consider what the patient in actual fact understands and not what the patient is presumed to have understood. The duty to inform patients of their diagnosis and matters related thereto were also considered. The nature and scope of disclosures was also examined. There are legislative requirements that need to be met in this regard. Judicial pronouncements indicate that a subjective patient-centred approach, as opposed to the reasonable doctor-approach, should be followed when disclosures are made. Unfortunately the position has been muddled by a more recent Supreme Court of Appeal decision.

The duty to exercise due care and skill was also scrutinised, as it is considered to be one of the most important duties a doctor has towards a patient. This duty has received attention from the courts who have interpreted the meaning thereof in order to give substance thereto. The criteria used in determining whether a doctor exercised the due care and skill is that of the reasonable doctor or reasonable specialist, depending on the applicable branch of the medical profession to which the doctor belongs.

Finally, the legal consequences of a breach of contract were examined. A doctor who deviates from the express or implied terms of an agreement, commits a breach of contract and may be held liable for patrimonial loss suffered as a result thereof. Non-pecuniary damages cannot be recovered in contract. A doctor should however always be aware that negligent treatment of a patient may lead to him or her incurring delictual liability, irrespective of the contractual relationship.

The following chapter will examine delictual liability.

Chapter Three: The Law of Obligations (Delictual Liability)

Overview

If there is no contract in place between the patient and a doctor or hospital, the relationship will be governed by the law of delict. In this chapter delictual liability as it relates to the doctor will be examined. Due to the nature of the medical profession, practitioners and hospitals are particularly vulnerable to lawsuits. The doctor's liability will be scrutinised in this context. The discussion will focus on the different remedies available to patients as well as the elements that need to be proven in order to found liability based on delict.

1. Introduction

As mentioned earlier, the relationship between the patient and the doctor or hospital is generally governed by the law of obligations, meaning the law of contract and the law of delict.³²² Delict is one of the primary sources of obligations.³²³ If there is no contract in place between the patient and a doctor or hospital, the relationship will be governed by the law of delict.³²⁴ In the widest sense a delict can be defined as a civil wrong.³²⁵ Delict has also been defined more narrowly as the unlawful, blameworthy conduct of a person that causes harm to another person.³²⁶ Delict considered in this sense, comprises of liability based on fault.³²⁷ Before the unwanted act can be qualified as a delict, five elements or requirements need to be met: conduct, wrongfulness, fault, causality and damage. If one or more of these elements are not met, the unwanted act will not qualify as a delict and in turn no liability will arise.

The law of delict prescribes what protection and remedies a person is entitled to if someone: wrongfully causes patrimonial or pecuniary loss; wrongfully inflicts pain or suffering as a result of a bodily injury; or wrongfully infringes interests of personality.³²⁸

Distinction is made between delicts that cause patrimonial or pecuniary loss (*damnum iniuria datum*) and delicts which result in injury to personal dignity (*iniuria*).

³²² Claassen & Verschoor (1992) 115; Carstens *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid* (Unpublished LLD Thesis, 1996 University of Pretoria); Dada & McQuoid-Mason (eds) (2001) 22; Carstens & Pearmain (2007) 283; Mcquoid-Mason (2008) LAWSA 30; Slabbert (2011) 69.

³²³ Midgley & Van Der Walt (2005) 'Delict' in *The Law of South Africa* 1.

³²⁴ Slabbert (2011) 71.

³²⁵ Boberg (1984) *The Law of Delict: Aquilian Liability* 1.

³²⁶ Burchell (1993) *Principles of Delict* 10 who notes that the definition of a delict as "an unlawful, blameworthy (ie intentional or negligent) act or omission which causes another person damage to person or property or injury to personality and for which a civil remedy for recovery of damages is available" does not accommodate strict or no-fault liability; Midgley & Van Der Walt (2005) LAWSA 2; Neethling & Potgieter (2010) *Deliktereg* 4.

³²⁷ No-fault or strict liability has been recognised in some circumstances. See Neethling & Potgieter (2010) 375ff.

³²⁸ Midgley & Van Der Walt (2005) LAWSA 2.

This distinction lays the foundation for two actions which form the pillars of the law of delict. With the first action, the *actio legis Aquiliae*, one would recover damages for the wrongful, blameworthy causing of patrimonial or pecuniary loss. The second action, the *actio iniuriarum*, is the appropriate remedy with which one recovers compensation as *solatium* for the wrongful and intentional injury to an interest of personality. These two actions cover almost the entire field of delictual liability.³²⁹ A further action, the Germanic remedy for pain and suffering, is considered to be the third pillar of the law delict, with this remedy one can recover compensation for non-patrimonial loss associated with bodily harm caused by the wrongful, negligent or intentional injury to the physical and mental integrity of a person.³³⁰

2. The Doctor's Liability

The nature of the medical profession and the activities which surround the practice of medicine have the effect of exposing doctors to delictual claims.³³¹ These claims can be either founded or unfounded, but doctors are particularly vulnerable to potential lawsuits.³³² In recent times the number of claims against medical professionals have increased dramatically, both abroad and in South Africa. This increase has been attributed to a variety of different factors, all of which will be discussed later in a different chapter. The increase in litigation has not only led to monetary implications for doctors and patients, but has given rise to other consequences which have a considerable effect on the medical profession and the practice of medicine. As most

³²⁹ *Edouard v Administrator, Natal* 1989 (2) SA 368 (D) at 389.

³³⁰ Midgley & Van Der Walt (2005) LAWSA 2; Neethling & Potgieter (2010) 5.

³³¹ The hospital authority can be held vicariously liable for the professional negligence of individuals employed by it if the blameworthy conduct was performed in the course and scope of the individual's employment. *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Dube v Administrator, Transvaal* 1963 (4) SA 260 (T); *Mtsetwa v Minister of Health* 1989 (3) SA 600 (D); Strauss (1991) 299.

³³² Strauss & Strydom (1967) 159.

claims instituted against doctors are founded on delict, the law of delict is of utmost importance when regard is had to the doctor's liability.³³³

It is expected of someone who enters a profession, in which special knowledge or skills are required, to exercise such knowledge and skill with a degree of competency. The competency demanded from a practitioner is that of the reasonable practitioner of such profession.³³⁴ The fact that a special relationship arises between the parties when a doctor agrees to examine or treat a patient, burdens the doctor with a duty of care. The duty owed to the patient, obligates the doctor to exercise reasonable skill and care while treating the patient.³³⁵ Failure to comply with the standard of reasonable care and skill will constitute unlawfulness and may lead to the doctor incurring delictual liability.³³⁶

Neethling, Visser and Potgieter draw attention to the fact that the same act, may lead to a doctor incurring liability both *ex contractu* and *ex delicto*.³³⁷ However, where it is possible to claim compensation for patrimonial damages as well as non-patrimonial damages in an action based on delict, in a claim based on contract a person is only entitled to compensation for patrimonial damages as non-patrimonial damages are not recoverable in contract.³³⁸

3. Remedies Available to the Patient

³³³ Strauss & Strydom (1967) 111; *Van Wyk v Lewis* at 443.

³³⁴ Claassen & Verschoor (1992) 118; Strauss & Strydom (1967) 266; *Van Wyk v Lewis* at 444.

³³⁵ Midgley & Van Der Walt (2005) LAWSA 60; Neethling & Potgieter (2010) 74.

³³⁶ Neethling & Potgieter (2010) 43. In assessing whether there was a failure to comply with a legal duty, the *boni mores* are applied as the judicial measure to determine if such failure amounts to unlawfulness.

³³⁷ Neethling & Potgieter (2010) 7. See also Claassen & Verschoor (1992) 118 where the authors give the following example: "A surgeon who, e.g. performs an operation in an improper manner is, firstly, guilty of breach of contract because he does not perform properly in terms of the agreement. Secondly, the commission of an unlawful act is also present because the surgeon injures the patient's rights of personality regarding the integrity of his person, despite the contract."

³³⁸ Midgley & Van Der Walt (2005) LAWSA 4; *Administrator, Natal v Edouard* [1990] 2 All SA 374 (A) at 386.

It is a well-recognised that in our law the loss lies where it falls. The basic point of departure in our law is that when harm is caused, someone must bear the loss. There are however, legally recognised circumstances in which the burden to compensate for the loss shifts from one person to another. If the loss was caused by the wrongful, blameworthy conduct of another person, that person will be held liable.³³⁹ The law of delict thus, determines when and under which circumstances a person may be held liable for damages caused to another.³⁴⁰

It is a foundational principle of the South African law of delict, that all harm caused by wrongful and blameworthy conduct can be recovered by delictual action.³⁴¹ Two actionable wrongs are recognised in the South African law of delict, they are, *damnum iniuria datum* (damage wrongfully caused) and *iniuria* (injury to personal dignity).³⁴² An action for damages is available to the patient who suffers harm or loss as a result of a delict.³⁴³ The Aquilian action is available to the patient, where pecuniary loss is suffered and if the patient suffers an injury to an interest of personality, redress may be claimed with the *actio iniuriarum*.³⁴⁴

The doctor who commits a delict has an obligation to compensate the victim for any loss suffered. The patient, as the victim, has the corresponding right to recover damages incurred as a result of the delict.³⁴⁵ The patient can, in the case of calculable pecuniary loss, recover patrimonial damages. *Solatium* or sentimental damages may be recovered if an injury is inflicted to personality. Non-patrimonial

³³⁹ Midgley & Van Der Walt (2005) LAWSA 23; Neethling & Potgieter (2010) 3. *Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA* 2006 (1) SA 461 (SCA) at 468 where Harms AR states: "The first principle of the law of delict, which is so easily forgotten and hardly appears in any local text on the subject, is...that everyone has to bear the loss he or she suffers. The Afrikaans aphorism is that 'skade rus waar dit val'. Aquilian liability provides for an exception to the rule and, in order to be liable for the loss of someone else, the act or omission of the defendant must have been wrongful and negligent and have caused the loss."

³⁴⁰ Neethling & Potgieter (2010) 3.

³⁴¹ Midgley & Van Der Walt (2005) LAWSA 23.

³⁴² Claassen & Verschoor (1992) 119; Neethling & Potgieter (2010) 5.

³⁴³ Midgley & Van Der Walt (2005) LAWSA 139.

³⁴⁴ *Ibid.*

³⁴⁵ Neethling & Potgieter (2010) 3.

harm associated with bodily injury is recovered by means of the remedy for pain and suffering.³⁴⁶

As mentioned earlier there are essentially three actions with which damages resulting from a delict can be claimed, namely, the *actio legis Aquiliae*, the *actio iniuriarum* and the action for pain and suffering. Each one, as they relate to the doctor's liability, will now be examined and discussed individually.

3.1 *Actio Legis Aquiliae*

A person who has suffered patrimonial loss as a result of the wrongful, culpable conduct of another can recover damages by means of the *actio legis Aquiliae*.³⁴⁷ Intentional conduct is not required to found liability on the part of the perpetrator, as mere negligence will suffice. Thus, the patient would need to prove either negligence (*culpa*) or intent (*dolus*), for a doctor to be held liable.³⁴⁸

According to Strauss and Strydom this form of liability is of particular significance to the medical practitioner.³⁴⁹ Where the patient suffers harm or if health problems arise due to the doctor's misconduct, the *actio legis Aquiliae* can be employed to recover damages. These damages may include further medical expenses for future treatments or surgeries. The patient may also claim damages from a doctor, for loss of income due to occupational disability.³⁵⁰

3.2 *Actio Iniuriarum*

³⁴⁶ Midgley & Van Der Walt (2005) LAWSA 139.

³⁴⁷ Midgley & Van Der Walt (2005) LAWSA 139; Neethling & Potgieter (2010) 5.

³⁴⁸ Midgley & Van Der Walt (2005) LAWSA 2; Strauss & Strydom (1967) 161.

³⁴⁹ Strauss & Strydom (1967) 161.

³⁵⁰ *Ibid.*

The *actio iniuriarum* is available as a remedy to a patient, in order to recover sentimental damages as a result of an injury to an interest of personality.³⁵¹ The main function of the *actio iniuriarum* arises from the fact that it is predominantly concerned with the protection of a person's *corpus*, *fama* or *dignitas*.³⁵² A patient will be able to recover sentimental damages or *solatium* from a doctor, if the patient is able to prove that the doctor acted in a wrongful and intentional manner when he or she infringed an interest of personality.³⁵³ Liability in terms of the *actio iniuriarum* differs from liability under the Aquilian action. To found liability for an injury to the personality, in terms of the *actio iniuriarum*, the doctor had to have acted intentionally.³⁵⁴ Unlike the *actio legis Aquiliae*, negligence will not suffice if one is to claim redress for *iniuria*.³⁵⁵

A patient, who wishes to claim damages in terms of either the *actio iniuriarum* or the *actio legis Aquiliae*, would not need to specify the action relied on in his or her pleadings.³⁵⁶ It is also unnecessary for the patient to bring two separate suits, as the patient can rely on both actions in the same proceedings.³⁵⁷ If the patient suffers an injury to a right of personality, sentimental damages resulting from the delict as *iniuria* may be recovered as *solatium* with the *actio iniuriarum*. Damages may also be recovered by means of the *actio legis Aquiliae* due to the delict *damnum iniuria datum*, if the patient has suffered patrimonial loss as a result of the intentional *iniuria*.³⁵⁸

³⁵¹ Midgley & Van Der Walt (2005) LAWSA 2; Neethling & Potgieter (2010) 5.

³⁵² Neethling & Potgieter (2010) 15.

³⁵³ Midgley & Van Der Walt (2005) LAWSA 2; Neethling & Potgieter (2010) 5.

³⁵⁴ Neethling & Potgieter (2010) 15; *Rex v Umfaan* 1908 TS 62 at 66 Innes CJ refers to Voet's description of *inuria* and states that, "it is a wrongful act designedly done in contempt of another, which infringes his dignity, his person or his reputation. If we look at the essentials of *injuria* we find ... that they are three. The act complained of must be wrongful; it must be intentional; and it must violate one or other of those real rights, those rights *in rem*, related to personality, which every free man is entitled to enjoy."

³⁵⁵ Neethling & Potgieter (2010) 15. The authors note that numerous voices have called for intention to be replaced by negligence as the requirement for liability for *iniuria*.

³⁵⁶ Strauss & Strydom (1967) 162.

³⁵⁷ *Ibid.*

³⁵⁸ Claassen & Verschoor (1992) 120.

3.3 The Action for Pain and Suffering

Unlike the *actio legis Aquiliae* and the *actio iniuriarum*, the action for pain and suffering did not originate from the Roman law. A person was unable to claim compensation for the negligent causing of a bodily injury in the Roman law.³⁵⁹ The action for pain and suffering was based on Germanic custom and natural law, and was accepted as part of Roman-Dutch law.³⁶⁰ It was recognised that pain and suffering as a result of bodily injuries justified an action in order to recover damages.³⁶¹ The action for pain and suffering was transferred from the Roman-Dutch law to the South African law, where it is acknowledged as a distinct action, separate from the *actio legis Aquiliae* and the *actio iniuriarum*.³⁶²

A patient may institute an action for pain and suffering to recover damages where the wrongful, culpable conduct of a doctor causes non-patrimonial loss associated with bodily injury.³⁶³ Although the action shares similarities and requirements comparable to the *actio legis Aquiliae*, the claim for pain and suffering is an action

³⁵⁹ Neethling & Potgieter (2010) 16.

³⁶⁰ *Hoffa NO v SA Mutual Fire & General Insurance Co Ltd* 1965 (2) SA 944 (C) at 951; Midgley & Van Der Walt (2005) LAWSA 2.

³⁶¹ Neethling & Potgieter (2010) 16.

³⁶² Midgley & Van Der Walt (2005) LAWSA 12; Neethling & Potgieter (2010) 17; *Hoffa NO v. S.A. Mutual Fire and General Insurance Co. Ltd.* at 950; *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1973 (1) SA 769 (A) at 769 in which Botha AR stated: "Appellant se aksie is 'n aksie *ex delicto* om genoegdoening en skadevergoeding weens skok, pyn, leed en ongeskiktheid. Genogdoening weens aantasting van liggaamlike integriteit word gevorder met die besondere aksie wat in die Romeins-Hollandse reg, onder invloed van die Germaanse gebruiksreg, ontwikkel het. Wat die vordering om vergoeding van vermoënskade betref, word met die *actio legis Aquiliae* geageer." Later in the judgement Botha AR held that, he can see no reason why, someone who suffers emotional distress or a psychological injury, as a result of the negligent conduct of another can't recover sentimental damages, if the consequences of the negligent act could have been foreseen by a reasonable person in the shoes of the wrongdoer.

³⁶³ *Government of the Republic of South Africa v Ngubane* 1972 (2) SA 601 (A) at 606; Midgley & Van Der Walt (2005) LAWSA 2.

sui generis.³⁶⁴ The defining characteristic, which sets the action for pain and suffering apart, is the fact that the claim is for intangible harm.³⁶⁵

According to Neethling, Potgieter and Visser, as a consequence of further development by our courts, the action for pain and suffering has been expanded to such point where it can be said that the action protects the entire physical and psychological integrity of a person.³⁶⁶ Apart from pain, suffering and bodily disfigurement, which had already been recognised in the common law, protection has been extended to cover numerous other forms of intangible harm. It is possible to claim redress for emotional shock, shortened life expectancy, loss of the amenities of life, impairment of health, change in personality, discomfort and inconvenience.³⁶⁷ The non-patrimonial loss needs to be closely associated with the patient's personal bodily injuries.³⁶⁸ Grief and distress as a result of the suffering or death of another will not be actionable.³⁶⁹

4. The Elements of Delict

4.1 Conduct

The law of delict determines where liability should lie when loss arises as a result of wrongful conduct.³⁷⁰ Conduct is thus a general requirement for delictual liability.³⁷¹ It

³⁶⁴ *Administrator, Natal v Edouard* 1990 (3) SA 581 (A) at 595; Neethling & Potgieter (2010) 17.

³⁶⁵ *Guardian National Insurance Co Ltd v Van Gool NO* 1992 (4) SA 61 (A); *Reyneke v Mutual & Federal Insurance Co Ltd* 1991 (3) SA 412 (W) at 419; Midgley & Van Der Walt (2005) LAWSA 2, 12.

³⁶⁶ Neethling & Potgieter (2010) 17.

³⁶⁷ *Edouard v Administrator, Natal* 1989 2 SA 368 (D) at 385, 394; Midgley & Van Der Walt (2005) LAWSA 39; Neethling & Potgieter (2010) 17.

³⁶⁸ Midgley & Van Der Walt (2005) LAWSA 39.

³⁶⁹ *Collins v Administrator, Cape* at 94.

³⁷⁰ Midgley & Van Der Walt (2005) LAWSA 58; Neethling & Potgieter (2010) 27.

³⁷¹ Midgley & Van Der Walt (2005) LAWSA 58; Neethling & Potgieter (2010) 27. According to the authors, there can be no question of delictual liability for a detrimental consequence if there was no

may consist of either a positive act or an omission.³⁷² Positive conduct may arise in various forms, and the various forms are treated differently for the purposes of delictual liability. Liability for omissions is generally more restricted than liability for positive acts.³⁷³ The law determines what qualifies as conduct and in that respect a normative approach is followed.³⁷⁴

Only an act of a human being can be considered to constitute conduct.³⁷⁵ A juristic person may be held liable for its wrongful conduct as it is possible for a juristic person to act through its organs (humans). Certain considerations come into play when determining whether the conduct of persons, can be attributed to the juristic person, thus founding liability on their part.³⁷⁶

An act will only qualify as conduct if it is voluntary, meaning, the act must be subject to the will of the person engaged in the conduct.³⁷⁷ A person, who alleges that he or she acted involuntary, will raise the defence of automatism. Automatism is raised as a defence where a person acts mechanically and not of their own free will. The courts have recognised that persons, in the following circumstances, were unable to act according to their own free will: compulsion by human agency, sleep, unconsciousness, a fainting fit, an epileptic fit, serious intoxication, a blackout, reflex, mental illness, hypnosis, heavy emotional pressure, low blood sugar and a heart attack.³⁷⁸ The defence of automatism will however not succeed if the situation in

conduct which caused it. This is the case even if the detrimental consequence or damage arises much later. Conduct is considered a fundamental requisite for delictual liability.

³⁷² Midgley & Van Der Walt (2005) LAWSA 58 where the authors indicate that in Roman law liability was probably only founded on positive acts. In the Roman-Dutch law it was however, accepted that liability can be founded on the basis of an omission. As a requisite for liability to arise in such an instance, a duty to act positively must have existed. See also Neethling & Potgieter (2010) 27.

³⁷³ Midgley & Van Der Walt (2005) LAWSA 58 According to the authors: "Liability for omissions is generally more restricted than liability for commissions, and additional policy considerations come into play where, for example, statements, and not physical conduct, cause someone loss. For reasons of public policy, the law is reluctant to assume too readily the existence of a legal duty in these instances."; Neethling & Potgieter (2010) 32.

³⁷⁴ Neethling & Potgieter (2010) 27.

³⁷⁵ *Ibid.*

³⁷⁶ *Id* 28.

³⁷⁷ *Ibid.*

³⁷⁸ Midgley & Van Der Walt (2005) LAWSA 58; Neethling & Potgieter (2010) 29.

which the person acts involuntarily was intentionally created in order to cause harm to another.³⁷⁹ This situation is known as *actio libera in causa* and the responsible person will be held liable for the damage caused by his actions.³⁸⁰

Conduct may consist of both positive acts (*commissio*) and omissions (*omissio*). As mentioned above, liability for omissions is generally more restricted than liability incurred for positive acts. Due to public policy considerations, the law is hesitant to find that a legal duty exists on someone to act positively in order to prevent damage occurring to another person.³⁸¹ Carstens and Pearmain indicate that section 27(3) of the Constitution³⁸² has altered the situation in the health care context.³⁸³ The right to not be refused emergency medical treatment may create an obligation, compelling certain persons to act in specific circumstances. According to the authors a health professional or healthcare establishment, in either the public or private sector, that

³⁷⁹ Midgley & Van Der Walt (2005) LAWSA 58 where the authors indicate that the same principle applies if the situation is negligently created, thus making the harm caused to another person reasonably foreseeable: “In *Wessels v Hall and Pickles (Coastal) (Pty) Ltd* the defendant, while driving a vehicle, had suffered a hypoglycaemic attack which resulted in a diabetic coma. He lost control of his vehicle and caused a collision. The defendant had been aware of his diabetic condition and the possibility of sudden attacks, and knew what precautionary measures needed to be taken. Because he failed to take the precautions, he was held to have been negligent in causing his incapacity. The defence of incapacity was therefore not available to him. It should be noted, however, that the mere fact that a person had, for example, intoxicated himself to such an extent that he was unable to act voluntarily, is not in itself sufficient to render his preceding conduct negligent. The circumstances at the time of the defendant’s preceding voluntary conduct must have been such that a reasonable person would have foreseen the possibility of harm to another and would have taken precautions against it.”

³⁸⁰ Neethling & Potgieter (2010) 30.

³⁸¹ *Id* 32.

³⁸² S 27 of the Constitution which provides for Health care, food, water and social security.

“(1) Everyone has the right to have access to—

(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.”

³⁸³ Carstens & Pearmain (2007) 507.

refuses to provide emergency medical treatment without good reason, may face a claim for the violation of this constitutional right.³⁸⁴ The claim will probably be based in delict, as the refusal to provide emergency treatment will found liability on the part of the health professional or healthcare establishment. The circumstances of the particular case will of course need to be taken into account when considering such a claim.³⁸⁵ The authors point out that although the wording of the particular section implies a positive act, the failure to provide emergency medical treatment would most likely constitute an omission.³⁸⁶

A legal duty may also exist on a doctor to intervene medically in some other instances. Such a duty may arise where a doctor assumes control over a potentially dangerous situation or object, a duty may be imposed by statute, the non-performance of a contractual duty may result in the doctor incurring liability and the *boni mores* may determine that a legal duty exists to act positively. Failure to act or intervene medically may lead to the doctor incurring liability for such an omission.³⁸⁷

4.2 Wrongfulness

Conduct, which causes harm to another, will in itself not be enough to constitute a delict. In order for delictual liability to be founded, the conduct must have been wrongful.³⁸⁸ As it represents a fundamental and distinct requirement, there can be no

³⁸⁴ Carstens & Pearmain (2007) 507.

³⁸⁵ Carstens & Pearmain (2007) 507.

³⁸⁶ Carstens & Pearmain (2007) 507.

³⁸⁷ For a general discussion of liability resulting from an omission see Strauss & Strydom (1967) 175; Strauss (1991) 23; Slabbert (2011) 77. For examples in case law see *Kovalsky v Krige*; *Mitchell v Dixon*; *Van Wyk v Lewis*; *Prowse v Kaplan*; *Allott v Patterson & Jackson*; *Dube v Administrator Transvaal*; *Buls v Tsatsarolakis*; *Richter and Another v Estate Hammann*; *Blyth v Van der Heever*; *S v Kramer* 1987 (1) SA 887 (W); *Pringle v Administrator, Transvaal*; *Castell v De Greef*; *Collins v Administrator, Cape*; *Louwrens v Oldwage*; *McDonald v Wroe*.

³⁸⁸ Midgley & Van Der Walt (2005) LAWSA 59 where the authors cite the following case law *Herschel v Mrupe* 1954 (3) SA 464 (A); *Smit v SA Vervoerdienste* 1984 (1) SA 246 (C) at 249; *Lillicrap, Wassenaar & Partners v Pilkington Bros (SA) (Pty) Ltd* 1985 (1) SA 475 (A); *Cape Town Municipality v Bakkerud* 1997 (4) SA 356 (C); *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage*

question of delictual liability if the element of wrongfulness is not present.³⁸⁹ Only harm caused in a legally unjustified or unreasonable manner will result in delictual liability.³⁹⁰

Conduct will be considered wrongful if it infringes a legally-recognised right or if it constitutes a breach of a legal duty owed to the patient.³⁹¹ A legal duty may be imposed by legislation or in terms of the common law, where the existence of such a duty will depend on the particular circumstances of the case.³⁹²

Carstens and Pearmain refer to wrongfulness as a question of public policy as informed by the values and principles of the Constitution.³⁹³ The *boni mores* criterion has been profoundly affected by the Constitution, it now needs to incorporate the values and norms thereof and give expression thereto.³⁹⁴ Courts also need to develop the concept in accordance with the spirit, purport and object of the Bill of Rights.³⁹⁵

According to Neethling, Potgieter and Visser the evaluation of wrongfulness comprises of a dual inquiry.³⁹⁶ Firstly, there has to be determined whether a legally recognised individual interest has been detrimentally affected.³⁹⁷ In other words, the

(*Pty*) Ltd 2000 (1) SA 827 (SCA). Also see Neethling & Potgieter (2010) 35 where the authors indicate that the requirement that the conduct must have been *non iure* or *contra ius* has long since been established in the Roman and Roman-Dutch law.

³⁸⁹ Midgley & Van Der Walt (2005) LAWSA 59; Neethling & Potgieter (2010) 35.

³⁹⁰ Neethling & Potgieter (2010) 35.

³⁹¹ Midgley & Van Der Walt (2005) LAWSA 60.

³⁹² *Ibid.*

³⁹³ Carstens & Pearmain (2007) 515-522; Neethling & Potgieter (2010) 41.

³⁹⁴ Neethling & Potgieter (2010) 41.

³⁹⁵ S 8(3)(a) and 39(2) of the Constitution of the Republic of South Africa, 1996; *Carmichele v Minister of Safety & Security (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC).

³⁹⁶ Neethling & Potgieter (2010) 35.

³⁹⁷ Neethling & Potgieter (2010) 35; *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* 2003 (6) SA 13 (SCA) at 31 where Lewis JA describes the position as follows: "For an act or an omission to be actionable, it must constitute an infringement of a legal interest. Just as there cannot be negligence in the air, so too there cannot be wrongfulness (the breach of a legal duty) in the air"; *Local Transitional Council of Delmas and Another v Boshoff* 2005 (5) SA 514 (SCA) at 522; *Minister*

adverse consequence must have been caused by the conduct. If that has been established, the second part of the inquiry is focussed on determining, with regard to legal norms, whether the conduct which caused the adverse consequence, was unjustified or unreasonable.³⁹⁸ The mere fact that an adverse consequence arose, will not justify a finding of wrongfulness. The conduct will only be wrongful if it is found to be objectionable and in violation of a legally recognised norm.³⁹⁹

Wrongfulness is assessed in an objective *ex post facto* manner.⁴⁰⁰ It is judged from the point of view of the ordinary, reasonable person, taking into account all the relevant facts and circumstances that were actually present and the consequences which in actual fact arose.⁴⁰¹

The benchmark used to determine whether conduct is in fact wrongful, is reasonableness.⁴⁰² If it is found that a doctor's conduct was unreasonable, as he or she is not expected to harm the patient under the particular circumstances, it will be

of Safety and Security and Another v Carmichele 2004 (3) SA 305 (SCA) at 324; *Minister of Safety and Security and Another v Rudman and Another* 2005 (2) SA 16 (SCA) at 36.

³⁹⁸ Neethling & Potgieter (2010) 35.

³⁹⁹ Neethling & Potgieter (2010) 36; *Bester v Calitz* 1982 (3) SA 864 (O) at 864; *Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk* 1977 (4) SA 376 (T).

⁴⁰⁰ Midgley & Van Der Walt (2005) LAWSA 59; Neethling & Potgieter (2010) 35; *Steenkamp NO v Provincial Tender Board, Eastern Cape* 2007 (3) SA 121 (CC) at 139 where Moseneke DCJ states that "the enquiry into wrongfulness is an after- the-fact, objective assessment"; *NM and Others v Smith and others (Freedom of Expression Institute as Amicus Curiae)* 2007 (5) SA 250 (CC) at 274 where Langa CJ declared: "Lawfulness is an *ex post facto* inquiry into whether the action is compatible with the *boni mores*. It is important that when we determine lawfulness we are not concerned with the facts that were known to the defendant, but with the facts that are now available to the Court."; *Alley Cat Clothing (Pty) Ltd v De Lisle Weare Racing* [2002] 1 All SA 129 (D) 134.

⁴⁰¹ Midgley & Van Der Walt (2005) LAWSA 59; Neethling & Potgieter (2010) 35.

⁴⁰² Midgley & Van Der Walt (2005) LAWSA 60 where the authors cite the following case law: *Marais v Richard* 1981 (1) SA 1157 (A) at 1168; *Lillicrap, Wassenaar & Partners v Pilkington Bros (SA) (Pty) Ltd* at 498; *Kadir v Minister of Law & Order* 1992 (3) SA 737 (C) at 741; *Minister van Polisie v Ewels* at 596; *Borgin v De Villiers* 1980 (3) SA 556 (A) at 577; *Ramsay v Minister van Polisie* 1981 (4) SA 802 (A) at 811; *Argus Printing & Publishing Co Ltd v IFP* 1992 (3) SA 579 (A) at 588; *Knop v Johannesburg City Council* 1995 (2) SA 1 (A) at 27; *SM Goldstein & Co (Pty) Ltd v Cathkin Park Hotel (Pty) Ltd* 2000 (4) SA 1019 (SCA); *Olitzki Property Holdings v State Tender Board* 2001 (3) SA 1247 (SCA); *Van Eeden (formerly Nadel) v Minister of Safety & Security* 2003 (1) SA 389 (SCA).

considered wrongful for purposes of the law of delict.⁴⁰³ Reasonableness, as a general criterion for wrongfulness is equivalent to the concept of the *boni mores*, or the legal convictions of the community.⁴⁰⁴ These concepts are used interchangeably and are merely different expressions of the same benchmark for determining wrongfulness.⁴⁰⁵ The courts take many factors into account when determining whether the conduct was reasonable or unreasonable.⁴⁰⁶ The court needs to determine the legal convictions of society with regard to legal policy, legal rules and previous court decisions where the convictions have already been expressed, supplemented by evidence and information gathered about the incident.⁴⁰⁷ In doing so, a court must consider all the circumstances of the particular case.⁴⁰⁸

Because of its vagueness, the reasonableness or *boni mores*-test is rarely applied to determine wrongfulness.⁴⁰⁹ More practical and reliable methods have developed to determine wrongfulness over the years. A presumption of wrongfulness will arise if a subjective right is infringed or if there is a failure to act in accordance with a legally recognised duty.⁴¹⁰ In practice reasonableness or the *boni mores* is applied as a supplementary criterion in the determination of wrongfulness.⁴¹¹

⁴⁰³ *Administrateur, Transvaal v Van der Merwe* 1994 (4) SA 347 (A) at 361; *Carmichele v Minister of Safety & Security*.

⁴⁰⁴ *Universiteit van Pretoria v Tommy Meyer Films (Edms) Bpk* 1977; *Clarke v Hurst* 1992 (4) SA 630 (D) at 651.

⁴⁰⁵ Midgley & Van Der Walt (2005) LAWSA 60.

⁴⁰⁶ Midgley & Van Der Walt (2005) LAWSA 60 where the authors list a number of factors that are considered in determining if the conduct was reasonable or unreasonable: "courts must consider and balance the particular conflicting interests of the parties, including facts which are subjective to them, the parties' relation to each other, the particular circumstances of the case, whether the harm was foreseeable, whether any superior legal rights exist, constitutional values and any other appropriate considerations of social policy."

⁴⁰⁷ Neethling & Potgieter (2010) 45.

⁴⁰⁸ Midgley & Van Der Walt (2005) LAWSA 60; Neethling & Potgieter (2010) 45.

⁴⁰⁹ Neethling & Potgieter (2010) 47.

⁴¹⁰ *Id* 49.

⁴¹¹ Midgley & Van Der Walt (2005) LAWSA 62-63; Neethling & Potgieter (2010) 49.

A doctor's conduct will not be wrongful if he or she can raise a ground of justification.⁴¹² Some of the justifications which are of practical importance to health professionals are: necessity, *negotiorum gestio* and *volenti non fit iniuria*.⁴¹³ A distinction is drawn between defences directed at the wrongfulness element and defences which serve to exclude fault.⁴¹⁴

4.3 Fault

Fault, or *culpa* in wide sense, is accepted as a general requirement for delictual liability.⁴¹⁵ It is the subjective element of a delict, as it is concerned with the attitude of the perpetrator.⁴¹⁶ Once it has been established that the doctor's conduct was wrongful, the question of fault arises.⁴¹⁷ There can be no question of fault if it has not been established that the doctor's conduct was wrongful.⁴¹⁸ Also wrongful conduct is imputable to a doctor only if the conduct was legally blameworthy.⁴¹⁹

⁴¹² Midgley & Van Der Walt (2005) LAWSA 85 where the authors describe the position as follows: "Grounds of justification are practical examples of circumstances justifying a *prima facie* infringement of a recognised right or interest, according to the fundamental criterion of reasonableness. They indicate the circumstances in which society condones *prima facie* unlawful conduct. Grounds of justification are an expression of society's legal convictions and therefore policy considerations underpin their existence. Although in practice they have developed to the full status of defences to an action in delict, they are in reality the expression of the *boni mores* test in typically recurring practical circumstances. In *Clarke v Hurst* the court said: "The stereotyped grounds of justification are specific grounds of justification of otherwise wrongful conduct which with the passage of time have become crystallised, with their own rules limiting the scope of their application."

⁴¹³ Strauss & Strydom (1967) 169.

⁴¹⁴ Midgley & Van Der Walt (2005) LAWSA 85; *May v Udwin* 1981 (1) SA 1 (A) at 10; *Ramsay v Minister van Polisie* 1981 (4) SA 802 (A) at 807.

⁴¹⁵ Neethling & Potgieter (2010) 133. The word "*culpa*" can be used to indicate either the concept of fault in a general sense or in a narrower sense, to indicate negligence.

⁴¹⁶ Midgley & Van Der Walt (2005) LAWSA 103; Neethling & Potgieter (2010) 133.

⁴¹⁷ Midgley & Van Der Walt (2005) LAWSA 103.

⁴¹⁸ Neethling & Potgieter (2010) 133.

⁴¹⁹ Midgley & Van Der Walt (2005) LAWSA 103.

Blameworthiness or fault can appear in two different forms, either intent (*dolus*) or negligence (*culpa* in the narrow sense).⁴²⁰ Negligence or intent is sufficient to found liability in terms of the *actio legis Aquiliae* and the action for pain and suffering, however with regard to the *actio iniuriarum* intent is generally required and negligence will not suffice.⁴²¹

When determining whether a doctor is at fault the subjective factors of the case need to be considered and evaluated. A court would assess the doctor's mental disposition and the degree of skill exercised at the time the wrongful conduct occurred.⁴²² If the doctor acted in a reprehensible state of mind, fault in the form of intent or *dolus*, would be present.⁴²³ If it is found that the doctor acted with insufficient care, the doctor's conduct would constitute fault in the form of negligence or *culpa*.⁴²⁴

It can only be established that the doctor wrongfully conducted him or herself in a blameworthy manner if the doctor can be held accountable therefor. Accountability on the part of the doctor is therefore a prerequisite for the existence of fault on his or her part.⁴²⁵

⁴²⁰ Neethling & Potgieter (2010) 133.

⁴²¹ *Id* 134.

⁴²² Midgley & Van Der Walt (2005) LAWSA 103.

⁴²³ Midgley & Van Der Walt (2005) LAWSA 105 define intent as "a legally reprehensible state of mind or mental disposition encompassing the direction of the will to the attainment of a particular consequence, and consciousness of the fact that such result is being achieved in an unlawful or wrongful manner. The concept is entirely subjective: intent is present only if the defendant in fact intended to bring about a particular result and was, at the same time, subjectively aware of the wrongful character of his or her conduct." Also see the following cited case law: *Dantex Investment Holdings (Pty) Ltd v Brenner* 1989 (1) SA 390 (A) at 396; *Nydo v Vengtas* 1965 (1) SA 1 (A) at 15; *SA Uitsaaikorporasie v O'Malley* 1977 (3) SA 394 (A) at 403; *Matlou v Makhubedu* 1978 (1) SA 946 (A) at 962; *Pakendorf v De Flamingh* 1982 (3) SA 146 (A) at 157; *Minister of Justice v Hofmeyr* 1993 (3) SA 131 (A) at 154; *Tödt v Ipser* 1993 (3) SA 577 (A) at 586.

⁴²⁴ Midgley & Van Der Walt (2005) LAWSA 103.

⁴²⁵ Midgley & Van Der Walt (2005) LAWSA 104 where the authors describe accountability as follows: "A person is accountable if he or she has, firstly, the capacity to appreciate the danger involved in a particular situation; secondly, the ability to avoid the danger or take precautionary measures; and, thirdly, the ability to control impulsive conduct. Accountability amounts to a mental capacity to appreciate the nature and possible consequences of conduct in a particular situation, and the ability to

Fault in the form of intent is more commonly found in criminal law than the law of delict. Negligence will thus be considered further and be the focus of the rest of the discussion. Negligence is also the form of fault most often encountered in the healthcare context.⁴²⁶

The doctor's conduct will be negligent if the degree of care which the law of delict expects is not observed.⁴²⁷ The measure employed in our law to determine whether a person acted carelessly and consequently in a negligent manner, is the objective standard of the reasonable person or *bonus paterfamilias*.⁴²⁸

The test for negligence was enunciated by Holmes JA in the authoritative case of *Kruger v Coetzee*.⁴²⁹

For the purposes of liability *culpa* arises if -

(a) a *diligens paterfamilias* in the position of the defendant -

(i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and

take precautionary or avoiding action – to appreciate the difference between right and wrong and to act in accordance with that appreciation. In order to determine the capacity to be at fault there must be an inquiry into the mental, intellectual and emotional development of a particular defendant. Subjective factors such as, for instance, the person's knowledge, experience, training, mental development and maturity must all be taken into account." Also see Neethling & Potgieter (2010) 134; *Jones v SANTAM Bpk* 1965 (2) SA 542 (A); *Neuhaus v Bastion Insurance Co Ltd* 1968 (1) SA 398 (A); *Weber v SANTAM Versekeringsmpy Bpk* 1983 (1) SA 381 (A).

⁴²⁶ Carstens & Pearmain (2007) 522.

⁴²⁷ Midgley & Van Der Walt (2005) LAWSA 116; Neethling & Potgieter (2010) 140.

⁴²⁸ Midgley & Van Der Walt (2005) LAWSA 116; Neethling & Potgieter (2010) 140-141. Also see the following cited case law: *Hammerstrand v Pretoria Municipality* 1913 TPD 374 at 377; *Transvaal & Rhodesian Estates Ltd v Golding* 1917 AD 18 at 28; *Farmer v Robinson Gold Mining Co Ltd* 1917 AD 501 at 521–524; *Cape Town Municipality v Paine* 1923 AD 207 at 216–217, 225; *Transvaal Provincial Administration v Coley* 1925 AD 24 at 27–28; *Colman v Dunbar* 1933 AD 141 at 157; *Dukes v Marthinusen* 1937 AD 12 at 22; *Joffe & Co Ltd v Hoskins*; *Joffe & Co Ltd v Bonamour* 1941 AD 431; *Coetzee & Sons v Smit* 1955 (2) SA 553 (A) at 559–560; *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430; *Gordon v Da Mata* 1969 (3) SA 285 (A) at 289; *Griffiths v Netherlands Insurance Co of SA Ltd* 1976 (4) SA 691 (A) at 695; *Buys v Lennox Residential Hotel* 1978 (3) SA 1037 (C); *Johannesburg Consolidated Investment Co Ltd v Langleigh Construction (Pty) Ltd* 1991 (1) SA 576 (A) at 579.

⁴²⁹ *Kruger v Coetzee* at 430.

- (ii) would take reasonable steps to guard against such occurrence; and
- (b) the defendant failed to take such steps.

This has been constantly stated by this Court for some 50 years. Requirement (a)(ii) is sometimes overlooked. Whether a *diligens paterfamilias* in the position of the person concerned would take any guarding steps at all and, if so, what steps would be reasonable, must always depend upon the particular circumstances of each case. No hard and fast basis can be laid down.

The test for negligence has since been reformulated in other cases.⁴³⁰ Regardless, whether or not conduct constitutes negligence will ultimately depend upon a realistic and sensible judicial approach taking into account all the relevant facts and circumstances of the particular matter.⁴³¹

The test for negligence is reformulated where the conduct of an expert is concerned.⁴³² The test one would then apply will not be that of the reasonable person, but rather that of the reasonable doctor.⁴³³ A higher standard of care is thus required.⁴³⁴ The test for medical negligence was enunciated by Innes ACJ in the case of *Mitchell v Dixon*⁴³⁵

“A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.”

⁴³⁰ *Groenewald v Groenewald* 1998 (2) SA 1106 (SCA); *Mukheiber v Raath* 1999 (3) SA 1065 (SCA); *Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd*.

⁴³¹ *Mkhatswa v Minister of Defence* 2000 (1) SA 1104 (SCA).

⁴³² Midgley & Van Der Walt (2005) LAWSA 125; Neethling & Potgieter (2010) 148-149.

⁴³³ Midgley & Van Der Walt (2005) LAWSA 125; Neethling & Potgieter (2010) 148-149; *Van Wyk v Lewis* at 444; *Blyth v Van den Heever* at 221; *S v Kramer* at 893–895; *Pringle v Administrator, Transvaal* at 384–385; *Castell v De Greef* 1993 (3) SA 501 (C) at 509; *Louwrens v Oldwage* at 208.

⁴³⁴ Carstens & Pearmain (2007) 619ff.

⁴³⁵ *Mitchell v Dixon* at 525.

In *Van Wyk v Lewis*⁴³⁶ the court stated that when evaluating what is considered reasonable the court will “have regard 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 the practitioner belongs”. The professional care and skill required, is not the highest possible degree of professional care and skill, but rather reasonable knowledge, ability, experience, care, skill and diligence.⁴³⁷

Another distinction is made, regarding the test for medical negligence, when evaluating a specialist’s conduct. If the physician is a specialist, the test is that of the reasonable specialist, with reference to the specific field of specialisation in which the physician practices.⁴³⁸

It is important to take note of the *imperitia culpa adnumeratur* rule.⁴³⁹ According to this principle a person who engages in an undertaking that requires a certain amount of training, knowledge, experience, skill or diligence, while fully mindful of the fact that he or she does not possess such qualities or abilities will be bound by his or her undertaking and be judged accordingly. Thus, a doctor who pretends to be a specialist will be judged as such.⁴⁴⁰

There exists uncertainty about whether locality considerations should impact on the standard of competence.⁴⁴¹ This is mainly due to conflicting judicial pronouncements made on the issue. On the question of whether or not the locality where a doctor

⁴³⁶ *Van Wyk v Lewis* at 444.

⁴³⁷ *Kovalsky v Krige; Mitchell v Dixon* at 525; *Coppen v Impey* at 314; *Van Wyk v Lewis* at 444; *Allot v Paterson & Jackson* at 224; *Dube v Administrator Transvaal* at 266; *Buls v Tsatsarolakis* at 893; *Blyth v Van der Heever* at 221; *S v Kramer* at 893; *Pringle v Administrator, Transvaal* at 384; *Castell v De Greef* 1994 (4) SA 408 (C) at 420; *Collins v Administrator, Cape* 1995 (4) SA 73 (C) at 81; *Clinton-Parker v Administrator, Transvaal* 1996 (2) SA 37 (W) at 39, 69; *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 (3) SA 1188 (SCA) at 1192. See Carstens & Pearmain (2007) 622 for examples of how the legal standard finds practical application in practice.

⁴³⁸ Strauss & Strydom (1967) 268; Carstens & Pearmain (2007) 623; Slabbert (2011) 107.

⁴³⁹ Strauss & Strydom (1967) 265ff; Claassen & Verschoor (1992) 16ff; Carstens & Pearmain (2007) 628ff; Slabbert (2011) 108.

⁴⁴⁰ *Coppen v Impey* 1916 CPD 309; *Dale v Hamilton* 1924 WLD 184; *R v Van der Merwe*; *S v Mkwetshana* 1965 (2) SA 493 (N); *McDonald v Wroe*.

⁴⁴¹ Strauss & Strydom (1967) 268; Claassen & Verschoor (1992) 18; Midgley & Van Der Walt (2005) LAWSA 125; Carstens & Pearmain (2007) 636; Slabbert (2011) 108.

practises plays a role when evaluating a doctor's medical negligence, the court, in the case of *Van Wyk v Lewis*⁴⁴², held opposing views. Innes CJ preferred to apply a general standard to all medical practitioners:

“The ordinary medical practitioner should, as it seems to me, exercise the same degree of skill and care, whether he carries on his work in the town or the country in one place or another. The fact that several incompetent or careless practitioners happen to settle at the same place cannot affect the standard of diligence and skill which local patients have a right to expect.”⁴⁴³

While Wessels JA, coming to an opposite conclusion, preferred the view that skill and care could differ according to locality:

“It seems to me, however, that you cannot expect the, same skill and care of a practitioner in a country town in the Union as you can of one in a large hospital in Cape Town or Johannesburg. In the same way you cannot expect the same skill in these towns as you will find with the leading surgeons in the large hospitals of London, Paris and Berlin. You can only expect of surgeons in South Africa that degree of skill and that degree of care which is generally to be found in surgeons practising in this country. It seems to me therefore that the locality where an operation is performed is an element in judging whether or not reasonable skill, care and judgment have been exercised.”⁴⁴⁴

The view held by Innes CJ seems to have garnered the most support.⁴⁴⁵ There has been argued that, due to advances in education, training, communication and the availability of information, locality as a factor should not play a significant role when

⁴⁴² *Van Wyk v Lewis*.

⁴⁴³ *Id* at 444.

⁴⁴⁴ *id* at 457.

⁴⁴⁵ Gordon, Turner & Price (1953) 112-113 where the authors stress that the implications of distinguishing cases on the basis of locality, would confuse the issue when determining the required standard of care; Strauss & Strydom (1967) 269-270; Claassen & Verschoor (1992) 18-19; Carstens & Pearmain (2007) 636-638.

assessing knowledge and skill. It has been stated that locality should not influence the standard of care and skill.⁴⁴⁶

There has however, also been convincingly argued that a distinction needs to be drawn between the subjective qualities and abilities of the doctor and the objective circumstances of the locality where the doctor practises or is employed.⁴⁴⁷ It is true that practitioners undergo uniform medical training of a high standard, but the reality is that the facilities and often a lack of resources encountered in a particular locality must be considered when evaluating the alleged medical negligence of a practitioner.⁴⁴⁸

Carstens and Pearmain are of the opinion that the so called “locality rule”, is a rule of “special circumstance” which should be considered in the assessment of medical negligence. According to the authors the locality where a doctor practises should be a factor taken into consideration in cases of medical negligence.⁴⁴⁹

⁴⁴⁶ Gordon, Turner & Price (1953) 112-113; Midgley & Van Der Walt (2005) LAWSA 125; Carstens & Pearmain (2007) 637; Slabbert (2011) 108.

⁴⁴⁷ Carstens & Pearmain (2007) 638.

⁴⁴⁸ Carstens & Pearmain (2007) 638 where the authors pose and answer the question, of whether a large city centre hospital can really be compared with the facilities at a rural hospital or clinic: “It is to be noted that this question does not imply that medical practitioners who practice in the larger city centres are subjectively ‘better’ doctors than their rural counterparts; both doctors have, after all, received the same uniform medical training. However, the medical practitioner in the larger city centre has access to better medical facilities and support services than his rural counterpart. In South Africa, specifically in remote tribal areas, one finds an absence of proper medical facilities and equipment and hospitals/clinics are mainly concerned to save human lives, provide access to primary health care, and to treat and prevent serious medical complications. Doctors and nursing staff in these hospitals/clinics do their best under difficult medically compromised circumstances. There are often shortages of medical staff and in many instances the doctors do not have access to the same medical facilities of their counterparts in the larger city centres.”

⁴⁴⁹ Carstens & Pearmain (2007) 638; Carstens “The locality rule in medical practice” (1990) *De Rebus* 421; *Collins v Administrator, Cape* at 82 where there is support for the view that a lack of resources may play a role in the evaluation of negligence. Scott J states: “No doubt there are other similar units elsewhere in the world where the staff to patient ratio is higher. But a standard of excellence cannot be expected which is beyond the financial resources of the hospital authority.” See also *S v Tembani* 2007 (1) SACR 355 (SCA) where it is clear that the locality (the difference between public health facilities and health facilities found in the private sector) is a factor that cannot be ignored in the

4.4 Causation

Causation as an element of a delict refers to the nexus between the conduct and the consequent damages caused by such conduct.⁴⁵⁰ If a person did not cause the damage, he or she cannot be held liable.⁴⁵¹ Whether a causal link exists between the conduct and the damages suffered, is a question of fact, which must be answered with reference to the available evidence and the relevant inferences of each particular case.⁴⁵² In some instances the issue of causation may arise at the start of

context of criminal medical negligence. Cameron JA sets out the situation as follows: “In a country where medical resources are not only sparse but grievously maldistributed, it seems to me quite wrong to impute legal liability on the supposition that efficient and reliable medical attention will be accessible to a victim, or to hold that its absence should exculpate a fatal assailant from responsibility for death. Such an approach would misrepresent reality, for it presumes levels of service and access to facilities that do not reflect the living conditions of a considerable part, perhaps the majority, of the country's population. To assume the uniform availability of sound medical intervention would impute legal liability in its absence on the basis of a fiction and this cannot serve the creation of a sound system of criminal liability. I therefore endorse the views of those writers who regard improper medical treatment as neither abnormal nor extraordinary and hold that the supervention of negligent treatment does not constitute an intervening cause that exculpates an assailant while the wound is still intrinsically fatal. In view of the allusion to it by some of the authorities, I should add that I do not consider that even gross negligence in the administration of medical treatment should be sufficient to relieve the original perpetrator of criminal liability for an ensuing death.” For an excellent discussion of this case and the implications thereof see Carstens “Judicial recognition of substandard medical treatment in South African public hospitals: the slippery slope of policy considerations and implications for liability in the context of criminal medical negligence” (2008) 23 *SA Public Law* 168.

⁴⁵⁰ Midgley & Van Der Walt (2005) *LAWSA* 128; Neethling & Potgieter (2010) 185.

⁴⁵¹ *First National Bank of South Africa Ltd v Duvenhage* 2006 (5) SA 319 (SCA) at 320; *mCubed International (Pty) Ltd and Another v Singer and Others NNO* 2009 (4) SA 471 (SCA) at 479; *Minister of Correctional Services v Lee* 2012 (3) SA 617 (SCA) at 626.

⁴⁵² Neethling & Potgieter (2010) 185. The authors state that expert evidence is of great importance when questions of causation arise. The case of *Accident and Guarantee Corporation Ltd v Koch* 1963 (4) SA 147 (A) is cited as an example where medical evidence was crucial in determining causation.

the proceedings and would need to be addressed first, thus, preceding the evaluation of wrongfulness or fault.⁴⁵³

The issue of causation in the law of delict involves two distinct problems.⁴⁵⁴ The first is a factual one and relates to the question as to whether the negligent act or omission in question caused or materially contributed to the harm giving rise to the claim.⁴⁵⁵ If it did not, then no legal liability can arise and the enquiry will be dropped. If it did, the second problem becomes relevant, that is to say, whether, or to what extent, the defendant should be held legally responsible for the consequences factually induced by his or her conduct.⁴⁵⁶ This is a juridical problem in which legal policy considerations may play a part.⁴⁵⁷

Causation in the law of delict is thus comprised of two essential elements: factual causation and legal causation.⁴⁵⁸

4.4.1 Factual Causation

Delictual liability will only arise if the damage was caused by the doctor.⁴⁵⁹ The question then becomes, how does one establish whether a causal link exists

⁴⁵³ Neethling & Potgieter (2010) 185; *First National Bank of South Africa Ltd v Duvenhage* at 320, 326.

⁴⁵⁴ *Minister of Police v Skosana* 1977 (1) SA 31 (A) at 34-35.

⁴⁵⁵ *Silva's Fishing Corporation (Pty) Ltd v Maweza* 1957 (2) SA 256 (AD) at 264; *Kakamas Bestuusraad v Louw* 1960 (2) SA 202 (AD) at 222.

⁴⁵⁶ Midgley & Van Der Walt (2005) LAWSA 129.

⁴⁵⁷ *Minister of Police v Skosana* at 34-35; *Muller v Mutual and Federal Insurance Co Ltd and Another* 1994 (2) SA 425 (C) at 449 where the court cites *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* 1984 (2) SA 888 (A) at 914-915; *International Shipping Co (Pty) Ltd v Bentley* 1990 (1) SA 680 (A) at 700-701 and *S v Mokgethi en Andere* 1990 (1) SA 32 (A) when concluding that "the problem of causation in delict involves two distinct enquiries. The first is whether the defendant's wrongful act was a cause of the plaintiff's loss ('factual causation'); the second is whether the wrongful act is linked sufficiently closely to the loss for legal liability to ensue ('legal causation' or remoteness).".

⁴⁵⁸ *Minister of Police v Skosana* at 34-35, 43-44; Midgley & Van Der Walt (2005) LAWSA 129; Neethling & Potgieter (2010) 186.

⁴⁵⁹ Neethling & Potgieter (2010) 186.

between the damage and the conduct, stated differently, what is the correct test for causality? The courts assess the alleged link by evaluating the evidence and the relevant probabilities. In practice the courts have come to rely on the *conditio sine quo non* test to determine the existence of factual causation.⁴⁶⁰

In *International Shipping Co (Pty) Ltd v Bentley*⁴⁶¹ the court stated:

“The first [enquiry] is a factual one and relates to the question as to whether the defendant's wrongful act was a cause of the plaintiff's loss. This has been referred to as 'factual causation'. The enquiry as to factual causation is generally conducted by applying the so-called 'but-for' test, which is designed to determine whether a postulated cause can be identified as a *causa sine qua non* of the loss in question. In order to apply this test one must make a hypothetical enquiry as to what probably would have happened but for the wrongful conduct of the defendant. This enquiry may involve the mental elimination of the wrongful conduct and the substitution of a hypothetical course of lawful conduct and the posing of the question as to whether upon such an hypothesis plaintiff's loss would have ensued or not. If it would in any event have ensued, then the wrongful conduct was not a cause of the plaintiff's loss; *aliter*, if it would not so have ensued. If the wrongful act is shown in this way not to be a *causa sine qua non* of the loss suffered, then no legal liability can arise.”⁴⁶²

⁴⁶⁰ Midgley & Van Der Walt (2005) LAWSA 130; Neethling & Potgieter (2010) 186. The *conditio sine quo non* test is also known as the “but for”- test.

⁴⁶¹ *International Shipping Co (Pty) Ltd v Bentley*.

⁴⁶² *International Shipping Co (Pty) Ltd v Bentley* at 700. The court goes on to say that the “demonstration that the wrongful act was a *causa sine qua non* of the loss does not necessarily result in legal liability”. See also *Ocean Accident & Guarantee Corporation Ltd v Koch* 1963 (4) SA 147 (A); *S v Van As* 1967 (4) SA 594 (A); *Kgobane v Minister of Justice* 1969 (3) SA 365 (A) at 373; *Da Silva v Coutinho* 1971 (3) SA 123 (A) at 147; *Minister of Police v Skosana*; *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* at 914-918; *First National Bank of South Africa Ltd v Duvenhage* at 324-325. Also see Midgley & Van Der Walt (2005) LAWSA 130 where the authors describe the theory as follows: “The *conditio sine qua non* theory is based on the premise that every event is the result of many conditions which are jointly sufficient to produce it. The complex set of conditions includes all antecedents, active or passive, which were factors necessarily contributing to the production of the

Where positive conduct (*commissio*) is concerned, the positive act is hypothetically eliminated from the circumstances prevailing at the time in order to determine whether the detrimental consequences would still have occurred, in the absence thereof. If the court concludes that, in spite of the elimination of the act, the consequences would still have occurred, it will be clear that the act was not a necessary condition and therefore cannot be regarded as the cause of the particular consequence.⁴⁶³

The process followed when assessing an omission (*omissio*) differs from that of a positive act, as a method of mental substitution is preferable in such an instance.⁴⁶⁴ This method involves the substitution of a hypothetical lawful positive act for the unlawful omission. If it is found that the hypothetical positive act would probably have prevented the particular consequence from occurring, then one can accept that the omission was a necessary condition and therefore a cause of the consequence.⁴⁶⁵

consequence. The conduct of the plaintiff can therefore only be considered as a cause-in-fact of the harmful consequence if it was a necessary condition – *conditio sine qua non* – of the occurrence and existence of the particular consequence.”.

⁴⁶³ Midgley & Van Der Walt (2005) LAWSA 130; Neethling & Potgieter (2010) 189.

⁴⁶⁴ Neethling & Potgieter (2010) 194; *S v Van As*; *Minister of Police v Skosana*; *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* at 915.

⁴⁶⁵ Midgley & Van Der Walt (2005) LAWSA 130; Neethling & Potgieter (2010) 189; *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) at 449 where the court elaborates on the issue: “There are conceptual hurdles to be crossed when reasoning along those lines for, once the conduct that actually occurred is mentally eliminated and replaced by hypothetical conduct, questions will immediately arise as to the extent to which consequential events would have been influenced by the changed circumstances. Inherent in that form of reasoning is thus considerable scope for speculation which can only broaden as the distance between the wrongful conduct and its alleged effect increases. No doubt a stage will be reached at which the distance between cause and effect is so great that the connection will become altogether too tenuous, but, in my view, that should not be permitted to be exaggerated unduly. A plaintiff is not required to establish the causal link with certainty, but only to establish that the wrongful conduct was probably a cause of the loss, which calls for a sensible retrospective analysis of what would probably have occurred, based upon the evidence and what can be expected to occur in the ordinary course of human affairs rather than an exercise in metaphysics.”.

The *conditio sine quo non* test, as set out above, has been accepted and utilised by most courts when dealing with the issue of factual causation.⁴⁶⁶ However, it is recognised that the *conditio sine quo non* approach is not the only way to determine factual causation, but it is favoured, as it is considered to be the most simple and understandable approach.⁴⁶⁷ Although it is widely used the *conditio sine qua non* theory does not suit all instances. In circumstances where the consequences can be attributed to multiple causes, whether in the form of concurrent or contemporaneous, or successive conduct or events, a common-sense approach to the evaluation of factual causation is more appropriate.⁴⁶⁸

The main objective, however, is to establish a factual link between the conduct and the consequences and once the link is established, the significance thereof in the light of legal causation, will be considered.⁴⁶⁹

4.4.2 Legal Causation

Once a factual causal link has been established between the unlawful, blameworthy conduct of a doctor and the detrimental consequences thereof, legal causation needs to be considered.⁴⁷⁰ A doctor will only be held liable for the harm suffered if a legally relevant causal link exists between the conduct and the damages suffered. Legal causation sets the bounds of liability for factually caused detrimental consequences, as a doctor cannot be held liable for consequences which are too remote to be imputed upon him or her.⁴⁷¹

⁴⁶⁶ Neethling & Potgieter (2010) 187.

⁴⁶⁷ Neethling & Potgieter (2010) 187, also see the authors at 190 ff. for criticism of the theory; *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* at 917-918 where the judge highlighted that Courts should not overlook the importance of applying common sense standards to the facts of a particular case; *S v Counter* 2003 (1) SACR 143 (SCA).

⁴⁶⁸ Neethling & Potgieter (2010) 190ff.; Midgley & Van Der Walt (2005) LAWSA 131.

⁴⁶⁹ Midgley & Van Der Walt (2005) LAWSA 131.

⁴⁷⁰ Midgley & Van Der Walt (2005) LAWSA 132; Neethling & Potgieter (2010) 198.

⁴⁷¹ Neethling & Potgieter (2010) 198; *International Shipping Co (Pty) Ltd v Bentley* at 700; *Napier v Collett and Another* 1995 (3) SA 140 (A) at 143 where the court stated: "The theoretical

In *International Shipping Co (Pty) Ltd v Bentley*⁴⁷² the court confirmed the position:

“[D]emonstration that the wrongful act was a *causa sine qua non* of the loss does not necessarily result in legal liability. The second enquiry then arises, viz whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote. This is basically a juridical problem in the solution of which considerations of policy may play a part. This is sometimes called 'legal causation'.”⁴⁷³

Inquiries into legal causation are concerned with the limits of legal liability, for reasons of policy not all harm factually caused can be attributed to a person's wrongful conduct. The connection between the damage and the conduct should be sufficiently close.⁴⁷⁴

The question about how legal causation should be determined or the appropriate test that should be applied has until recently elicited quite a number of different opinions.⁴⁷⁵ In *Smit v Abrahams*⁴⁷⁶ the court acknowledged two tests from literature. The court identified the direct consequences test and the foreseeability test. The direct consequences theory as formulated in the case of *In re Polemis v Furness, Withy & Co Ltd*⁴⁷⁷ was expressed as follows:

“The presence or absence of reasonable anticipation of damage determines the legal quality of the act as negligent or innocent. If it be

consequences of an act stretch into infinity. Some means must be found to limit legal responsibility for such consequences in a reasonable, practical and just manner”; *First National Bank of South Africa Ltd v Duvenhage* at 321;

⁴⁷² 1990 (1) SA 680 (A).

⁴⁷³ *International Shipping Co (Pty) Ltd v Bentley* at 700. See also *Minister of Police v Skosana* at 44; *Siman & Co (Pty) Ltd v Barclays National Bank Ltd* at 914; *Tuck v Commissioner for Inland Revenue* at 832–833; *Muller v Mutual & Federal Insurance Co Ltd* at 449; *Standard Chartered Bank of Canada v Nedperm Bank Ltd* at 764; *Road Accident Fund v Sauls* 2002 (2) SA 55 (SCA).

⁴⁷⁴ Neethling & Potgieter (2010) 199; *S v Daniëls en 'n Ander* 1983 (3) SA 275 (A) at 331; *Clarke v Hurst NO and Others* at 660; *Smit v Abrahams* 1994 (4) SA 1 (A) at 16;

⁴⁷⁵ Neethling & Potgieter (2010) 201. See the discussion in *Smit v Abrahams*.

⁴⁷⁶ 1992 (3) SA 158 (C).

⁴⁷⁷ *In re Polemis v Furness, Withy & Co Ltd* 1921 3 KB 560 (CA).

thus determined to be negligent, then the question whether particular damages are recoverable depends only on the answer to the question whether they are the direct consequence of the act.”⁴⁷⁸

This view is based on the belief that an innocent victim of a delict should be allowed to recover damage flowing from all the direct consequences of the wrongdoer's conduct.⁴⁷⁹

In terms of the foreseeability test a defendant cannot be held liable for consequences which no reasonable person could have foreseen would follow from his or her conduct.⁴⁸⁰ The court in *Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co Ltd*⁴⁸¹ rejected the direct consequence test in favour of the foreseeability theory:

“...[I]t does not seem consonant with current ideas of justice or morality that for an act of negligence, however slight or venial, which results in some trivial foreseeable damage, the actor should be liable for all consequences however unforeseeable and however grave, so long as they can be said to be "direct". It is a principle of civil liability, subject only to qualifications which have no present relevance, that a man must be considered to be responsible for the probable consequences of his act. To demand more of him is too harsh a rule, to demand less is to ignore that civilised order requires the observance of a minimum standard of behaviour.”⁴⁸²

⁴⁷⁸ *Ibid.*

⁴⁷⁹ Midgley & Van Der Walt (2005) LAWSA 132. The authors indicate that the theory of direct consequences has its origin in the judgments of *Smith v London & South Western Railway Co* (1870) LR 6 CP 14 and *Weld-Blundell v Stephens* 1920 AC 956 at 984.

⁴⁸⁰ Midgley & Van Der Walt (2005) LAWSA 132. According to the authors the foreseeability test has its origin in the judgments of Baron Pollock in *Greenland v Chaplin* (1850) 5 Ex 243 and *Rigby v Hewitt* (1850) 5 Ex 240.

⁴⁸¹ *Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co Ltd* [1961] AC 388 (PC)

⁴⁸² Farlam AJ in *Smit v Abrahams* states that the principle upheld in *Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co Ltd* is subject to at least two qualifications: a) as long as the 'kind of damage' is foreseeable the extent need not be; and b) the precise manner of occurrence need not be foreseeable.

If the two main theories are considered, one comes to the conclusion that they are significantly different in their approach to the question of legal causation. The wrongdoer may be unduly favoured at the expense of the innocent victim, if the foreseeability theory is too rigorously followed.⁴⁸³ Then again, if the direct consequences theory is favoured the wrongdoer may be burdened with excessive liability entirely disproportionate to the severity of his or her fault.⁴⁸⁴

The Appellate Division, in *S v Mokgethi*⁴⁸⁵, has however, expressed a preference for an elastic approach, which recognises that the application of a single criterion to each particular situation would not suffice.⁴⁸⁶ When determining whether a sufficiently close link exists between the wrongful conduct and the consequences thereof, considerations of public policy will inevitably play a role and one must evaluate legal liability in the light of concepts such as reasonableness, fairness and justice.⁴⁸⁷

In *Standard Chartered Bank of Canada v Nedperm Bank Ltd*⁴⁸⁸ the test for determining legal causation was described by Corbett CJ as “a flexible one in which factors such as reasonable foreseeability, directness, the absence or presence of a *novus actus interveniens*, legal policy, reasonability, fairness and justice all play their part.”⁴⁸⁹ The other theories regarding legal causation used in the past, have not been discarded, but may be of use in a subsidiary capacity when employing the elastic approach⁴⁹⁰ It is further important to note that courts are not bound by one measure or criterion, and may apply whichever one they should choose depending on the particular circumstances of each case, the main objective being the achievement of

⁴⁸³ Neethling & Potgieter (2010) 201. The authors indicate that the courts used to prefer this theory.

⁴⁸⁴ Midgley & Van Der Walt (2005) LAWSA 132.

⁴⁸⁵ 1990 (1) SA 32 (A).

⁴⁸⁶ *S v Mokgethi en Andere* at 39.

⁴⁸⁷ *S v Mokgethi en Andere* at 40. See also *International Shipping Co (Pty) Ltd v Bentley* at 701; *Muller v Mutual & Federal Insurance Co Ltd* at 451; *Smit v Abrahams* 1994 at 14-15, 18-19, 21.

⁴⁸⁸ 1994 (4) SA 747 (A).

⁴⁸⁹ *Standard Chartered Bank of Canada v Nedperm Bank Ltd* at 765.

⁴⁹⁰ Midgley & Van Der Walt (2005) LAWSA 132; Neethling & Potgieter (2010) 202; *Smit v Abrahams*; *Thoroughbred Breeders' Association of SA v Price Waterhouse* 2001 (4) SA 551 (SCA).

a just outcome.⁴⁹¹ The complex issues involved in determining legal causation, cannot be approached in a dogmatic or oversimplified manner.⁴⁹²

4.5 Loss

The primary object of the law of delict is to compensate a person who has suffered damages as a result of another's wrongful, blameworthy conduct.⁴⁹³ The damage element of a delict is fundamental and loss is suffered if there is any negative impact to a person's legally recognised patrimonial or non-patrimonial interests.⁴⁹⁴ By awarding damages one attempts, as far as possible, to place the injured party in the same position he or she would have been in, had the delict not occurred.⁴⁹⁵ It is possible for a victim of wrongful conduct to claim patrimonial and non-patrimonial damages in terms of the law of delict, whereas a claim based on contract would only be possible for patrimonial damages suffered.

Damage is a wide concept that includes both patrimonial and non-patrimonial loss⁴⁹⁶

4.5.1 Patrimonial Loss

⁴⁹¹ Neethling & Potgieter (2010) 203. See also *Clinton-Parker v Administrator, Transvaal*; *Dawkins v Administrator, Transvaal*; *McDonald v Wroe* at 568 where the court describes the position as follows: "Legal causation is present in the event where there is a close enough relationship between the wrongdoer's conduct and its consequence for such consequence to be imputed to the wrongdoer in view of policy considerations based on reasonableness, fairness and justice."

⁴⁹² Midgley & Van Der Walt (2005) LAWSA 132.

⁴⁹³ Midgley & Van Der Walt (2005) LAWSA 143; Neethling & Potgieter (2010) 223.

⁴⁹⁴ Neethling & Potgieter (2010) 224.

⁴⁹⁵ *Union Government (Minister of Railways & Harbours) v Warneke* 1911 AD 657 at 662; *Whittaker v Roos & Bateman*; *Morant v Roos & Bateman* 1912 AD 92 at 122-123; *Dippenaar v Shield Insurance Co Ltd* 1979 (2) SA 904 (A) at 917; *Standard General Insurance Co Ltd v Dugmore* 1997 (1) SA 33 (A) at 41; *Transnet Ltd v Sechaba Photoscan (Pty) Ltd* 2005 (1) SA 299 (SCA); *Van der Merwe v Road Accident Fund and Another (Women's Legal Centre Trust as Amicus Curiae)* 2006 (4) SA 230 (CC) at 252.

⁴⁹⁶ Visser & Potgieter (2003) *Law of Damages* 30; Neethling & Potgieter (2010) 225.

Patrimonial damage is suffered if there is an adverse effect on a legally recognised patrimonial interest. It can also be described as a loss or diminution of a positive patrimonial element or asset, or as the increase of a negative patrimonial element or debt.⁴⁹⁷

According to the juridical understanding of patrimony, a person's patrimony consists of both positive as well as negative elements.⁴⁹⁸ The positive elements include patrimonial rights, such as different types of real rights, personal rights and immaterial property rights.⁴⁹⁹ Expectations of patrimonial rights or benefits are also considered to be a positive element of one's patrimony and can be described as a legally recognised expectation of acquiring patrimonial rights or benefits in the future.⁵⁰⁰ The negative elements of a person's patrimony are comprised of patrimonial debts or expenses and expectations of patrimonial debts or expenses.⁵⁰¹

Patrimonial damage is incurred when a patrimonial element loses value or gets destroyed; additionally the creation or increase of a patrimonial debt, or expectation of a patrimonial debt, also gives rise to patrimonial damage.⁵⁰² Different views exist as to how one would determine whether patrimonial damage was suffered and the extent of the damage sustained, however it is clear that a method of comparison is applied.⁵⁰³

In terms of the traditional sum-formula approach the victim's current patrimonial position is compared to the hypothetical position which would have currently existed if the delict never occurred.⁵⁰⁴ If the concrete method of determining damage is

⁴⁹⁷ Neethling & Potgieter (2010) 230-231.

⁴⁹⁸ Neethling & Potgieter (2010) 231; Visser & Potgieter (2003) 51.

⁴⁹⁹ Visser & Potgieter (2003) 50; Neethling & Potgieter (2010) 231.

⁵⁰⁰ Visser & Potgieter (2003) 51; Neethling & Potgieter (2010) 231.

⁵⁰¹ Visser & Potgieter (2003) 54; Neethling & Potgieter (2010) 231. Future medical treatments for injuries suffered is cited as an example of an expected patrimonial debt or expense.

⁵⁰² Neethling & Potgieter (2010) 232.

⁵⁰³ Visser & Potgieter (2003) 64; Neethling & Potgieter (2010) 233.

⁵⁰⁴ Visser & Potgieter (2003) 64; Neethling & Potgieter (2010) 233. See also *Union Government (Minister of Railways & Harbours) v Warneke*; *Dippenaar v Shield Insurance Co Ltd*; *Transnet Ltd v Sechaba Photoscan (Pty) Ltd* at 304 where the court stated: "It is now beyond question that damages in delict (and contract) are assessed according to the comparative method. Essentially, that method, in my view, determines the difference, or, literally, the *interesse*. The award of delictual damages

employed, the pecuniary position of the person before the commission of the delict is compared with his or her position thereafter.⁵⁰⁵

In the healthcare context it is important to note that a patient who suffers damages must take all necessary reasonable steps to prevent the accumulation of damages.⁵⁰⁶ A patient is entitled to claim damages for expenses related to the reasonable steps taken.⁵⁰⁷ The failure to take preventative steps may prohibit the patient from claiming damages for loss or harm suffered, if such loss or harm could have been prevented by taking reasonable action.⁵⁰⁸ Although, the standard of reasonableness is not very high considering that the other person is at fault. The onus of proving that the patient should have prevented the accumulation of damages also rests on the wrongdoer.⁵⁰⁹

The wrongdoer in a claim for damages will not be absolved of paying damages to the patient if a third party has already partly or completely extinguished the damages suffered.⁵¹⁰ Where the patient receives a benefit from a third party it is seen as *res inter alios acta* and not taken into account when calculating the damages the patient

seeks to compensate for the difference between the actual position that obtains as a result of the delict and the hypothetical position that would have obtained had there been no delict.”.

⁵⁰⁵ Visser & Potgieter (2003) 71; Neethling & Potgieter (2010) 234. See also *Santam Versekeringsmaatskappy Bpk v Byleveldt* 1973 (2) SA 146 (A) at 150; *De Vos v Suid-Afrikaanse Eagle Versekeringsmaatskappy Bpk* 1984 (1) SA 724 (O) at 727; *Kantey & Templer (Pty) Ltd and Another v Van Zyl NO* 2007 (1) SA 610 (C) at 625. It has been suggested that the concrete approach be followed, with the exception of cases where prospective loss and loss of profit are concerned. See Visser & Potgieter (2003) 16; Neethling & Potgieter (2010) 235 for a discussion of prospective damage.

⁵⁰⁶ Strauss & Strydom (1967) 328; Visser & Potgieter (2003) 262; Neethling & Potgieter (2010) 246.

⁵⁰⁷ Visser & Potgieter (2003) 262; Neethling & Potgieter (2010) 246.

⁵⁰⁸ *Williams v Oosthuizen* 1981 (4) SA 182 (C) where it was held that receiving treatment from a public hospital would qualify as reasonable; *Ngubane v South African Transport Services* 1991 (1) SA 756 (A) it was decided that private medical treatment would also be reasonable.

⁵⁰⁹ Visser & Potgieter (2003) 268; Neethling & Potgieter (2010) 246.

⁵¹⁰ Neethling & Potgieter (2010) 240.

is entitled to.⁵¹¹ Thus, if a medical aid fund partly or completely covers a patient's damages, it will not be relevant in the evaluation of the extent of the loss suffered.⁵¹²

The extent of the patrimonial loss is determined by utilising a comparative approach and a monetary equivalent of the harm suffered is paid to a person in order to eliminate, as far as possible, past as well as future damage.⁵¹³

4.5.2 Non-Patrimonial Loss

A person suffers non-patrimonial loss if there is an adverse effect on his or her legally recognised highly personal (or personality) interests, without it affecting the patrimony of such a person.⁵¹⁴ Non-patrimonial loss is determined with reference to the diminution of personality interests. Our law recognises and protects the following personality interests: bodily integrity, dignity, mental integrity, bodily freedom, reputation, privacy, feeling, and identity.⁵¹⁵ A victim will be entitled to non-patrimonial damages if the quality of these personality interests or rights are wrongfully diminished.⁵¹⁶ Non-patrimonial loss, as is the case with patrimonial loss, can consist of loss already suffered as well as prospective loss. Prospective loss occurs, if the justified expectation that the quality or utility of a personality interest will increase or not be diminished, is hindered.⁵¹⁷

⁵¹¹ A generally accepted explanation for the problem of *res inter alios acta* has not yet been found. See Neethling & Potgieter (2010) 244 for a discussion of the issues surrounding the rule.

⁵¹² Neethling & Potgieter (2010) 241; *Thompson v Thompson* 2002 (5) SA 541 (W) at 547; *D'Ambrosi v Bane* 2006 (5) SA (K) at 134.

⁵¹³ Visser & Potgieter (2003) 164; Neethling & Potgieter (2010) 247.

⁵¹⁴ Visser & Potgieter (2003) 94; Neethling & Potgieter (2010) 252; *Edouard v Administrator, Natal* 1989 (2) SA 368 (D) at 386; *Van der Merwe v Road Accident Fund and Another (Women's Legal Centre Trust as Amicus Curiae)* at 253. This type of damage is also sometimes referred to as injury to personality, immaterial damage, ideal loss, damage to feelings, moral damage or incorporeal loss.

⁵¹⁵ Visser & Potgieter (2003) 95; *Van der Merwe v Road Accident Fund and Another (Women's Legal Centre Trust as Amicus Curiae)* at 253-254.

⁵¹⁶ *Van der Merwe v Road Accident Fund and Another (Women's Legal Centre Trust as Amicus Curiae)* at 254.

⁵¹⁷ Visser & Potgieter (2003) 98; Neethling & Potgieter (2010) 253.

According to Visser and Potgieter the extent of non-patrimonial loss may be generally expressed as a product of the following: the intensity of an injury to feelings, its nature and its duration. In evaluating the intensity of the injury a court will take certain objectively ascertainable factors into account, these may include the person's age, gender, social status, culture, lifestyle and degree of consciousness.⁵¹⁸ A court may award compensation as a way to counterbalance the person's unhappiness, or the award may serve to enable the person to overcome the effects of his or her injuries, or the object of the award may be to provide psychological satisfaction for the injustice done to the person.⁵¹⁹

Quantification is the process through which a sum of money is awarded to a person who has suffered damage to his or her personality interests.⁵²⁰ When it comes to the quantification of non-patrimonial damages, there are certain challenges, as the interests affected do not have an exact monetary value and cannot be directly expressed as a sum of money.⁵²¹ A comparison method is utilised to determine whether non-patrimonial loss was suffered and what the extent of the loss sustained is.⁵²² The quality and utility of the specific personality interest before and after the commission of the delict are compared, in order to determine the existence and extent of the loss.⁵²³ Courts assess damages for non-patrimonial loss by considering previous awards in comparable cases.⁵²⁴

The *locus classicus* on the technique of considering previous comparable cases is *Protea Assurance Co Ltd v Lamb*⁵²⁵, where Potgieter JA described the process of comparison as follows:

⁵¹⁸ Visser & Potgieter (2003) 436.

⁵¹⁹ *Id* 437.

⁵²⁰ Neethling & Potgieter (2010) 262.

⁵²¹ Visser & Potgieter (2003) 164; Erasmus & Gauntlett (2004) 'Damages' in *The Law of South Africa* 27.

⁵²² Neethling & Potgieter (2010) 253.

⁵²³ *Id* 254.

⁵²⁴ Visser & Potgieter (2003) 439. In practice the books of Corbett and Buchanan (which are now edited by Gauntlett and Honey) are often consulted to determine what would be considered a fair and appropriate award under the circumstances.

⁵²⁵ 1971 (1) SA 530 (A).

“It should be emphasised, however, that this process of comparison does not take the form of a meticulous examination of awards made in other cases in order to fix the amount of compensation; nor should the process be allowed so to dominate the enquiry as to become a fetter upon the Court's general discretion in such matters. Comparable cases, when available, should rather be used to afford some guidance, in a general way, towards assisting the Court in arriving at an award which is not substantially out of general accord with previous awards in broadly similar cases, regard being had to all the factors which are considered to be relevant in the assessment of general damages. At the same time it may be permissible, in an appropriate case, to test any assessment arrived at upon this basis by reference to the general pattern of previous awards in cases where the injuries and their *sequelae* may have been either more serious or less than those in the case under consideration.”⁵²⁶

When determining the quantum that stands to be awarded, where an injury to the personality amounts to a detrimental impact to a person's physical-mental integrity, certain factors need to be taken into account.⁵²⁷ There needs to be a link between the amount awarded for pain and suffering and the extent of the harm suffered, the intended compensation should reflect that link and be directly proportional thereto.⁵²⁸ If a patient is injured during treatment, he or she can institute a claim for pain and suffering caused by the delict, and also for pain and suffering caused by subsequent treatments which were necessitated by the original injury.⁵²⁹ Awards should be fair to both sides and should err on the side of conservatism; the court must compensate the victim, without placing an unjust burden on the wrongdoer, by letting sympathy for the victim influence their decision with regard to the amount.⁵³⁰ Injury to the

⁵²⁶ *Protea Assurance Co Ltd v Lamb* at 535-536. Also see Visser & Potgieter (2003) 439.

⁵²⁷ Neethling & Potgieter (2010) 262.

⁵²⁸ *Ibid.*

⁵²⁹ Strauss & Strydom (1967) 328.

⁵³⁰ Neethling & Potgieter (2010) 263.

personality can take numerous different forms and different principles are applied to each specific form of injury.⁵³¹

Satisfaction for intentional personality infringement (*iniuria*) is awarded in terms of the *actio iniuriarum*.⁵³² The *actio iniuriarum* is primarily concerned with the reparation of the *iniuria*. A court ordering redress, in other words compelling the wrongdoer to compensate the victim for harm caused as a result of the infringement, neutralises the feeling of outrage, hurt or suffering on the part of the plaintiff.⁵³³

There is no fixed formula for the assessment of damages with the *actio iniuriarum*.⁵³⁴ The courts thus have the power to determine an amount *ex aequo et bono*, with fairness playing a dominant role in the assessment.⁵³⁵ The courts enjoy a wide discretion in this regard and many factors are considered. According to Visser and Potgieter, fairness implies that policy considerations as well as the relevant factors which may influence the amount and the circumstances of each particular case are taken into account when determining compensation.⁵³⁶ The benchmark of the reasonable person or the legal convictions of the community are often employed in assessing fairness.⁵³⁷

⁵³¹ Visser & Potgieter (2003) 442ff. The different forms of injury to personality include: pain and suffering, shock, loss of the amenities of life, disfigurement and shortened life expectancy.

⁵³² Visser & Potgieter (2003) 448; Neethling & Potgieter (2010) 264.

⁵³³ Visser & Potgieter (2003) 448.

⁵³⁴ *Ibid.*

⁵³⁵ *Ibid.*

⁵³⁶ Visser & Potgieter (2003) 449.

⁵³⁷ *Ibid.*

Chapter Three: Conclusion

The relationship between the patient and the doctor or hospital is generally governed by the law of obligations. If there is no contract in place between the patient and a doctor or hospital, the relationship will be governed by the law of delict. Delictual liability may in actual fact also be incurred even if there is an existing contractual relationship.

The chapter begins with some introductory remarks on the law of delict as it pertains to the healthcare context. Delict in these circumstances is defined as the unlawful, blameworthy conduct of a practitioner that causes harm to a patient. Doctors are particularly vulnerable when it comes to lawsuits based on delict due to the nature of the medical profession and the interventions involved. There has in recent times been an increase in medical malpractice litigation. This increase has not only led to monetary implications for doctors, but has given rise to other consequences which have a considerable effect on the medical profession and the practice of medicine.

Most claims instituted against doctors are founded on delict. The law of delict is thus of utmost importance when regard is had to a doctor's liability. The doctor is burdened with a duty of care when he treats a patient; this duty flows from the special relationship that exists between the parties. This obligates the doctor to exercise reasonable skill and care during treatment. Failure to comply with the standard of reasonable care and skill may lead to the doctor incurring delictual liability.

There are essentially three actions with which damages resulting from a delict can be claimed, namely, the *actio*

legis Aquiliae, the *actio iniuriarum* and the action for pain and suffering.

A patient who has suffered patrimonial loss as a result of the wrongful, culpable conduct of another can recover damages by means of the *actio legis Aquiliae*. A patient would need to prove either negligence (*culpa*) or intent (*dolus*), for a doctor to be held liable.

The *actio iniuriarum* is available as a remedy to a patient, in order to recover sentimental damages as a result of an injury to an interest of personality; it is thus predominantly concerned with the protection of a person's *corpus*, *fama* or *dignitas*. It differs from the Aquilian action in that liability is only founded if the doctor acted intentionally. A patient may claim damages in terms of either the *actio iniuriarum* or the *actio legis Aquiliae*, and would not need to specify the action relied on in his or her pleadings. A patient may also rely on both actions in the same proceedings.

A patient may also institute an action for pain and suffering to recover damages where the wrongful, culpable conduct of a doctor caused non-patrimonial loss associated with bodily injury. This action has been expanded to such point where it can be said that it protects the entire physical and psychological integrity of a person.

The elements that need to be proven to found delictual liability were also canvassed in the chapter. Conduct, wrongfulness, fault, causation and loss were all discussed.

The primary object of the law of delict is to compensate a person who has suffered damages as a result of another's wrongful, blameworthy conduct. In this regard it was seen that patients are able to claim patrimonial as well as non-patrimonial damages in terms of the law of delict. Whereas

only patrimonial damage may be recovered for claims instituted for breach of contract.

This chapter concludes the overview of the existing regulatory and civil liability system. A more critical assessment of the role of the regulatory and civil liability system in the provision of quality care and the assurance of patient safety will be conducted in a subsequent chapter.

Section Two: Healthcare and Malpractice Liability Reform

Chapter Four: The National Health Insurance Proposal

Overview

The release of the Green Paper on National Health Insurance signifies the government's intent to completely reform the health system. This chapter will critically evaluate the proposal and some of the more recent developments that have occurred since the release of the policy document. Problems facing our healthcare system as identified in the Green Paper will be examined. The arguments advanced for the establishment of a National Health Insurance scheme will then be analysed accordingly. The chapter will attempt to determine whether the National Health Insurance as currently proposed would be the best mechanism with which to cure the ailing public health system. The private health sector's role and contribution will also be considered in this context. The consequences of introducing an inadequate National Health Insurance scheme will have a devastating effect on the provision of quality care and patient safety. It is thus important to extensively scrutinise any proposed systems and structures envisioned thereby.

1. Introduction

On 12 August 2011 the Minister of Health released a Green Paper titled “Policy on National Health Insurance”, which endeavoured to set out the Department of Health’s proposal for health reform.⁵³⁸ Therein clarity is provided on resolutions made at the 52nd Annual Conference of the African National Congress.⁵³⁹ Health was declared a key priority of the ANC and the conference resolved to implement the National Health Insurance System by “further strengthening the public health care system and ensuring adequate provision of funding”.⁵⁴⁰

1.1 The First Description of the Current NHI

National Health Insurance, as currently proposed, was first described in January 2009 in an issue of ANC today.⁵⁴¹ The description indicated that the funding model for health would need to be transformed and that health care delivery would need to be reorganised in order to implement the National Health Insurance plan. Universal coverage was the target and according to the ANC this could only be achieved if the public sector was strengthened and resources in the public, as well as the private sector, were shared and optimally used by all.

The ANC based the argument for reform on the observed inequities of the current health system, stating that it intends to address the structural and systemic issues through redistributive and social justice measures. The right to health and social solidarity were identified as the two core principles on which the establishment of the National Health Insurance was predicated. The first principle relates to the measures the state must take to achieve the progressive realisation of the right to access

⁵³⁸ Department of Health (2011) Policy on National Health Insurance. GN 657 in GG 34523 of 12 August 2011.

⁵³⁹ African National Congress (2007) 52nd National Conference: Resolutions.

⁵⁴⁰ *Ibid.*

⁵⁴¹ African National Congress (2009) ANC Today. National Health Insurance: A revolution in health care.

health services.⁵⁴² The second principle, described as social solidarity, consists of a mandatory contribution to health care funding. Allocations from general tax revenue and a mandatory health insurance contribution were to be combined into a single pooled NHI fund, which would then fund the services provided under the scheme.

In the publication the ANC rather ambitiously and perhaps optimistically stated that the “challenges for such substantial transformation of all aspects of funding and providing health services in South Africa are well appreciated and understood that is why it is critical that the process be phased in over a period of up to five years”. It was indicated that legislative reforms, which would provide for the legal framework for the implementation of the scheme, would soon be introduced.

1.2 ANC NHI Policy Proposal 2009

In order to implement the National Health Insurance in the five year timeframe, as set out in the resolution, the NEC subcommittee for Education & Health appointed a task team led by Dr Shisana. The task team had to prepare a policy proposal for consideration by the subcommittee and later the NEC. The proposal was intended to give substance to the resolution. After the completion of the policy proposal it was handed over to the subcommittee for consideration and adoption. The task team made note of the fact that there was strong opposition to the implementation of the proposed National Health Insurance. The proposal encountered resistance from opposition parties, the media and the business sector. This in turn led to the establishment of a NHI Campaigns’ Committee. The NHI Campaigns’ Committee developed a plan aimed at mass mobilisation to get their members and the general public behind the National Health Insurance.⁵⁴³

The final version of the policy proposal was made available to the Minister of Health for consideration in June 2009.⁵⁴⁴ Reading through the proposed policy, it is

⁵⁴² S 27(2) of the Constitution of the Republic of South Africa, 1996.

⁵⁴³ Correspondence between the Coordinator of the NEC Subcommittee for Education and Health and the Secretary General of the ANC. 13 July 2009.

⁵⁴⁴ African National Congress (2009) National Health Insurance Policy Proposal, 22 June 2009.

abundantly clear that health reform was considered a key priority, especially if South Africa was to meet the Millennium Development Goals for health.⁵⁴⁵

1.2.1 Health System Reform

The policy proposal called for a fundamental transformation of the health care system to address the “imbalances in access and utilisation of health services as well as health outcomes”.⁵⁴⁶ The introduction of a “National Health Insurance system (NHI) that enables an integrated, pre-payment-based mechanism and ensures the realisation of the right to health care for all” was offered as a solution.⁵⁴⁷

The rationale for the establishment of the NHI is that it would provide a mechanism for cross-subsidisation in the health system, which would entail that contributions would correspond to an individual's ability to pay and an individual's need for care would entitle him or her to health service benefits. This would apparently be achieved by pooling contributions into a single fund.⁵⁴⁸

The right to health and social solidarity encompassing universal coverage were again put forth as the core principles, on which the NHI will be based, with the principle of public administration being a new addition to the proposal. According to the proposal, public administration denotes a “mandatory national health insurance system that is structured as a single funder public entity which would support strategies to achieve economies of scale, the redistribution of health resources and cost-containment”.⁵⁴⁹

The policy proposal called for the phased implementation of the NHI over a number of years.⁵⁵⁰ However, no documents were finalised for public consultation. On 11 September 2009 the Minister of Health established a National Health Insurance

⁵⁴⁵ African National Congress (2009) 21.

⁵⁴⁶ *Ibid.*

⁵⁴⁷ *Ibid.*

⁵⁴⁸ *Id* 22.

⁵⁴⁹ *Id* 26.

⁵⁵⁰ *Id* 60.

Advisory Committee.⁵⁵¹ The Advisory Committee was established with the purpose of advising the Minister on the development of policy and legislation relating to the introduction of a National Health Insurance System and the implementation thereof. The timeframes for finalisation of the public consultation process, draft proposals on NHI legislation and the NHI implementation plan proposal were set out in the notice. These needed to be concluded by June 2010. Regular reports on the progress of the implementation of NHI were also to be made available to Minister.

No report emerged from the Advisory Committee and no consultation process was undertaken. A document was, however, released by the Chairperson of the Advisory Committee at the National General Council meeting of the ANC in September 2010.⁵⁵²

It was little less than a year later when the Green Paper on NHI was finally released, with a mere two month period for consultations. The consultation period was extended to the 30th of December 2011, after the Department received numerous requests to do so.⁵⁵³

2. The Green Paper: Policy on National Health Insurance

2.1 Introduction

⁵⁵¹ GN 903 in GG 32564 of 11 September 2009.

⁵⁵² African National Congress (2010) National General Council: Additional Discussion Documents. There was some confusion over the document, as it contained work done by the Advisory Committee, but was not their report. The status and relevance of the document was thus questioned by stakeholders and civil society groups. The secrecy with which the activities of the Advisory Committee had been conducted was also considered a cause for concern. Another document was released by the Times which included work done by the Task Team on National Health Insurance on behalf of the Health and Education Sub-Committee. Task Team on National Health Insurance (2009) National Health Insurance Plan for South Africa. 16 February 2009.

⁵⁵³ GN 743 in GG 34606 of 15 September 2011.

The main arguments for reforming the South African health system are set out and summarised in the introduction to the Green Paper.⁵⁵⁴ It is submitted that the National Health Insurance (NHI) will improve service provision, and promote equity and efficiency in order to ensure that South Africans have access to affordable, quality healthcare services.⁵⁵⁵ The NHI is supposed to be phased in over a period of 14 years and it is acknowledged that service delivery structures and management systems would need to be significantly improved.⁵⁵⁶

The argument advanced for this complete reform of the healthcare system, resides in an apparent lack of equity between the existing public and private healthcare sectors.⁵⁵⁷ It is argued that financial and human resources are disproportionately allocated in the “two-tiered” structure, thus unfairly benefiting the minority of the population who make use of the private healthcare sector.⁵⁵⁸ The poor health outcomes and problems encountered by the South African health system are accordingly, implicitly blamed on the bifurcated healthcare structure, which results in unequal access to health resources.

The National Development Plan⁵⁵⁹ takes a rather more considered view of the current pressing situation facing the health sector, stating that:

“South Africa’s broken public health system must be fixed. While greater use of private care, paid for either by users or health insurance, is part of the solution, it is no substitute for improving public health care. A root-and-branch effort to improve the quality of care is needed, especially at primary level.”⁵⁶⁰

⁵⁵⁴ Department of Health (2011) Policy on National Health Insurance 4.

⁵⁵⁵ *Ibid.*

⁵⁵⁶ *Ibid.*

⁵⁵⁷ *Ibid.*

⁵⁵⁸ *Id* 5.

⁵⁵⁹ National Planning Commission (2012) National Development Plan 2030: Our Future - Make It Work.

⁵⁶⁰ National Planning Commission (2012) 51.

In the Green Paper the NHI is identified as the panacea, as it will apparently provide coverage to the whole population on an equitable and sustainable basis.⁵⁶¹ According to the Green Paper this model of delivering healthcare is well accepted and promoted by the World Health Organisation as “universal coverage”.⁵⁶²

This statement however, conflates the achievement of universal coverage with a mechanism with which universal coverage may be achieved. The World Health Organisation realises that “there are substantial differences across countries in the institutional and organizational arrangements used to ensure funds are raised, pooled and used to purchase or provide services”.⁵⁶³ The achievement of universal coverage depends on how efficient and equitable the system is in its revenue collection, pooling and purchasing, not the name used to describe it.⁵⁶⁴

2.2 Problem Statement

The Green Paper’s problem statement commences with an introductory section on the history of the South African healthcare system.⁵⁶⁵ It is argued that the current government inherited a fragmented health system, which was designed along racial lines.⁵⁶⁶ This has led to healthcare disparities and a resultant systematically under-resourced public health system, the impact of which is still being experienced by a large part of the population to this day.⁵⁶⁷ The historical roots of the current public health challenges cannot be ignored; however, neither can the failures in leadership and management which have plagued the post-apartheid health system.⁵⁶⁸

⁵⁶¹ *Ibid.*

⁵⁶² *Ibid.*

⁵⁶³ Carrin *et al* “Universal coverage of health services: tailoring its implementation” (2008) 86 *Bulletin of the World Health Organization* 859.

⁵⁶⁴ Carrin *et al* (2008) 86 *Bull. World Health Organ.* 861.

⁵⁶⁵ Department of Health (2011) Policy on National Health Insurance 5.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ *Ibid.*

⁵⁶⁸ Nadasen (2000) *Public Health Law in South Africa: An Introduction*; Coovadia *et al* (2009) 374 *Lancet* 817; National Planning Commission (2012) 332. The commission raise their concerns about

The existing “two-tiered system” of healthcare is identified as the main problem and the contentions in the Green Paper are all directed at supporting this conclusion.⁵⁶⁹ Reference is made to the World Health Organisation’s, 2008 World Health Report and comparisons are drawn between the descriptions contained in that report and the negative attributes of the current South African health system.⁵⁷⁰ Accordingly, it is argued that the existing two-tiered system is “unsustainable, destructive, very costly and highly curative or hospi-centric”.⁵⁷¹ A claim of this magnitude needs to be substantiated. Unfortunately the Green Paper provides no empirical research to support such a contention.

The Green Paper acknowledges that the quality of healthcare services in the public sector has declined or remained poor.⁵⁷² It is conceded that the public sector would need to be considerably improved if it is to change the negative perception harboured by the public.⁵⁷³ Due to its reputation for poor quality services the public sector is avoided.⁵⁷⁴ The first five years of NHI development will thus be focused on strengthening the public sector in preparation for new NHI systems.⁵⁷⁵ The underlying problems and systemic challenges of the public sector would need to be addressed or they would likely continue under the NHI.⁵⁷⁶ This includes deteriorating

the existing health system and centralisation as follows: “The management of the health system is centralised and top-down. Poor authority, feeble accountability, the marginalisation of clinicians, and low staff morale are characteristics of the health system. Centralised control has not worked because health personnel lack discipline, perform inappropriate functions, are not held accountable, do not adhere to policy, and are inadequately overseen. In addition, the institutional links between the different levels of services are weak”.

⁵⁶⁹ Department of Health (2011) Policy on National Health Insurance 6.

⁵⁷⁰ *Ibid.*

⁵⁷¹ *Ibid.*

⁵⁷² *Ibid.*

⁵⁷³ *Ibid.*

⁵⁷⁴ *Ibid.*

⁵⁷⁵ Matsoso & Fryatt (2012) *SAHR* 22.

⁵⁷⁶ National Planning Commission (2012) 51. The authors call for a reform of the public health system by: improving management; increasing the number of trained health professionals; promoting greater discretion over clinical and administrative matters at facility level combined with effective accountability; utilising better patient information systems which support decentralised and home-based care models; and focussing on maternal and infant health care.

infrastructure, poor management, lack of key human resources, the burden of disease and underfunding as identified in the Green Paper.⁵⁷⁷

The focus then quickly shifts back to the private sector, which is apparently unsustainable over the medium to long term due to the high costs of services.⁵⁷⁸ This assertion is based on inaccurate and misleading information, as described below. The private sector is continually criticised in the Green Paper in order to strengthen the argument for health reform.

A number of subsections follow the introduction and raise wide-ranging concerns about the health system.

2.2.1 The Burden of Disease

The Green Paper suggests that the burden of disease should be taken into account when introducing the NHI.⁵⁷⁹ The four health problems that South Africa must overcome, has been described as the quadruple burden of disease and includes: HIV/AIDS and TB; maternal, child and infant mortality; non-communicable diseases; and injury and violence.⁵⁸⁰

The purpose of including this as a subsection in the problem statement is not clear, as all countries must deal with their burden of disease. It is also dealt with in a superficial manner and shortcomings in the institutional models are not identified or analysed.⁵⁸¹ This limits the effective discussion and implementation of improvements as there is no indication of which institutional mechanisms are failing.

⁵⁷⁷ Department of Health (2011) Policy on National Health Insurance 6.

⁵⁷⁸ *Id* 7.

⁵⁷⁹ *Ibid.*

⁵⁸⁰ *Id* 8.

⁵⁸¹ Chopra *et al* "Achieving the health Millennium Development Goals for South Africa: challenges and priorities" (2009) 374 *Lancet* 1028. The authors examine the challenges faced by the country and indicate which actions should be prioritised if we are to achieve the Millennium Development Goals. The Green Paper should have provided more detail with regard to these important issues.

2.2.2 Quality of Healthcare

It is acknowledged that quality problems still persist in the public sector and some of the most commonly cited and experienced by the public, are identified in the Green Paper as: “cleanliness, safety and security of staff and patients, long waiting times, staff attitudes, infection control and drug stock-outs”.⁵⁸² These concerns have resulted in the public more readily approaching the private sector for their healthcare needs, even if it means paying more.⁵⁸³ Accordingly, the improvement of quality in the public health system is identified as a key reform.⁵⁸⁴

What is lacking from the description of the quality concerns are the causes of the concerns. These are not addressed at all and the failure to be able to adequately identify the systemic problems may lead to the failure to adequately rectify and improve these problems. The focus is once again placed on how the quality failures drive the public to the private sector and the costs they then incur, rather than scrutinising the causes of the failures and setting out substantive strategies to remedy the situation .

2.2.3 Healthcare Expenditure in South Africa

In this section it is argued that even though South Africa spends 8.5% of its GDP on health, the health outcomes remain poor when compared to similar middle-income countries, and that the poor outcomes can be mainly attributed to the inequities between the public and private sector.⁵⁸⁵ The World Health Organisation is invoked to support the argument that South Africa spends way more than the recommended minimum of 5% of the GDP on Health. It is however just a minimum amount suggested by the WHO, and no comment is made on the appropriateness or not of spending in excess of that recommended percentage.⁵⁸⁶ Van den Heever indicates

⁵⁸² Department of Health (2011) Policy on National Health Insurance 9.

⁵⁸³ *Ibid.*

⁵⁸⁴ *Ibid.*

⁵⁸⁵ *Ibid.*

⁵⁸⁶ Van den Heever (2011) Evaluation of the Green Paper on National Health Insurance 41.

that the Green Paper misleads when it attempts to imply that a causal relationship exists between expenditure equity and health outcomes, as high expenditure in the private sector has no impact on public sector performance and no evidence exists to confirm such an assertion.⁵⁸⁷ The author continues to state that poor health outcomes are the exclusive result of the manner in which the public system is managed and have little to nothing to do with the private sector.⁵⁸⁸

South Africa's public health expenditure actually compares well to similar developing countries.⁵⁸⁹ The evidence does not support the contention that the poor health outcomes are a result of a lack of funding.⁵⁹⁰ South Africa performs poorly relative to its peer countries, even the countries with far lower levels of per capita health expenditure and Gross National Income per capita.⁵⁹¹ It is indicated that the health system is actually under-performing given its level of expenditure.⁵⁹²

With it having been established that the country's healthcare expenditure is actually normal when compared to other countries, there is no negative feedback effect from the private system.⁵⁹³ It can even be argued that increased private sector participation allows public sector resources to be spread over a smaller part of the population, increasing the redistributive effect of general taxes for healthcare.⁵⁹⁴ With less people making use of the public sector, the remaining healthcare budget can be

⁵⁸⁷ *Ibid.*

⁵⁸⁸ *Id* 42.

⁵⁸⁹ Development Bank of South Africa (2008) 15; World Health Organisation (2013) World Health Statistics 2013.

⁵⁹⁰ Development Bank of South Africa (2008) 15.

⁵⁹¹ *Ibid.*

⁵⁹² *Ibid.*

⁵⁹³ Van den Heever (2011) 42; Development Bank of South Africa (2008) 24. The report addresses the issue of distribution between the public and private sectors stating that: "One possible negative outcome of a large private system is that it can lure away health professionals from the public sector. However apart from that, there is little evidence that the private system is systemically harmful to the public sector." The report goes on to state that "many of the human resource problems within the public system arise primarily from decisions of the public system itself".

⁵⁹⁴ Van den Heever (2011) 42.

spent on fewer beneficiaries, leading to a more advantageous distribution of resources.⁵⁹⁵

The Green Paper continues to criticise the private sector as being disproportionately costly.⁵⁹⁶ In order to justify its arguments for reform the private sector is once again painted in a negative light as being unsustainable. The information presented indicates that private hospital costs have increased by 121% over the past decade and that specialist costs have increased by 120% over the same period.⁵⁹⁷ This information is taken from the 2008 Annual Report of the Council for Medical Schemes. However, the two latest reports which were available during the drafting of the Green Paper are not referenced.⁵⁹⁸ Worse still, the information quoted is incorrect, if the actual figures from the CMS for the past decade are used; hospitals have shown an increase of 72% and specialists an increase of 46.2%.⁵⁹⁹ The data provided also does not match any information provided in the Annual Report for 2008.⁶⁰⁰ The actual real increase for hospitals and specialists over the period from 1999 to 2008 is 67.1% and 60.7% respectively.⁶⁰¹ Over the seven year period from 2004 to 2010 hospital and specialists costs have increased by only 12.7% and 26.7% respectively.⁶⁰² Although the costs are unacceptably high, they have not nearly increased as much as the Green Paper makes out. This misrepresentation is cause for great concern.

According to the information presented, medical scheme contribution rates have also doubled over a seven-year period.⁶⁰³ Unfortunately, this information also has no basis in fact. According to the CMS Annual Report for 2010, medical scheme

⁵⁹⁵ *Ibid.*

⁵⁹⁶ Department of Health (2011) Policy on National Health Insurance 10.

⁵⁹⁷ *Ibid.*

⁵⁹⁸ Council for Medical Schemes (2009) Annual Report 2008-2009.

⁵⁹⁹ Van den Heever (2011) 45.

⁶⁰⁰ *Ibid.*

⁶⁰¹ *Ibid.*

⁶⁰² *Ibid.*

⁶⁰³ Department of Health (2011) Policy on National Health Insurance 10. It is unclear which seven year period is referred to or why a seven-year period was selected, as opposed to the ten year period used for the hospital and specialist cost comparison.

contributions have since 2002 been similar to inflation.⁶⁰⁴ There has also been a real increase of only 27.3% over the past decade.⁶⁰⁵ Contribution rates have actually remained stable for a number of years, largely in part to the Council for Medical Schemes, which has been able to better regulate and manage scheme costs.⁶⁰⁶ The attack on the sustainability of medical schemes is not justified by the evidence and it raises serious questions about the transparency with which the implementation of the NHI is being conducted. The fact that inaccurate information is relied on misleads stakeholders and prevents informed, meaningful discussion.

Denouncing the private health system as unsustainable in order to build the case for health reform serves a very narrow interest. The focus should rather be placed on better regulation of the private health sector.⁶⁰⁷ Lack of proper government intervention in the health insurance market has led to rising costs and the exclusion of vulnerable groups.⁶⁰⁸ The Medical Schemes Amendment Bill of 2008 would have alleviated some of the concerns and provided mechanisms to address problems in the industry, but the portfolio committee decided not to proceed with the Bill. There are however, recent reports that the Council for Medical Schemes has submitted draft amendments on the Medical Scheme Act to the Department of Health.⁶⁰⁹

The fact that medical scheme membership has continued to increase would seem to contradict the sustainability argument relied on by the Green Paper. Membership has increased by 22.9% since 2000 and there are currently 8.7 million beneficiaries.⁶¹⁰

It is contended that it would be reckless of government to replace all alternative healthcare funding sources, when other viable mechanisms exist.⁶¹¹

⁶⁰⁴ Council for Medical Schemes (2011) Annual Report 2010-2011 37.

⁶⁰⁵ Van den Heever (2011) 46.

⁶⁰⁶ *Id* 47.

⁶⁰⁷ Development Bank of South Africa (2008) 24; National Planning Commission (2012) 345.

⁶⁰⁸ Van den Heever (2011) 49.

⁶⁰⁹“Medical schemes move to address regulatory backlog” Business Day 20 August 2013. It was stated that it is unlikely that the Bill will come into effect before 2015.

⁶¹⁰ Council for Medical Schemes (2012) Annual Report 2012-2013 229.

⁶¹¹ World Health Organisation (2000) The World Health Report 2000 103, 111; Van den Heever (2011) 50.

2.2.4 Distribution of Financial and Human Resources

According to the Green Paper there is a mal-distribution of healthcare resources and this has led to a skewed distribution of key healthcare professionals in favour of the private sector.⁶¹² It is submitted that the ratio of patients to health professionals is lower in the private sector.⁶¹³ The amount spent on healthcare in the private sector is again criticised as being against the “principles of social justice and equity”.⁶¹⁴ This continues the trend of the Green Paper in asserting that the private health sector is responsible for inequality in South Africa. No evidence or accurate analysis is however, presented to substantiate these claims. Reference is made to “recent estimates”, such an imprecise statement in a proposal of this magnitude, which bases its whole argument on the inequitable distribution of resources, is disappointing. It is believed that the estimates refer to the data contained in the 2010 ANC NHI proposal.

Research has shown that there is an almost equal distribution of general practitioners between the public and private sector.⁶¹⁵ There are currently 2861 people per GP in the public sector and 2723 people per GP in the private sector.⁶¹⁶ Contrary to what the Green Paper states about the distribution of human resources, the majority of general practitioners, 61.9%, work in the public sector.⁶¹⁷ The distribution of specialists is also much less skewed than commonly believed, as 43.8% work in the public sector.⁶¹⁸ In making its case for reform the Green Paper continually overstates the resource differential between the public and private sectors.⁶¹⁹ Van den Heever questions the integrity of the information provided, stating that he believes it was deliberately produced in this manner to

⁶¹² Department of Health (2011) Policy on National Health Insurance 10.

⁶¹³ *Ibid.*

⁶¹⁴ *Ibid.*

⁶¹⁵ Econex (2010) Health Reform Note 7: Updated GP and Specialist Numbers for SA.

⁶¹⁶ *Id* 5.

⁶¹⁷ *Ibid.*

⁶¹⁸ *Ibid.*

⁶¹⁹ Van den Heever (2011) 57. The Green Paper relies on inaccurate numbers when presenting its case.

mislead.⁶²⁰ Although it is true that the distribution of human resources may have an impact on fairness, it has been shown that the distribution of doctors and specialists is not nearly as uneven as the government would lead us to believe. That being said, there is an urgent need to fill post with, skilled committed and competent individuals.⁶²¹ There is a dramatic staff shortfall in South Africa.⁶²² Evidence suggests that public health staffing levels have decreased due to constrained budgets and increased unit costs, thus private sector increases have had no effect.⁶²³ Staffing levels have also been affected by medium-term supply constraints.⁶²⁴ The Department of Health has launched a Human Resources for Health Strategy to address the concerns.⁶²⁵

The Green Paper still however, relies on expenditure variations between the two sectors to bolster their equity argument. On this point the Green Paper indicates that per capita annual expenditure for the medical aid group has been estimated at R11 150.00, whereas per capita annual health expenditure for the public sector is estimated at R2 766.00.⁶²⁶ It is accordingly vaguely stated, that this is not an efficient way of financing healthcare.⁶²⁷ This argument equates differential costs to resource distributions and confounds the two. Unit cost differentials between the sectors cannot by themselves defeat the principles of social justice and equity.⁶²⁸ The only reasonable conclusion may be that consumers in the private sector may not be getting value for money, but then again it may be argued that compared to the quality of care in the public sector, they are and the higher costs are justified.⁶²⁹ This line of reasoning by the Green Paper cannot stand, the mere fact that there are

⁶²⁰ Van den Heever (2011) 59. With specific reference to the data provided in the NHI pamphlet published by the Department of Health together with the Green Paper.

⁶²¹ Wadee and Khan "Human resources for health" (2007) *SAHR* 141; National Planning Commission (2012) 334.

⁶²² Development Bank of South Africa (2008) 20.

⁶²³ *Ibid.*

⁶²⁴ *Ibid.*

⁶²⁵ National Department of Health (2011) Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/2013-2016/2017.

⁶²⁶ Department of Health (2011) Policy on National Health Insurance 10.

⁶²⁷ *Id* 11.

⁶²⁸ Van den Heever (2011) 63.

⁶²⁹ *Ibid.*

deviations in distribution of health expenditure and resources, and that it is not precisely equally allocated, does not inevitably render it unfair. The public choose to use their disposable income to voluntarily contribute to medical schemes and unless there is a negative feedback effect, such expenditure is irrelevant in calculating equity.⁶³⁰ How revenue is spent in the public sector also contributes to the poor health outcomes.⁶³¹

2.2.5 Medical Schemes Industry

In this section the Green Paper once again calls the sustainability of medical schemes into question. It is argued, without any references or evidence, that medical schemes are failing, that contribution costs are too high and that member benefits are being reduced.⁶³² According to the Green Paper uncontrolled commercialism is at the centre of the problem, the World Health Organisation is again invoked without reference to support this claim.⁶³³ The Green Paper concludes that, taking all of the above into account, “clearly something completely different is needed in the South African health sector”.⁶³⁴

The Green Paper indicates that a number of medical schemes have collapsed over the years; this statement is meant to imply that medical schemes are unsustainable. It was however, a policy decision by the Department of Health to reduce the number of medical schemes to increase efficiencies in the purchasing of healthcare.⁶³⁵ Regulations published in terms of the Medical Schemes Act⁶³⁶ required that medical schemes must have a minimum of 6000 members.⁶³⁷ This was done in order to remove small unsustainable schemes from the system. The number of large- and

⁶³⁰ *Ibid.*

⁶³¹ Engelbrecht & Crisp “Improving the performance of the health system” (2010) *SAHR* 199.

⁶³² Department of Health (2011) Policy on National Health Insurance 11.

⁶³³ *Ibid.*

⁶³⁴ *Ibid.*

⁶³⁵ Van den Heever (2011) 64.

⁶³⁶ Medical Schemes Act 131 of 1998.

⁶³⁷ Reg 2(3) of the Medical Schemes Act 131 of 1998.

medium-sized medical schemes has stayed relatively constant over a number of years.⁶³⁸

There is also no sufficient link between the arguments that high contribution costs coupled with decreasing benefits have impacted on the sustainability of the industry. As indicated earlier, contribution costs have since 2002 been similar to inflation.⁶³⁹ Scheme membership has continued to increase.⁶⁴⁰ There is also no evidence presented for the claim that benefit shortfalls are an increasing occurrence.⁶⁴¹ Solvency has also been maintained at healthy levels.⁶⁴²

Concerns have been raised about the Department of Health's understanding of how medical schemes are run and regulated, which is worrying seeing that the uninformed conclusions reached are responsible for the Green Paper's policy proposals.⁶⁴³

2.2.6 Out of Pocket Payments and Co-Payments

In this section the Green Paper contends that out of pocket payments account for a significant part of health expenditure and this confirms that full cover is not provided

⁶³⁸ Council for Medical Schemes (2012) 227.

⁶³⁹ Council for Medical Schemes (2011) 37.

⁶⁴⁰ Council for Medical Schemes (2012) 228. Beneficiaries increased to 8.7 million in 2012 from 6.7 million in 2000 (a 22.9% increase).

⁶⁴¹ Non-risk pooled benefits, such as savings accounts, do often run out; however risk-pooled benefits are usually not exhausted. The system of minimum prescribed benefits also ensures that members are protected, as schemes are compelled to risk-pool for such an occurrence.

⁶⁴² Council for Medical Schemes (2012) 263.

⁶⁴³ Van den Heever (2011) 68. The author raises his concerns on multiple occasions, calling into question the integrity of the process: "The incorporation here of fabricated information (while presented as factual) again raises questions about the integrity of the process. Firstly, the inaccuracies indicate that the policy framework is not well researched. This raises questions about the ultimate policy prescriptions and whether Government truly understands the terrain. Secondly, and more seriously, as with the workforce-related information, the errors appear to be deliberate".

by the current health system.⁶⁴⁴ General statements are also made about the unpredictability of medical expenses, which expose households to financial hardship.⁶⁴⁵ An article by Meng *et al*⁶⁴⁶ is referenced for the purposes of indicating that certain uninsured vulnerable groups are not adequately covered. However, South Africa has a general tax funded public health system, which renders the reference to the Meng *et al* article rather irrelevant, as our mechanism differs completely from the health insurance mechanisms discussed by the authors.⁶⁴⁷

South Africa's levels of out of pocket payments are actually normal when compared to international levels and a reform of the health system would not necessarily result in a change thereof.⁶⁴⁸ Many individuals, who do pay out of pocket for private health services, do so to avoid poor quality care in the public health sector.⁶⁴⁹

2.3 National Health Insurance

The National Health Insurance is presented as the remedy for all the problems identified in the problem statement section.⁶⁵⁰ The rationale for the introduction thereof is rather vaguely set out and idealistic statements are made without any real analysis or evidence to support such ambitious declarations. According to the Green Paper, those with the greatest need for health care have the least access and suffer poor health outcomes and the current tiered system is to blame.⁶⁵¹ This continues the line of reasoning the Green Paper has followed up to this point, in which it attributes the problems of the health system on the existence of the private sector. In

⁶⁴⁴ Department of Health (2011) Policy on National Health Insurance 11. It is also stated that an out of pocket payment can have catastrophic effects for individuals who are not on medical aid.

⁶⁴⁵ *Ibid.*

⁶⁴⁶ Meng *et al* "Expanding health insurance coverage in vulnerable groups: a systematic review of options" (2011) 26 *Health Policy and Planning* 93.

⁶⁴⁷ Van den Heever (2011) 71.

⁶⁴⁸ *Ibid.*

⁶⁴⁹ Centre for Development and Enterprise (2011) Reforming Healthcare in South Africa: What Role for the Private Sector? 42.

⁶⁵⁰ Department of Health (2011) Policy on National Health Insurance 15.

⁶⁵¹ *Ibid.*

doing so the public sector's own failures and shortcomings are overlooked. The focus should be on identifying the underlying systemic problems in the public health sector, instead of shifting the responsibility and blame for poor health outcomes.

The other reasons advanced for implementing the NHI include the improvement of access to quality healthcare services and the provision of financial risk protection against catastrophic health-related expenditures for the whole population.⁶⁵² The proposed NHI will also provide a mechanism for improved cross-subsidisation in the overall health system, which would ensure that funding contributions would correspond with an individual's ability to pay and the benefits received will be linked to the individual's need for care.⁶⁵³ This is however, already provided for by both the public system and medical schemes. General tax contributions are linked to an individual's ability to pay and these taxes enable many to access subsidised healthcare services.⁶⁵⁴ Medical scheme contributions, which the individual pays out

⁶⁵² *Ibid.*

⁶⁵³ *Id* 16.

⁶⁵⁴ S 4 of the National Health Act 61 of 2003.

"Eligibility for free health services in public health establishments.—(1) The Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed.

(2) In prescribing any condition contemplated in subsection (1), the Minister must have regard to—

- (a) the range of free health services currently available;
- (b) the categories of persons already receiving free health services;
- (c) the impact of any such condition on access to health services; and
- (d) the needs of vulnerable groups such as women, children, older persons and persons with disabilities.

(3) Subject to any condition prescribed by the Minister, the State and clinics and community health centres funded by the State must provide—

- (a) pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;
- (b) all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary health care services; and
- (c) women, subject to the Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996), free termination of pregnancy services." Pregnant Woman and children under the age of six years are eligible for free health services. GN 657 in GG 15817 of 1 July 1994. South African citizens, who do not belong to medical schemes, are also eligible for free primary health care services at state

of his or her disposable income, entitle the individual to health benefits and a set of prescribed minimum benefits.⁶⁵⁵ The Green Paper does not evaluate the different mechanisms, nor does it state how the objectives will be better achieved through the implementation of the NHI system.

The Green Paper goes on to state that everyone will have access to a defined comprehensive package of healthcare services, which will be provided through accredited and contracted public and private providers.⁶⁵⁶ There will also be a focus on health promotion and prevention services at the community and household level.⁶⁵⁷

It is not exactly clear how this differs from the current situation where private providers are already contracted to provide services to individuals in the public sector.⁶⁵⁸ Prioritising health promotion and prevention services should be done without consequently deprioritising hospital services. The shift in focus and funding from hospital services to primary care services, which was carried out since 1994, has had a severe detrimental effect on the public hospital system.⁶⁵⁹ A change in policy and strategy, without proper planning, also carries the risk of funds being diverted away from functioning services and possibly wasted on ill-informed programmes. If new programmes are to be implemented, it should be well-considered and based on a detailed evaluation of all the available information. If the evidence calls for new programmes, provision must then be made for strong management structures, suitable supervision and a monitoring and evaluation framework to ensure proper functioning.⁶⁶⁰

facilities. GN 1514 in GG 17507 of 25 October 1996. In accordance with the Uniform Patient Fee Schedule, patients are divided into full paying, full subsidised and partially subsidised categories.

⁶⁵⁵ Chapter 3 of the regulations published under the Medical Schemes Act 131 of 1998. Also see Carstens & Pearmain (2007) 230.

⁶⁵⁶ Department of Health (2011) Policy on National Health Insurance 16.

⁶⁵⁷ *Ibid.*

⁶⁵⁸ Shuping & Kabane "Public-private partnerships: A case study of the Pelonomi and Universitas hospital co-location project" (2007) *SAHR* 151; Wolvaardt *et al* "The role of private and other non-governmental organisations in primary health care" (2008) *SAHR* 223.

⁶⁵⁹ Van den Heever (2011) 73.

⁶⁶⁰ *Ibid.*

2.4 Principles of National Health Insurance

According to the Green Paper the NHI will be guided by the following principles: The right to access as entrenched in section 27 of the Constitution; social solidarity; effectiveness; appropriateness; equity; affordability and efficiency.⁶⁶¹ These principles are indeed important and should underlie any health system, regardless of the mechanism used to ensure universal quality healthcare.⁶⁶² The NHI is however, just one such proposed mechanism. These principles should in actual fact form part of our existing health system. Unfortunately due to poor management, a lack of good governance and accountability, ineffective monitoring and evaluation, an absence of proper policy interventions and regulation, corruption and other factors these principles are not realised.

2.5 Objectives of National Health Insurance

The Green Paper states that NHI is aimed at providing universal coverage.⁶⁶³ The objectives of NHI are described as: i) improving access to quality health services for all South Africans; ii) the creation of a single fund to achieve equity and social solidarity; iii) procuring services on behalf of the entire population; and iv) strengthening the under-performing public sector.⁶⁶⁴

It is argued that universal coverage already exists in the South African health system, with the only barrier being the poor performance of the public health system.⁶⁶⁵ Universal coverage can be achieved through different mechanisms, NHI

⁶⁶¹ Department of Health (2011) Policy on National Health Insurance 16.

⁶⁶² Pearmain *A Critical Analysis of the Law on Health Service Delivery in South Africa* (Unpublished LLD Thesis, 2004 University of Pretoria) 111ff. Where health care services are examined in the light of the Constitution.

⁶⁶³ Department of Health (2011) Policy on National Health Insurance 18.

⁶⁶⁴ *Ibid.*

⁶⁶⁵ Engelbrecht & Crisp (2010) *SAHR* 196.

is only one such mechanism and it has not been sufficiently established that the transition to such a system would be more beneficial than merely addressing the problems faced by the public sector and effectively regulating the private sector.⁶⁶⁶ No evidence-based research is presented to support the contention that the NHI will achieve the objectives or that it is the most effective mechanism to do so.

The creation of a single fund which will procure services on behalf of the population also raises a number of concerns. Managing a fund of that size will be a huge administrative undertaking and the complexities and the consequences of mismanagement should not be underestimated. It is important to note the systemic failures of the public system in this regard.⁶⁶⁷

2.6 Socio-Economic Benefits of National Health Insurance

There is no question that a proper functioning health care system would result in socioeconomic benefits.⁶⁶⁸ The emphasis however, is on a proper functioning health system, which may or may not take the form of NHI. The concept of universal coverage is also conflated with NHI, which is only a mechanism with which one would potentially achieve universal coverage.⁶⁶⁹ The Green Paper does not provide any evidence to indicate that the NHI is the most effective mechanism to achieve this

⁶⁶⁶ Centre for Development and Enterprise (2011) 56.

⁶⁶⁷ Heywood “Crumbling provincial health departments cost lives and will affect NSP outcomes” (2012) 5 *NSP Review* 1 in which the Executive Director of Section27 summarises the dire position as follows: “In 2012 it has become clearer than ever that the crisis is overwhelmingly one of management rather than a shortage of funds. Corruption and nepotism join forces with a lack of accountability and oversight to give most officials apparent *de facto* tenure in their positions, able to destroy hopes and lives with impunity. Rarely are health officials held accountable or interventions launched to stem the crisis.”; Bateman “Will our public healthcare sector fail the NHI?” (2012) 102 *The South African Medical Journal* 817; Section27 (2013) Monitoring Our Health: An analysis of the breakdown of health care services in selected Gauteng facilities: A report for the period January - December 2012; Treatment Action Campaign and Section27 (2013) Death and dying in the Eastern Cape: An investigation into the collapse of a health system.

⁶⁶⁸ Department of Health (2011) Policy on National Health Insurance 19.

⁶⁶⁹ Van den Heever (2011) 75.

goal or how it compares to other possible mechanisms. If South Africa is to invest in health, there should be concrete evidence that the proposed investment will be the most effective option. A complete reform of the health system will be costly and may or may not be effective. It should be considered whether the same outcomes could potentially be achieved, more economically, by improving and investing in the existing system.

Referring to the outcomes other countries have achieved without providing proper context and disregarding factors such as social inequality, geographical features, demographic diversity, economic growth and disparities between rural and urban communities limits the value thereof. Further, if reference is made to the outcomes of other countries, proper evaluation and analysis should be presented, especially if those outcomes inform the proposed health reform policy.⁶⁷⁰

Again one feels that the decision was taken to implement a NHI system and justify it by referring to the problems faced and the potential benefits, rather than the problems and benefits, justifying the implementation of the NHI.

2.6.1 Economic Impact Modelling

The Green Paper states that macro-economic modelling undertaken suggests that “the implementation of National Health Insurance could have positive or negative implications, depending on the model utilised and its outcomes”.⁶⁷¹ It also states that the NHI could have a positive impact provided it succeeds in improving the health indicators of the country, which includes an improvement in life expectancy and child mortality.⁶⁷²

This section is vague and adds nothing to the discussion. Stating that the NHI could have positive or negative implications is rather concerning, as one would be mindful of the limited resources available in South Africa.⁶⁷³ One would hope that the

⁶⁷⁰ *Ibid.*

⁶⁷¹ Department of Health (2011) Policy on National Health Insurance 21.

⁶⁷² *Ibid.*

⁶⁷³ National Planning Commission (2012) 343.

government would only embark on such a costly venture if there is evidence indicating that the outcomes would be guaranteed to be overwhelmingly positive. The lack of information and evaluation of possible alternative models is troubling; hopefully the matter will become clearer when Treasury releases the final report.

Improvement in health indicators should be the basis of any proposed health reform. There would be no point in proposing to reform the health system if there is uncertainty about the ability to improve the health indicators.

The last sentence of this section states that the NHI will only have positive macro-economic implications if it addresses the current institutional and staff constraints; significantly improves the country's health indicators; achieves productivity gains and remains affordable.⁶⁷⁴ Unfortunately no information is provided as to how the NHI will address these challenges.

2.7 The Three Dimensions of Universal Coverage

In this section of the Green Paper merely sets out the World Health Organisation's explanation of the three dimensions of universal coverage.⁶⁷⁵ As indicated earlier, South Africa has arguably already achieved universal coverage through a combination of public service delivery and medical schemes.⁶⁷⁶ The objective of universal coverage has already been met, where the existing system falls short is in the quality of public health care services and the cost of private health care.⁶⁷⁷ These areas should be addressed. As no further information is presented in this section, proper discussion is impeded.

⁶⁷⁴ Department of Health (2011) Policy on National Health Insurance 21; World Health Organisation (2010) The World Health Report 2010 12.

⁶⁷⁵ Department of Health (2011) Policy on National Health Insurance 21.

⁶⁷⁶ Van den Heever (2011) 77.

⁶⁷⁷ Centre for Development and Enterprise (2011) 23.

It should once again be emphasised that the NHI is only one mechanism with which to achieve universal coverage and it should not be conflated with the concept of universal coverage.⁶⁷⁸

2.8 Population Coverage under National Health Insurance

According to the Green Paper, the NHI will cover all South Africans and legal permanent residents.⁶⁷⁹ A clear framework would need to be developed, especially if one considers the large number of undocumented immigrants currently in the country.⁶⁸⁰ Constitutional questions relating to access to health care services may arise.⁶⁸¹

2.9 The Re-Engineered Primary Health Care System

As indicated in the Green Paper, a primary health care approach had been outlined by the World Health Organisation in the conference on PHC held in Alma-Ata in 1978.⁶⁸² The prioritisation of the PHC approach has been emphasised for decades now, and it was recognised as an integral part of the ANC's national health plan in 1994 and the Department of Health's White Paper for the transformation of the

⁶⁷⁸ World Health Organisation (2010) 12; Lagomarsino *et al* "Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia" (2012) 380 *Lancet* 933; Mills *et al* "Progress towards universal coverage: the health systems of Ghana, South Africa and Tanzania" (2012) 27 *Health Policy and Planning* i5.

⁶⁷⁹ Department of Health (2011) Policy on National Health Insurance 23.

⁶⁸⁰ Klaaren "Non-citizens and equality" (1998) *South African Journal on Human Rights* 286; Pieterse "Foreigners and socio-economic rights: Legal entitlements or wishful thinking?" (2000) *Tydskrif Vir Hedendaagse Romeins-Hollandse Reg* 51; Carstens & Pearmain (2007) 66.

⁶⁸¹ Carstens & Pearmain (2007) 64; Bilchitz (2006) 'Health' in *Constitutional Law of South Africa* 13.

⁶⁸² Department of Health (2011) Policy on National Health Insurance 23; World Health Organisation (1987) Declaration of Alma-Ata, International Conference on Primary Health Care. 6-12 September 1978.

health system in South Africa.⁶⁸³ The National Health Act also states that free primary health care services should be provided through state funded facilities.⁶⁸⁴

It is clear that the PHC approach has formed part of the Department of Health's policy for a considerable time and that the Green Paper seems to provide a mere reiteration of the policy. This raises concerns as to why this policy has not yet been effectively implemented in all these years. The failure to get primary health care and the district health system to function properly has "contributed significantly to the failure of the health system".⁶⁸⁵ Referring to the re-engineering of the primary health care system generally without providing substantive proposals, indicating shortcomings of the previous attempts to implement such an approach or indicating what exactly this primary health care package of services would consist of is also unfortunate. However, the implementation of an effective primary health care system is supported.⁶⁸⁶

2.9.1 District Clinical Specialist Support Teams

District clinical support teams will be established in order to address high levels of maternal and child mortality and to improve health outcomes.⁶⁸⁷ District clinical support teams will include obstetricians and gynaecologists, paediatricians, family physicians, anaesthetists, midwives and primary health care professional nurses.⁶⁸⁸ This intervention aims to deliver specialist health care services closer to the patients'

⁶⁸³ African National Congress (1994) A National Health Plan for South Africa 20, 41, 54, 59, 61; Department of Health (1997) White Paper for the Transformation of the Health System in South Africa. GN 667 in GG 17910 of 16 April 1997 4, 6, 17.

⁶⁸⁴ S 4 of the National Health Act 61 of 2003.

⁶⁸⁵ National Planning Commission (2012) 331.

⁶⁸⁶ The Green Paper states that the district health system will be "the vehicle by which all PHC is delivered". The 1997 Health White Paper called for the urgent implementation of the district health system. Failure to implement such a proper functioning system in all these years may explain some of the failures of the current public health system.

⁶⁸⁷ Department of Health (2011) Policy on National Health Insurance 24.

⁶⁸⁸ Matsoso & Fryatt (2012) SAHR 26.

home and improve the quality of services rendered at the first level of care by ensuring adherence to treatment guidelines and protocols.⁶⁸⁹

In South Africa, it is estimated that each year 2500 mothers die, 20 000 babies are stillborn, another 21 900 die before they are a month old, and a further 52 600 children die before their 5th birthday.⁶⁹⁰ Providing specialist support at this level may improve the quality of care and is supported, but a lack of human resources is a concern in this regard.

Further concurrent interventions should, however, still be implemented to improve the distressingly high levels of maternal and child mortality. HIV prevention and the improvement of obstetric care should be prioritised.⁶⁹¹ The World Health Organisation's evidence-based recommendations, highlighted in the World Health Report of 2005 should be implemented.⁶⁹² Shortcomings identified by the National Perinatal Morbidity and Mortality Committee and the National Committee for the Confidential Enquiries into Maternal Deaths should also be dealt with, taking into account their respective recommendations.⁶⁹³

Proper leadership combined with accountability mechanisms and interventions aimed at providing quality care will be required.⁶⁹⁴

2.10 Healthcare Benefits under National Health Insurance

According to the Green Paper a “comprehensive benefit package” will be provided under the NHI.⁶⁹⁵ There is however, no indication of what this benefit package would consist of under the NHI or how it differs from the services which are currently

⁶⁸⁹ Department of Health (2011) Policy on National Health Insurance 25.

⁶⁹⁰ Chopra *et al* (2009) 374 *Lancet* 836.

⁶⁹¹ *Id* 837.

⁶⁹² World Health Organisation (2005) The World Health Report 2005 125.

⁶⁹³ National Perinatal Morbidity and Mortality Committee (2011) Triennial Report 2008-2010 98; National Committee for Confidential Enquiries in Maternal Deaths (2012) Saving Mothers 2008–2010: Fifth report on the confidential enquiries into maternal deaths in South Africa 28.

⁶⁹⁴ Chopra *et al* (2009) 374 *Lancet* 843.

⁶⁹⁵ Department of Health (2011) Policy on National Health Insurance 26.

provided. There at least needs to be a clear differentiation between what currently exists and what would be offered. The Green Paper indicates that there are barriers which prevent access to the benefit packages, without identifying the barriers or specifying how access will improve under the NHI.⁶⁹⁶

Mention is made of certain norms and standards for the provision of the benefit package; these will outline which measurable targets must be achieved and the standards of care which providers must comply with.⁶⁹⁷ It is said that this would allow managers at different levels to compare performance and challenges between facilities.⁶⁹⁸ This proposal is very vague and lacks necessary detail, but it is welcomed nonetheless. Implementing such a system will however, require the collection of accurate and reliable data if it is to be successful. Much more information is needed on this point.

The problems with regard to the delivery of services in the public system are not adequately addressed and there is no indication of how this would be improved with the implementation of the NHI.

Some of the issues that need to be addressed in the district health context are set out and include: the availability of health services at convenient hours with enough professional staff to attend to needs; the consideration of the user's privacy, confidentiality, fair treatment by staff members and ensuring that the user's dignity is respected at all times; and the compliance with core standards.⁶⁹⁹ There needs to be an enquiry into why these issues exist. The root of the problem needs to be identified, and any proposals to address the issues should be based thereon.

It is envisioned that PHC services will be delivered through accredited and contracted private providers practicing within a district.⁷⁰⁰ The Green Paper recognises that a large proportion of people use the private sector for their health care needs, but the contention that it normally involves a substantial out of pocket

⁶⁹⁶ *Id* 27.

⁶⁹⁷ *Ibid.*

⁶⁹⁸ *Ibid.*

⁶⁹⁹ Department of Health (2011) Policy on National Health Insurance 28.

⁷⁰⁰ *Ibid.*

payment, is unsubstantiated and most likely incorrect, as the majority of people who make use of private providers are members of medical schemes.

This section doesn't really provide much more information on the role that private providers would play, other than indicating that they will play a role in the NHI.⁷⁰¹ The importance of public-private partnerships in the health sector should not be overlooked.⁷⁰²

According to the Green Paper services rendered at the hospital level will be based on a "defined comprehensive package that is appropriate to the level of care and referral systems".⁷⁰³ This package of health services will be evidence-based and include all levels of care.⁷⁰⁴ Once again these statements lack any sufficient detail. It is not clear what the package of services would consist of and there is no explanation of what research there is relied on in asserting that these services would be "evidenced-based". Will the research be conducted by the Department of Health? In any case, one would hope that all the services rendered are supported by the necessary evidence and would only consist of recognised interventions.⁷⁰⁵

The Green Paper states that hospitals will be re-designated as part of the overhaul of the health system in order to improve the management thereof.⁷⁰⁶ Hospitals will be re-designated into five different levels as follows: District hospitals; regional hospitals, tertiary hospitals, central hospitals; and specialised hospitals.⁷⁰⁷ It is

⁷⁰¹ Econex (2013) *The South African Private Healthcare Sector: Role and Contribution to the Economy*. The authors of the report indicate that the private sector plays a pivotal role in providing quality health services to the public and that it should be seen as a national asset. The report also highlights the private sector's importance to the economy, as it contributes to "employment, investment, taxation, development and training, and the sustaining of various upstream and downstream industries". Also see Centre for Development and Enterprise (2011).

⁷⁰² National Planning Commission (2012) 349.

⁷⁰³ Department of Health (2011) *Policy on National Health Insurance* 28.

⁷⁰⁴ *Ibid.*

⁷⁰⁵ Sackett *et al* "Evidence based medicine: what it is and what it isn't" (1996) 312 *BMJ* 71 in which the authors give a clear overview of evidence based medicine.

⁷⁰⁶ Department of Health (2011) *Policy on National Health Insurance* 29.

⁷⁰⁷ *Ibid.*

encouraging to note that apparently these hospitals will be managed by people who possess the appropriate qualifications and skills.⁷⁰⁸

On the 2nd of March 2012 regulations on the categories of hospitals and the policy on the management of public hospitals were published.⁷⁰⁹ Public hospitals have now been divided into five categories namely district (categorised as small, medium or large), regional, tertiary, central, and specialised. Each category of hospital must meet prescribed requirements and provide specific services, as clarified in the regulations. These hospitals must be managed in accordance with the national policy.

The national policy on the management of hospitals is aimed at “ensuring the management of hospitals will be underpinned by the principles of effectiveness, efficiency and transparency”. It also hopes to ensure that skilled and competent managers are appointed who will be trained in leadership, management and governance, that management is decentralised and that accountability frameworks are developed.⁷¹⁰ The majority of new CEO positions have been filled and in future all senior managers will need to undergo specialist training and be accredited by the newly established South African Leadership and Management Academy.⁷¹¹

We shall see if these changes have the desired effect, as many of the problems experienced in the public system are due to a lack of proper management.⁷¹² However, these changes are not dependent on the introduction of the NHI and no proper case has been made for why it should be preferred as a mechanism over alternative options. There is also little information provided on how private hospitals fit into this structure, having been categorised as either “for profit private hospitals” and “not for profit private hospitals”, it seems as though they will function entirely separately from the public sector.

⁷⁰⁸ *Ibid.*

⁷⁰⁹ GN 185 in GG 35101 of 2 March 2012; GN 186 in GG 35101 of 2 March 2012.

⁷¹⁰ Matsoso & Fryatt (2012) *SAHR* 22.

⁷¹¹ Matsoso & Fryatt (2012) *SAHR* 22.

⁷¹² Development Bank of South Africa (2008) 21; National Department of Health (2011) *Human Resources for Health* 57.

2.11 Accreditation of Providers of Health Care Services

2.11.1 The Office of Health Standards Compliance

The Green Paper contains little concrete information on how quality will be upheld or how liability will be managed in terms of the NHI.⁷¹³ From the scarce information available it seems that the government will rely on massive investment in health infrastructure, quality improvement plans and the establishment of the Office of Health Standards Compliance (OHSC) to ensure that quality healthcare services will be provided under the NHI.⁷¹⁴ Strengthening the health system by promoting quality and measuring actual performance against standards for quality is seen as a priority.⁷¹⁵ The National Planning Commission, in evaluating the quality of the health system, acknowledges that infrastructure and equipment in health facilities are in a “desperate state”.⁷¹⁶ They support attempts to improve the public system, including the auditing of facilities and the setting of appropriate standards.⁷¹⁷

During the period of May 2011 to May 2012 an audit of every health facility in the public sector was conducted.⁷¹⁸ It assessed infrastructure, classification of facilities, compliance to priority areas of quality and function, human resources, access and range of services offered, and geographic positioning (GPS) for location of facilities. The Office of Standards Compliance developed the National Core Standards (NCS) for Health Establishments in South Africa that serve as a benchmark of quality

⁷¹³ National Department of Health (2010) National Strategic Plan 2010/11-2012/13. The Department of Health has published a 10 Point Plan to improve the health sector. One of the objectives is improving the quality of health services, through improved patient care and accreditation of health facilities; National Department of Health (2010) Negotiated Service Delivery Agreement (NSDA) 2010-2014. The introduction of the Negotiated Service Delivery Agreement has also reaffirmed the importance of improving quality and the government’s commitment thereto.

⁷¹⁴ Department of Health (2011) Policy on National Health Insurance 31.

⁷¹⁵ National Planning Commission (2012) 336.

⁷¹⁶ *Id* 337.

⁷¹⁷ *Id* 345.

⁷¹⁸ Health Systems Trust (2012) National Health Care Facilities Baseline Audit: National Summary Report 4.

against which the delivery of health services can be monitored.⁷¹⁹ The audit utilised the NCS quality assessment framework to collect baseline data from all public health facilities in the country.⁷²⁰ The audit focussed on the seven domains of the NCS⁷²¹, which included the six priority areas⁷²² for fast-tracking quality improvement in patient-centred care.⁷²³ A total of 3 880 facilities were covered by the audit.⁷²⁴

Public health facilities only scored more than 50% compliance in two of the six priority areas.⁷²⁵ Primary care facilities on average scored lower than hospitals in all priority areas.⁷²⁶ Facilities in Gauteng achieved the highest compliance scores, while facilities in the Northern Cape obtained the lowest scores.⁷²⁷ The audit also found many other areas which require attention.

Improving the quality and standard of care is of critical importance, an enormous and difficult task lies ahead for the OHSC.⁷²⁸

On the 24th of July 2013 an Amendment Act was published which established the OHSC.⁷²⁹ The main provisions of the Act are discussed under their corresponding headings.

⁷¹⁹ National Department of Health (2011) National Core Standards for Health Establishments in South Africa 8; Whittaker *et al* "Quality standards for healthcare establishments in South Africa" (2011) SAHR 62.

⁷²⁰ Health Systems Trust (2012) 7.

⁷²¹ National Department of Health (2011) National Core Standards 10. These seven domains are identified as: patient rights; patient safety, clinical governance and care; clinical support services; public health; leadership and corporate governance; operational management; and facilities and infrastructure.

⁷²² National Department of Health (2011) National Core Standards 15. The six priority areas are identified as: values and attitudes of staff; cleanliness; waiting times; patient safety and security; infection prevention control; and the availability of basic medicines and supplies.

⁷²³ Health Systems Trust (2012) 7.

⁷²⁴ *Id* 11.

⁷²⁵ *Id* 14.

⁷²⁶ *Id* 21.

⁷²⁷ *Id* 15.

⁷²⁸ Whittaker *et al* (2011) SAHR 64.

2.11.1.1 Objects of the Office

The OHSC was established as a juristic person, with the object of protecting and promoting the health and safety of health care users.⁷³⁰ To achieve these objectives the OHCS will monitor and enforce the compliance of norms and standards in health establishments, as prescribed by the Minister of Health. Furthermore, complaints relating to non-compliance will be considered and investigated in a procedurally fair, economical and expeditious manner.⁷³¹

2.11.1.2 Functions of the Office

The functions of the OHCS are set out in section 79 and include: a) advising the Minister on matters relating to the determination of norms and standards; b) inspection and certification of health establishments as either compliant or non-compliant; c) investigation of complaints where the norms and standards have not been met; d) monitoring risk indicators as an early warning system and immediately reporting any breaches of norms and standards to the Minister; e) identification of areas which require intervention and making recommendations to ensure compliance with the prescribed norms and standards; f) publication of information relating to the prescribed norms and standards; g) recommendation of quality assurance and management systems for the national health system; h) keeping records of all its activities; and i) advising the Minister on any matter referred to it by the Minister.⁷³²

⁷²⁹ National Health Amendment Act 12 Of 2013. A proclamation was published in the *Government Gazette* on the 30th of August 2013 which determined that certain sections of the Amendment Act would come into operation on the 2nd of September 2013.

⁷³⁰ S 78 National Health Act 61 of 2003.

⁷³¹ *Ibid.*

⁷³² S 79(1).

The OHSC may also issue guidelines to assist health establishments, collect or request information relating to prescribed norms and standards, and liaise with and negotiate cooperative agreements with any other regulatory authority.⁷³³

2.11.1.3 The Office of Health Standards Compliance Board

The Office functions under the control of the Board, which is responsible for determining the policy and conducting the required planning in connection with the functions of the Office.⁷³⁴ The Board is appointed by the Minister and consists of between 7 and 12 members who possess the relevant qualifications, skills and expertise.⁷³⁵ A Board, consisting of 12 members, has recently been appointed by the Minister; they will serve as members of the Board for a period of three years.⁷³⁶ Committees may be established to assist the Board with the performance of its functions and the exercise of its powers.⁷³⁷

The Board in consultation with the Minister is also responsible for the appointment of the Chief Executive Officer of the Office.⁷³⁸ The CEO, as head of the Office, has a number of functions in terms of the Act. These include, amongst others, the appointment of employees of the Office in accordance with an organisational structure approved by the Board in consultation with the Minister.⁷³⁹ The CEO may enter into contracts with persons or organisations, or appoint expert or technical committees to assist the Office in the performance of its functions.⁷⁴⁰

The CEO must also take appropriate action to ensure that the Ombud's findings and recommendations are implemented and may, subject thereto, request the intervention of the Minister, a member of the executive council responsible for health

⁷³³ S 79(2).

⁷³⁴ S 79A.

⁷³⁵ S 79B.

⁷³⁶ GN 65 in GG 37282 of 29 January 2014.

⁷³⁷ S 79G.

⁷³⁸ S 79H.

⁷³⁹ S 79I(1).

⁷⁴⁰ S 79I(3).

in the province or a member of the municipal council responsible for health if a complaint relates to a matter falling under the national department or that particular province or municipality.⁷⁴¹

2.11.1.4 Health Officers and Inspectors

The Minister, relevant member of the Executive Council or mayor of a municipal council may designate any person in the employ of the national department, province or municipality, as the case may be, as a health officer.⁷⁴² As mentioned above, the CEO appoints qualified persons as inspectors.⁷⁴³ They are issued with a certificate, which must be kept in their possession and showed to persons affected by their actions.⁷⁴⁴ The health officers and inspectors performing their functions in terms of the Act have the powers of a peace officer and may exercise any of the powers conferred on a peace officer by law.⁷⁴⁵

2.11.1.5 The Ombud

The Minister must, after consultation with the Board, appoint an Ombud.⁷⁴⁶ The Ombud is located within the Office, and reports to the Minister.⁷⁴⁷

The Ombud may consider, investigate and dispose of complaints relating to norms and standards in a fair, economical and expeditious manner.⁷⁴⁸ Complaints may

⁷⁴¹ S 79l(4) and (5).

⁷⁴² S 80(1).

⁷⁴³ S 80(2).

⁷⁴⁴ S 80(3) and (4).

⁷⁴⁵ S 80(4)(c).

⁷⁴⁶ S 81(1).

⁷⁴⁷ S 81(3).

⁷⁴⁸ S 81A(1).

involve an act or omission by a person in charge of or employed by a health establishment or facility.⁷⁴⁹

In conducting an investigation the Ombud may: be assisted by any person contemplated in section 81(2)(c)⁷⁵⁰; obtain affidavits or declarations from any person; direct any person to appear before him or her; direct any person to give evidence or produce any documentation relating to the matter under investigation; and interrogate such a person.⁷⁵¹ The Ombud may also request an explanation from any person and require any person appearing as a witness to give evidence under oath or after having made an affirmation.⁷⁵² The Ombud may, when considering or investigating a complaint, require the assistance of or refer the complaint to any other authority established in terms of legislation or any other appropriate and suitable body or entity to investigate similar complaints.⁷⁵³ Such authority, body or entity must provide the assistance required and report to the Ombud on progress made in relation to complaints referred to it.⁷⁵⁴

A report together with recommendations on appropriate action must be submitted to the CEO after each investigation.⁷⁵⁵ If the CEO fails to Act in accordance with the findings, the Ombud may request the intervention of the Minister.⁷⁵⁶

2.11.1.6 Independence, Impartiality and Accountability of Ombud

The Act provides that the Ombud, when dealing with any complaint, is independent and impartial, and must perform the functions in good faith without fear, favour, bias or prejudice.⁷⁵⁷ The Minister, national department and Office is obliged to afford the

⁷⁴⁹ S 81A(2).

⁷⁵⁰ S 81A(3)(a). This paragraph erroneously refers to a section not contained in the Act, the legislature probably meant to refer to S 81(3)(c).

⁷⁵¹ S 81A(3)(b).

⁷⁵² S 81A(3)(c) and (d).

⁷⁵³ S 81A(6).

⁷⁵⁴ S 81A(7).

⁷⁵⁵ S 81A(9).

⁷⁵⁶ S 81A(10).

⁷⁵⁷ S 81B(2).

Ombud assistance and support to enable the Ombud to perform his or her functions effectively and efficiently.⁷⁵⁸

There are concerns about the independence of the Ombud seeing that he or she is appointed and reports to the Minister, rather than the Board.⁷⁵⁹ The Minister is also responsible for the determination of remuneration and other terms and conditions of service of the Ombud.⁷⁶⁰ Furthermore, the Minister may terminate the employment of the Ombud.⁷⁶¹

2.11.1.7 Inspections

The Act provides for inspections of health establishments and certain other premises. Health officers may enter any premises, excluding a private dwelling, whereas an inspector may enter any health establishment at any reasonable time in order to: inspect such premises or health establishment to ensure compliance with the Act; question any person who may possess relevant information; require that documentation and health records be produced by the person in charge; and take samples of any substance or photographs relevant to the inspection.⁷⁶²

If any norm, standard or provision of the Act is not complied with, a compliance notice may be issued to the person in charge of the premises or health establishment.⁷⁶³ The compliance notice remains in force until the relevant provision of the Act has been complied with and a compliance certificate has been issued.⁷⁶⁴ Compliance certificates are only valid for four years and must be renewed before or on the expiry date in a prescribed manner.⁷⁶⁵

⁷⁵⁸ S 81B(3).

⁷⁵⁹ S 81(1).

⁷⁶⁰ S 81(4).

⁷⁶¹ S 81(6).

⁷⁶² S 82(1).

⁷⁶³ S 82(3).

⁷⁶⁴ S 82(4).

⁷⁶⁵ S 82(7).

2.11.1.8 Non-Compliance with Prescribed Norms and Standards

More details about the consequences of non-compliance are contained in section 82A of the Act.⁷⁶⁶ If a health establishment fails to comply with any prescribed norm or standard a compliance notice may be issued to the person in charge of that establishment.⁷⁶⁷ The compliance notice must set out the following: a) the health establishment to which the notice applies; b) the prescribed norms and standards which have not been complied with; c) details of the nature and extent of non-compliance; d) the steps required and the period over which such steps must be taken; and e) the penalties that may be imposed in the event of continued non-compliance.⁷⁶⁸

The compliance notice issued in terms of this section remains in force until the Office issues a certificate of compliance or until it is set aside by the tribunal after considering an appeal.⁷⁶⁹

The Office may take certain steps if a person in charge of a health establishment fails to comply with the notice. These steps will be influenced by the nature, extent, gravity and severity of the contravention and include: a) issuing a written warning; b) requiring a written response from the health establishment; c) recommending that a relevant authority take appropriate and suitable action against persons responsible for the non-compliance; d) revoking the compliance certificate and recommending that the Minister temporarily or permanently closes the health establishment or part thereof that poses a serious risk to public health or health care users; e) imposing fines on a person or health establishment; and f) referring the matter to the National Prosecuting Authority for prosecution.⁷⁷⁰

⁷⁶⁶ S 82A.

⁷⁶⁷ S 82A(1).

⁷⁶⁸ S 82A(2).

⁷⁶⁹ S 82A(3).

⁷⁷⁰ S 82A(4).

The CEO must inform the head of a national or provincial department, the municipal manager or the head of a health establishment of any persistent non-compliance.⁷⁷¹

2.11.1.9 Environmental Health Investigations

Health officers, registered as environmental health practitioners, are entitled to investigate conditions, which violate rights contained in section 24(a) of the Constitution, constitute pollution detrimental to health, or are likely to cause a health nuisance or constitute a health nuisance.⁷⁷² A compliance notice is then issued to the person determined to be responsible for such condition.⁷⁷³

2.11.1.10 Entry and Search of a Premises or Health Establishments

Health officers or inspectors, accompanied by a police official may, on the authority of a warrant, enter any premises or health establishment in order to conduct a search or to seize certain relevant items.⁷⁷⁴ A warrant may be issued by a judge or magistrate in relation to the premises or health establishment on or from which there is reason to believe an act has been or is being committed in contravention of the Act and if there are reasonable grounds to believe that there is evidence available in or upon such premises or health establishment of a contravention of the Act.⁷⁷⁵

A health officer or inspector may enter or search a premises or health establishment without a warrant, if a person competent to do so consents thereto or if there are reasonable grounds to believe that a warrant would be issued in terms of the Act, but that the delay in obtaining the warrant would defeat the object thereof.⁷⁷⁶

⁷⁷¹ S 82A(5).

⁷⁷² S 83(1).

⁷⁷³ S 83(3).

⁷⁷⁴ S 84(1).

⁷⁷⁵ S 84(5).

⁷⁷⁶ S 86.

The Act explicitly states that any entry upon or search of a premises or health establishment must be conducted with strict regard to decency and good order, and must take into account a person's rights to dignity, freedom and security, and privacy.⁷⁷⁷

2.11.1.11 Appeals against Decisions of the Office or Ombud

The Act provides that any person aggrieved by a decision of the Office or any finding and recommendation of the Ombud, may within 30 days after gaining knowledge thereof, lodge a written appeal with the Minister.⁷⁷⁸ The Minister must then, upon receipt of such a written appeal, appoint an independent *ad hoc* tribunal and submit the appeal to it for adjudication.⁷⁷⁹ The tribunal consists of a chairperson, who must be a retired judge or magistrate, and two persons appointed on account of their knowledge of the health care industry.⁷⁸⁰

Decisions of the Office or Ombud may be confirmed, set aside or varied by the tribunal and it must notify the parties of its finding.⁷⁸¹

2.11.1.12 Offences and Penalties

There are a number of offences in terms of the Act, the failure to comply with a compliance notice being one of them.⁷⁸² If convicted of an offence a person would be liable on conviction to a fine or to imprisonment for a period not exceeding 10 years, or to both a fine and imprisonment.⁷⁸³

⁷⁷⁷ S 86A.

⁷⁷⁸ S 88A(1).

⁷⁷⁹ S 88A(2).

⁷⁸⁰ S 88A(3).

⁷⁸¹ S 88A(4).

⁷⁸² S 89(1).

⁷⁸³ S 89(2).

2.11.2 Conclusion

The establishment of an OHSC is welcomed and a much needed step in ensuring that quality care is provided in the health sector. There are however concerns about the independence thereof. Political interference may prohibit the proper functioning of the Office and will make it impossible for it to live up to its potential or serve its designated purpose. The Office will impact on many stakeholders in the sector, which further necessitates its impartiality and independence.

The OHSC's work has already started; inspectors have been trained and are carrying out voluntary "mock" inspections to develop the tools, procedures and the prescribed norms.⁷⁸⁴ Inspections will become mandatory in the near future, for both the public and private sectors.⁷⁸⁵

2.12 Payment of Providers under National Health Insurance

The Green Paper proposes that existing provider payment mechanisms and accountability processes should be changed to ensure effective cost-containment and the future sustainability of the NHI.⁷⁸⁶

This section contains a broad overview of payment mechanisms. Very little detail is provided on matters which are inherently complex and immensely important to the proper functioning of the health system. A proper accountability and monitoring framework should be implemented, especially if one takes into account the public sector's poor record of financial management. Unfortunately, the Green Paper remains silent on this issue.

According to the Green Paper accredited providers at the primary care level will be reimbursed according to a risk-adjusted capitation system linked to a performance-

⁷⁸⁴ Matsoso & Fryatt (2012) SAHR 24.

⁷⁸⁵ *Ibid.*

⁷⁸⁶ Department of Health (2011) Policy on National Health Insurance 32.

based mechanism. The size of the registered population, epidemiological profile, target utilisation and cost levels will determine the annual capitation amount.⁷⁸⁷

A complex payment mechanism, such as the one proposed, would require a functioning health information system and health coding system, which is currently not available in the public sector. It would take years before such a system could realistically be implemented as the information to ensure the proper functioning thereof is not accurately available.⁷⁸⁸

Capitation involves the payment of a sum of money in advance for the on-going care of each individual enrolled with a provider for a particular fixed period of time.⁷⁸⁹ Capitation may even have an effect on the quality of care provided, as it could influence doctors' decision making. This could have positive effects, in that a doctor would manage the care of his or her patients, focussing on preventative care, cost-containment, increased productivity or it could have negative effects, such as the underservicing of patients, since spending less on patients would mean higher profits.⁷⁹⁰

At the hospital level, reimbursement will be through global budgets, with a *gradual* move towards Diagnostic Related Groups, with a strong emphasis on performance management.⁷⁹¹

There is an urgent need for a proper hospital reimbursement system. The failure to introduce the necessary reform has contributed to the decline in the quality of public hospital services.⁷⁹²

Public emergency medical services will also initially be reimbursed through global budgets, eventually transitioning toward a case-based mechanism.⁷⁹³ The case-based approach will be used to reimburse contracted private emergency services.⁷⁹⁴

⁷⁸⁷ *Ibid.*

⁷⁸⁸ For an overview of the benefits and drawbacks of different payment mechanisms in the South African context see Econex (2010) Health Reform Note 6: Provider Payment Systems.

⁷⁸⁹ Berwick "Payment by capitation and the quality of care" (1996) 335 *N. Engl. J. Med.* 1227.

⁷⁹⁰ Berwick (1996) 335 *N. Engl. J. Med.* 1230; Econex (2010) Provider Payment Systems 5.

⁷⁹¹ Department of Health (2011) Policy on National Health Insurance 32.

⁷⁹² Van den Heever (2011) 87; Econex (2010) Provider Payment Systems 10.

There seems to be a real emphasis on the incorporation of performance-based payment mechanisms, with incentives for health workers and professionals playing a central role.⁷⁹⁵ More information on the payment mechanisms are required and proper evaluation will not be possible until sufficient detail is provided.⁷⁹⁶

2.13 Healthcare Coding Systems and Reimbursement

It is envisioned that a coding system will be adopted under the NHI to ensure uniformity in reporting services rendered or goods provided for purposes of reimbursement.⁷⁹⁷ This proposed coding system will also be utilised for health information, planning and decision making purposes.⁷⁹⁸

A healthcare coding system is an integral part of any health information system.⁷⁹⁹ They are however, very complex to develop and would need to be specifically adapted for the South African context.⁸⁰⁰ A coding system would also need to be extensive and comprehensive if it is to adequately support and enable the reimbursement and other healthcare aspects as envisioned by the Green Paper. The existence of some sort of coding system would be a pre-requisite to many of the proposals contained in the NHI submission.

The International Classification of Diseases diagnostic coding standard (ICD-10)⁸⁰¹, published and maintained by the World Health Organisation, has been adopted by

⁷⁹³ Department of Health (2011) Policy on National Health Insurance 32.

⁷⁹⁴ *Ibid.*

⁷⁹⁵ *Ibid.*

⁷⁹⁶ For an overview of payment methods, and their strengths and weaknesses see International Labour Organization (1999) *Modelling in Health Care Finance: A Compendium of Quantitative Techniques for Health Care Financing* 58.

⁷⁹⁷ Department of Health (2011) Policy on National Health Insurance 33.

⁷⁹⁸ *Id* 34.

⁷⁹⁹ Engelbrecht & Crisp (2010) *SAHR* 200.

⁸⁰⁰ Du Toit & Carnelley "ICD diagnostic codes and the constitutional rights of patients" (2007) 28 *Obiter* 537.

⁸⁰¹ World Health Organization (1992) International Classification of Diseases and Related Health Problems 10th Revision.

the National Health Information System of South Africa. It was accepted as the national standard for diagnosis coding in both the public and private sectors in 1995. The implementation process started in 2004 with the formation of a National Task Team on ICD-10 implementation.⁸⁰² Unfortunately it is not utilised in all public health institutions yet. The private sector uses the diagnostic coding system for classification of diseases and billing purposes.⁸⁰³ It is seen as a key priority to train and improve the skills of those involved in coding.⁸⁰⁴

With regard to procedural coding, there is currently no standardised National Procedural Coding System available in South Africa. The government hopes to develop a standardised coding system, adapted to the local health environment as soon as possible.⁸⁰⁵

2.14 Unit of Contracting Providers of Health Care Services

The responsibility of contracting with the NHI to purchase health services will fall upon the District Health Authority, whose contracting unit will be supported by the NHI Fund's sub-national offices in managing contracts with accredited providers.⁸⁰⁶ The District Health Authority will have to ensure that services are adequate and accessible for the population in the specified health district. The District Health Authority will also be responsible for the monitoring the performance of contracted providers. The reimbursement mechanism will take the performance of contracted providers into account and hopefully health outcomes will improve as a result thereof.⁸⁰⁷

⁸⁰² Matshidze & Hanmer "Health information systems in the private health sector" (2007) *SAHR* 95.

⁸⁰³ Matshidze & Hanmer (2007) *SAHR* 95.

⁸⁰⁴ Matsoso & Fryatt (2012) *SAHR* 23.

⁸⁰⁵ Matsoso & Fryatt (2012) *SAHR* 23. The need to develop other coding systems is also recognised, as well as the establishment of some form of 'National Health Data Dictionary'.

⁸⁰⁶ *Ibid.*

⁸⁰⁷ *Ibid.*

To avoid duplication of administrative processes and to minimise administrative costs, the purchasing and provision of services functions, would be separated, with clear roles designated for the respective spheres of government and the NHI.⁸⁰⁸

There is so little information provided on the District Health Authority that it is almost impossible to comment thereon. The Green Paper does not clarify how this entity will be established or how it will function. The structure and composition thereof is also a mystery and no mention is made of oversight mechanisms. It is also not clear how exactly a District Health Authority will contract with the NHI. The interaction between the District Health Authority and the NHI Fund with its sub-national offices is also not clear. An absence of information hinders proper discussion and engagement.

The role of provincial government, with its concurrent powers over health services, is not explained.⁸⁰⁹ Will they continue to raise revenue, allocate budgets, contract with providers and monitor the achievement of specific goals?

If the District Health Authority is meant to function as a third tier of the health system, that would be supported and would strengthen the health system.⁸¹⁰ There would however, need to be extensive research done to create a policy document with such a proposal adequately set out.

Work is apparently underway to develop District Health Authorities. Assessing the costs involved and implications of scaling up are currently an aim of the NHI pilot districts.⁸¹¹ It seems that these authorities will function as a management and accountability mechanism in the district health system.⁸¹² Further still, that each of the 52 districts would likely in the future have to plan and procure services for the local inhabitants, by entering into contracts with accredited providers and then monitoring the performance of those contracted providers.

⁸⁰⁸ *Ibid.*

⁸⁰⁹ Schedule 4 Part A of the Constitution of the Republic of South Africa, 1996.

⁸¹⁰ Proposals for a District Health System are contained in the Department of Health's 1997 White Paper for the Transformation of the Health System in South Africa.

⁸¹¹ Matsoso & Fryatt (2012) SAHR 28.

⁸¹² *Id* 29.

2.15 Principal Funding Mechanisms for National Health Insurance

The funding mechanisms are yet to be finalised, but it is apparent that there will be payment in advance and that these funds will then be pooled in order to exercise more control over the purchasing of health services.⁸¹³ The Green Paper indicated that the revenue base should be as broad as possible and that funds could be raised from a combination of sources, which may include the fiscus, employers and individuals.⁸¹⁴ A timeframe of six months was given to complete the technical work and clarify the specifics of the funding mechanisms.⁸¹⁵ The six month period has expired without the publication of any information.

In October 2013 the Director-General for health indicated that Treasury's discussion document on financing options for NHI was "nearly ready".⁸¹⁶ The deadline for the release of the discussion document has been repeatedly extended.⁸¹⁷ In his 2013 budget speech Finance Minister Pravin Gordhan said that no new revenue demands will be placed on the fiscus during the initial phase of NHI development, but that a tax increase is anticipated over the longer term.⁸¹⁸ The Minister indicated that National Treasury was working with the Department of Health "to examine the funding arrangements and system reforms required for NHI" and that a discussion paper would be made available in 2013.⁸¹⁹ This release has not yet occurred.

Any proposed funding mechanism would need to be mindful of the economic realities faced by the country.⁸²⁰ Although strides have been made by the South African Revenue Service to increase the number of registered tax payers, there are only

⁸¹³ Department of Health (2011) Policy on National Health Insurance 35.

⁸¹⁴ *Ibid.*

⁸¹⁵ *Ibid.*

⁸¹⁶ "Treasury's NHI discussion document nearly ready" Business Day 23 October 2013.

⁸¹⁷ When Finance Minister Pravin Gordhan delivered his budget speech in February 2012, he said that the discussion document would be published by April 2013. National Treasury (2012) Budget Speech.

⁸¹⁸ National Treasury (2013) Budget Speech 17.

⁸¹⁹ *Ibid.*

⁸²⁰ Van den Heever "A financial feasibility review of National Health Insurance proposals for South Africa" (2010) *SAHR* 157.

15.4 million individuals registered for income tax.⁸²¹ These are only the registered individuals; the actual number of citizens who earn enough to be taxed is much lower. The tax burden of this small income tax base needs to be acknowledged. Any additional revenue from this source is limited.⁸²² The slow economic growth rate and other factors would also need to be factored into any new proposals.⁸²³

2.15.1 The Role of Co-Payments under National Health Insurance

According to the Green Paper, under the NHI co-payments would only be required in exceptional instances. A few examples are listed and include: services which are not rendered in accordance with NHI treatment protocols and guidelines, services which are not covered under the NHI or are rendered by providers not accredited or contracted by the NHI and the non-adherence to the referral system.⁸²⁴

2.16 How much will National Health Insurance Cost?

The costing estimates presented in the Green Paper are said to rely on approximate resource requirements needed for the achievement of universal coverage, which is based on cost effective delivery of health services.⁸²⁵ Prior to the release of the Green Paper background work was done on two costing models, which was based on work by McLeod *et al.*⁸²⁶ Another comprehensive costing model by the Actuarial Society of South Africa was also developed.⁸²⁷ The Green Paper does concede that

⁸²¹ National Treasury and South African Revenue Service (2013) Tax Statistics 2013 3.

⁸²² Steenekamp "The progressivity of personal income tax in South Africa since 1994 and directions for tax reform" (2012) 16 *Southern African Business Review* 45.

⁸²³ National Planning Commission (2012) 343.

⁸²⁴ Department of Health (2011) Policy on National Health Insurance 35.

⁸²⁵ *Id* 36.

⁸²⁶ McLeod, Grobler & Van der Berg (2010) Preliminary Estimate of NHI Costing in 2009 Rand Terms: Methodology and Assumptions: A briefing paper prepared for National Treasury 18 February 2010.

⁸²⁷ Actuarial Society of South Africa (2010) Discussion Document: Burden of Disease: Actuarial Society of South Africa NHI Model 8 March 2010.

further work will need to be undertaken to refine the cost estimates as more detailed proposals are developed.⁸²⁸

The Green Paper attempts to cost a NHI system that has not yet been adequately defined. There is no indication of what the benefit package will consist of, the profile of persons who will utilise the services or how the system will be administered and governed. National Treasury and the National Department of Health are currently doing more detailed costing work.⁸²⁹ The NHI pilot districts and other reforms will inform future costing.⁸³⁰ It may be years before a reliable costing model can be developed.

The costing model used in the preliminary costing, is based on an approach which is apparently recommended by the International Labour Office and is presented as: “Total expenditure = user population x service utilisation rates x unit costs”.⁸³¹

Under the proposed costing model, resource requirements increase from R125 billion in 2012 to R214 billion in 2020 and R255 billion in 2025 if implemented gradually over a 14-year period.⁸³² The Green Paper does state that further costing will be undertaken by Treasury and the Department of Health to refine the model and to examine long term fiscal implications and effects of the NHI contribution on households.⁸³³ At the moment the Green Paper does not justify the substantial increase in public health expenditure, the public is left in the dark as to which services are changing or why they are changing. This merely comes across as a budget increase intended to fit medical scheme expenditure.

The argument is made that increased spending on the NHI will be partially offset by the decline in spending on medical schemes. The Green Paper tries to justify the spending by comparing it to the current level of medical scheme contributions and the belief that the public will forgo their medical schemes and rather use the services

⁸²⁸ Department of Health (2011) Policy on National Health Insurance 36.

⁸²⁹ Matsoso & Fryatt (2012) SAHR 29.

⁸³⁰ *Ibid.*

⁸³¹ Department of Health (2011) Policy on National Health Insurance 37.

⁸³² *Ibid.*

⁸³³ *Id* 38.

provided under the NHI.⁸³⁴ There is however, no evidence presented that this would be the case. Individuals, who use their disposable income to obtain medical scheme membership, do so to be covered in the event of catastrophic medical expenses. Primary health care services, which will be a main focus of the NHI⁸³⁵, would be less important to these individuals and most income earners would be able to pay out of pocket therefor. Thus, individuals will most likely continue to belong to medical schemes because of the perceived higher levels of quality in the private sector and their insistence on the best possible care if they were to be hospitalised.⁸³⁶ This will have macroeconomic implications.⁸³⁷ The individuals who may not be able to afford medical scheme coverage anymore, because of their mandatory contribution toward the NHI, will also place a substantial additional burden on the public health system.⁸³⁸ How will this increased demand be met?

The Green Paper concedes as follows: “No amount of funding will be sufficient to ensure the sustainability of National Health Insurance unless the systemic challenges within the health system are also addressed”.⁸³⁹ Strengthening of the public health system and transformation of the health services delivery platform is described as critical for the success of NHI.⁸⁴⁰

All of the funding for personal health care services will flow through the National Health Insurance Fund, with revenue, including the mandatory contribution, being collected by the South African Revenue Services. The Green Paper states that “Treasury will allocate general tax revenue for personal healthcare services and the

⁸³⁴ *Id* 40.

⁸³⁵ “Primary healthcare will be heartbeat of NHI, says health minister” Business Day 16 October 2013.

⁸³⁶ “National Health Insurance ‘not the end’ of medical schemes industry” Business Day 20 August 2013.

⁸³⁷ Van den Heever (2011) 97.

⁸³⁸ Econex (2012) Research Note 27: Public vs. Private Health Sector Rationing Mechanisms: Theoretical and Practical Considerations; “Public, private hospital costs ‘similar’” Business Day 29 October 2013.

⁸³⁹ Department of Health (2011) Policy on National Health Insurance 40.

⁸⁴⁰ *Id* 41.

payroll-linked mandatory contribution to National Health Insurance in consultation with the Minister of Health and the National Health Insurance”.⁸⁴¹

The costing of the NHI will only be possible when more reliable information is available. Previous attempts to cost the system have shown that costs vary considerably depending on the comprehensiveness of benefits offered and other factors.⁸⁴²

2.17 The Establishment of the National Health Insurance Fund

The Green Paper states that in order to implement the NHI, there will have to be a considerable reconfiguration of all the existing institutions and organisations involved in the funding, pooling, purchasing and provision of health care services in the country.⁸⁴³ This reconfiguration would see the establishment of a National Health Insurance Fund.⁸⁴⁴ The NHI Fund will pool resources in order to purchase health services for the entire population from contracted public and private providers. It is said to be established in 2014/2015.⁸⁴⁵ Work to determine the “different options for the roles, responsibilities and relationships” of the NHI funding body is currently being conducted.⁸⁴⁶

The “reconfiguration” contemplated in the Green Paper would need to be mindful of the fact that health services are a concurrent function under the Constitution⁸⁴⁷ and

⁸⁴¹ *Ibid.*

⁸⁴² Matsoso & Fryatt (2012) *SAHR* 29. For attempts to cost the NHI see: the COSATU costing by Calikoglu & Bond; the HEU costing by McIntyre, Ataguba & Cleary; the Actuarial Society of South Africa, Deloitte, Discovery Health model; preliminary costing by McLeod, Grobler & Van der Berg; costing and evaluation by ECONEX; and costing and evaluation by Alex van den Heever. The HEU costing by McIntyre *et al* was used by the Ministerial Advisory Committee on NHI.

⁸⁴³ Department of Health (2011) Policy on National Health Insurance 41.

⁸⁴⁴ *Ibid.*

⁸⁴⁵ Matsoso & Fryatt (2012) *SAHR* 22.

⁸⁴⁶ *Id* 30.

⁸⁴⁷ Schedule 4 Part A of the Constitution of the Republic of South Africa, 1996.

any change to National or Provincial competencies may require a constitutional amendment, which would have to be very carefully considered.

The Fund will be a publicly administered, government-owned entity. The Green Paper states that the NHI Fund will be managed by a Chief Executive Officer and will report to the Minister of Health and Parliament.⁸⁴⁸ This is concerning, as the Department of Health will be both a provider and purchaser of health services, there is a conflict of interest and the lack of independence will be problematic. A politicised governance structure also increases the risk of corruption and inefficiency.⁸⁴⁹

It is envisioned that the fund will function as a single payer entity with sub-national offices. The sub-national structures will have to manage contracts with the District Health Authorities and accredited health care providers. These contracts will be negotiated at a national level.⁸⁵⁰

Although a single-payer system is described as the preferred option, according to the Green Paper, a multi-payer system will apparently be explored as an alternative.⁸⁵¹

A single fund will have considerable administrative challenges. There is no indication of why a single fund will function better than other possible arrangements.⁸⁵² A proper case for such a radical change has not been presented; it needs to be justified by indicating which weaknesses it seeks to address and then convincingly

⁸⁴⁸ Department of Health (2011) Policy on National Health Insurance 42.

⁸⁴⁹ Gupta, Davoodi & Tiongson (2000) Corruption and the provision of health care and education services. IMF Working Paper; Van den Heever (2011) 110. The absence of information on accountability and monitoring structures is also worrying.

⁸⁵⁰ Chopra *et al* (2009) 374 *Lancet* 1025. Decentralisation of the public health system is recommended. The centralisation of decision-making may have a negative impact on accountability and efficiency of health care provision.

⁸⁵¹ Department of Health (2011) Policy on National Health Insurance 42.

⁸⁵² Econex (2011) Health Reform Note 15: National Health Systems: Public Service vs. Insurance-Based Models. After examining two different systems the authors reach the conclusion that, the upgrading and expanding of the existing tax-based public health system, may be more efficient than implementing an insurance-based system. There is also a negligible difference in health outcomes between the two systems. An insurance-based system could be much more costly to run, without additional benefit to the public. See Pearmain (2008) *The Law of Medical Schemes in South Africa* for detailed discussion of the medical schemes industry.

demonstrating that a single fund will be the best option to address those weaknesses. The need to remedy systemic failures in provincial and local government exists, however the Green Paper fails to identify or confront those failures with this proposal.

2.18 The Role of Medical Schemes

The Green Paper clearly states that NHI membership would be mandatory.⁸⁵³ This will not mean that medical schemes will cease to exist, but any contribution to a private medical scheme will be voluntary and will require an additional contribution, over and above the mandatory contribution already made towards the NHI. Those who choose to continue their medical scheme coverage will also not be eligible for a tax subsidy.

The public health system would need drastic improvement. Many people have lost faith in the public system's ability to provide quality care and those who can afford it have joined medical schemes in order to access private sector health care. If NHI membership and the corresponding contribution become mandatory, many people will no longer be able to afford medical scheme coverage. This will place an additional burden on the public sector. The Green Paper does acknowledge the need for quality improvement and it should be one of the main priorities of the Department of Health, it has however, not been shown that the NHI is the appropriate mechanism to achieve that goal. Forcing everyone into a publically administered system, without first addressing the existing problems will do more harm than good.

The Green Paper recognises the wealth of experience possessed by those who currently administer and manage insurance funds, stating that their expertise will be required to develop the functional capacity of the NHI.⁸⁵⁴

⁸⁵³ Department of Health (2011) Policy on National Health Insurance 43.

⁸⁵⁴ *Ibid.*

2.19 Registration of the Population

According to the Green Paper the NHI fund will only deal with registered citizens, as provided by the Department of Home Affairs, and only registered citizens will have access to the defined package of services.⁸⁵⁵ It would be unconstitutional to only grant NHI benefits to citizens.⁸⁵⁶ This contradicts statements made elsewhere in the Green Paper which indicate that permanent residents would also be covered under the NHI.⁸⁵⁷

It is envisioned that every citizen will be issued a NHI card, which will allow for access to all their medical records and health information.⁸⁵⁸ A partnership has been entered into with the Department of Science and Technology and consultations with the Council for Scientific and Industrial Research are underway on population enrolment for NHI and the linkage to facilities.⁸⁵⁹ Data captured by the Department of Home Affairs and public health facilities will be utilised for the process. A strategy to capture outstanding data and information will be piloted before agreeing on a full acquisition strategy for a population register.⁸⁶⁰

2.20 Information Systems for National Health Insurance

The need for an integrated and enhanced National Health Information System is emphasised in the Green Paper.⁸⁶¹ The information system will be used to determine the population's health needs and measure health outcomes.⁸⁶² The system will also be essential for portability of services for the population.⁸⁶³

⁸⁵⁵ *Ibid.*

⁸⁵⁶ *Khosa and Others v Minister of Social Development and Others; Mahlaule and Another v Minister of Social Development and Others* 2004 (6) BCLR 569 (CC).

⁸⁵⁷ Department of Health (2011) Policy on National Health Insurance 5, 23.

⁸⁵⁸ *Id* 43.

⁸⁵⁹ Matsoso & Fryatt (2012) *SAHR* 30.

⁸⁶⁰ *Ibid.*

⁸⁶¹ Department of Health (2011) Policy on National Health Insurance 44.

⁸⁶² *Ibid.*

Very little information is provided on the exact functioning of the information system, but it is said that it will be based on an electronic platform with links between the NHI membership database and accredited, contracted health care providers.⁸⁶⁴

The National Health Act requires the coordination of a national health information system.⁸⁶⁵ The Department coordinates and facilitates the health information system through the National Health Information System of South Africa committee. The health information systems, despite large investment, are not functioning as they should and are unable to support the business processes of the health system. These existing systems are unable to produce adequate data and information for management and monitoring purposes. Consequently, it is also not currently possible to evaluate the performance of the national health system.⁸⁶⁶

South Africa has fragmented systems and a lack of human capacity and experience in health informatics.⁸⁶⁷ Many of the systems are still paper based.⁸⁶⁸ A number of other challenges have also been identified.⁸⁶⁹ The National Department of Health has launched an e-Health strategy to address these problems.⁸⁷⁰

2.21 Migration from the Current Health System into the National Health Insurance Environment

⁸⁶³ *Ibid.*

⁸⁶⁴ *Ibid.*

⁸⁶⁵ S 74 of the National Health Act 61 of 2003.

⁸⁶⁶ National Department of Health (2010) NSDA 2010-2014 11.

⁸⁶⁷ Vital Wave Consulting (2009) Health Information Systems in Developing Countries: A Landscape Analysis 89. This analysis was funded by the Bill and Melinda Gates Foundation. It places South Africa's health information system development at stage 3 out of 5.

⁸⁶⁸ *Ibid.*

⁸⁶⁹ Kumalo "Health management information systems" (2006) *SAHR* 71; Development Bank of South Africa (2008) 27.

⁸⁷⁰ National Department of Health (2012) eHealth Strategy South Africa 2012/13-2016/17.

The Green Paper states that the NHI will be phased in over a period of 14 years, noting that a well-articulated implementation plan would be required.⁸⁷¹ This section merely restates a number of points mentioned earlier in the Green Paper, such as amongst others, the need to strengthen district health structures, the implementation of quality improvement measures, and the importance of addressing human resources shortages. No additional substantive information is provided on exactly how these processes will be realised.

It is proposed that changes to the health system be piloted in certain districts in order to evaluate management capacity, the planned service package and the delivery of services through contracted providers.⁸⁷² A NHI conditional grant will be allocated to the Department of Health for this purpose.⁸⁷³

The conditional grant is meant to help strengthen the health system, test innovations necessary for implementing the NHI and support revenue collection at central hospitals. R150 million has been made available for the development of new systems and capacities in pilot districts and central hospitals.⁸⁷⁴ Activities will be scaled up and the grant amount will increase to R300 million in 2013/14, and R450 million in 2014/2015.⁸⁷⁵ A review presented to parliament, showed that most districts have failed to spend their budgets and that only a third of the primary healthcare facilities were ready to start contracting services from private sector general practitioners.⁸⁷⁶

The migration process will also include the review of existing laws and the preparation of a new Bill to implement the NHI and the NHI fund in South Africa. In December 2011 an international conference was held, which featured experts from a number of countries, who presented findings on their experiences in introducing

⁸⁷¹ Department of Health (2011) Policy on National Health Insurance 44.

⁸⁷² *Id* 45.

⁸⁷³ *Id* 47.

⁸⁷⁴ Matsoso & Fryatt (2012) *SAHR* 29.

⁸⁷⁵ National Treasury (2012) GEMS Annual Symposium: Financing NHI and Pilot Districts. Sandton, South Africa. 15-16 August 2012.

⁸⁷⁶ "Most districts in NHI study have failed to spend their budgets" Business Day 24 July 2013.

similar health reforms and moving towards universal coverage.⁸⁷⁷ Consultations and meetings with stakeholders have also been conducted and the Minister ventured into the NHI pilot districts as part of his “road-show” to engage with affected parties.⁸⁷⁸ These consultations and meetings will contribute to the development of the White Paper on National Health Insurance.

The long awaited White Paper, which was expected to be released in 2013, is yet to be released.⁸⁷⁹

⁸⁷⁷ National Department of Health (2011) National Health Insurance Conference: Lessons for South Africa. National Consultative Health Forum (NCHF). Johannesburg, South Africa. 7-8 December 2011.

⁸⁷⁸ Matsoso & Fryatt (2012) *SAHR* 22.

⁸⁷⁹ *Ibid.*

Chapter Four: Conclusion

The Green Paper on National Health Insurance and the developments since its release were critically examined in this Chapter. The principal arguments for reforming the South African health system are set out and summarised in the introduction to the policy document. It indicated that the NHI will improve service provision, and promote equity and efficiency in order to ensure that all South Africans have access to affordable, quality healthcare services. In essence a complete reform of the health system is proposed that would see a reorganisation of service delivery and financing structures.

The problems as identified in the Green Paper were also addressed. Therein, it is argued that the current government inherited a fragmented health system, which was designed along racial lines and has led to healthcare disparities and a resultant systematically under-resourced public health system. Although it is true that many of the existing challenges are a consequence of devastating policies of the past, the failures in leadership and management that have plagued the post-apartheid health system cannot be ignored.

The drafters of the policy document have identified the existing "two-tiered system" of healthcare as the main problem and the contentions in the Green Paper are all directed at supporting this conclusion. The private sector is continually criticised in the Green Paper in order to strengthen the argument for health reform. Numerous assertions in this regard are however based on inaccurate and misleading information.

Many of the real challenges faced by the health system are dealt with in a superficial manner and shortcomings in the institutional models are not identified or analysed by the

National Health Department. For example, it is acknowledged that problems relating to quality care persist in the public sector. What is however, lacking from the description of the quality concerns are the causes of the concerns. These are not addressed at all and the failure to be able to adequately identify the systemic problems may lead to the failure to adequately rectify and improve these problems. The focus placed on how the quality failures drive the public to the private sector and the costs they then incur, rather than scrutinising the causes of the failures and setting out substantive strategies to remedy the situation.

South Africa spends 8.5% of its GDP on health, yet the health outcomes remain poor when compared to similar middle-income countries. The drafters of the Green Paper attribute these poor health outcomes to the inequities between the public and private sector. It was indicated that the Green Paper misleads when it attempts to imply that a causal relationship exists between expenditure equity and health outcomes, as high expenditure in the private sector has no impact on public sector performance and no evidence is presented to confirm such an assertion. The poor health outcomes are thus the exclusive result of the manner in which the public system is managed and have little to nothing to do with the private sector. South Africa's public health expenditure actually compares well to similar developing countries. The evidence does not support the contention that the poor health outcomes are as a result of a lack of funding. The health system is actually under-performing given its level of expenditure.

It can even be argued that increased private sector participation allows public sector resources to be spread over a smaller part of the population, increasing the redistributive effect of general taxes for healthcare. With less people making use of the public sector, the remaining

healthcare budget can be spent on fewer beneficiaries, leading to a more advantageous distribution of resources.

The Green Paper attacks the private sector as being very costly and it is true that costs are unacceptably high. There is however a misrepresentation of these costs and this is cause for great concern. Similar unsubstantiated claims are made about the sustainability of medical schemes. These arguments are not supported by the evidence and raise questions about the transparency with which the implementation of the NHI is being conducted. The fact that inaccurate information is relied on misleads stakeholders and prevents informed, meaningful discussion. Denouncing the private health system as unsustainable in order to build the case for health reform serves a very narrow interest. The focus should rather be placed on better regulation of the private health sector.

In making its case for reform the Green Paper continually overstates the human and financial resource differential between the public and private sectors. Although it is true that the distribution of human resources may have an impact on fairness, it has been shown that the distribution of doctors and specialists is not nearly as uneven as the government would lead us to believe. That being said, there is an urgent need to fill post with, skilled committed and competent individuals. There is a dramatic staff shortfall in South Africa. Evidence suggests that public health staffing levels have decreased due to constrained budgets and increased unit costs, thus private sector increases have had little to no effect. Staffing levels have also been affected by medium-term supply constraints. The Department of Health has launched a Human Resources for Health Strategy to address the concerns.

The Green Paper relies on expenditure variations between the two sectors to bolster their equity argument. This argument equates differential costs to resource distributions and

confounds the two. Unit cost differentials between the sectors cannot by themselves defeat the principles of social justice and equity. The only reasonable conclusion may be that consumers in the private sector may not be getting value for money, but then again it may be argued that compared to the quality of care in the public sector, they are and the higher costs are justified. This line of reasoning by the Green Paper cannot stand, the mere fact that there are deviations in distribution of health expenditure and resources, and that it is not precisely equally allocated, does not inevitably render it unfair. The public choose to use their disposable income to voluntarily contribute to medical schemes and unless there is a negative feedback effect, such expenditure is irrelevant in calculating equity. How revenue is spent in the public sector may in actual fact be contributing to the poor health outcomes.

The National Health Insurance is presented by the drafters as the remedy for all the problems identified in the problem statement section. The rationale for the introduction thereof is rather vaguely set out and idealistic statements are made without any real analysis or evidence to support such ambitious declarations. According to the Green Paper, those with the greatest need for health care have the least access and suffer poor health outcomes and the current two-tiered system is to blame. The policy document attributes the problems of the health system on the existence of the private sector. However, in doing so the public sector's own failures and shortcomings are overlooked. The focus should be on identifying the underlying systemic problems in the public health sector, instead of shifting the responsibility and blame for poor health outcomes.

The other reasons advanced for implementing the NHI include the improvement of access to quality healthcare services and

the provision of financial risk protection against catastrophic health-related expenditures for the whole population. The proposed NHI will apparently also provide a mechanism for improved cross-subsidisation in the overall health system, which would ensure that funding contributions would correspond with an individual's ability to pay and the benefits received will be linked to the individual's need for care. This is however, already provided for by both the public system and medical schemes. General tax contributions are linked to an individual's ability to pay and these taxes enable many to access subsidised healthcare services. Medical scheme contributions that are paid out of the individual's disposable income entitle him or her to health benefits and a set of prescribed minimum benefits. The Green Paper does not evaluate the alternative mechanisms, nor does it state how the objectives will be better achieved through the implementation of the NHI system.

The principles by which the NHI will be guided were also examined. These principles should in actual fact form part of our existing health system. Unfortunately due to poor management, a lack of good governance and accountability, ineffective monitoring and evaluation, an absence of proper policy interventions and regulation, corruption and other factors these principles are not realised.

Questions were also raised about the objectives of the NHI. Achieving universal coverage is identified as one of the most important goals. It is argued that universal coverage already exists in the South African health system, with the only barrier being the poor performance of the public health system. Universal coverage can be achieved through different mechanisms, NHI is only one such mechanism and it has not been sufficiently established that the transition to such a system would be more beneficial than merely addressing the problems

faced by the public sector and effectively regulating the private sector. No evidence-based research is presented to support the contention that the NHI will achieve the objectives or that it is the most effective mechanism to do so. The concept of universal coverage is also often conflated with NHI, which is only a mechanism with which one would potentially achieve universal coverage. The Green Paper does not provide any evidence to indicate that the NHI is the most effective mechanism to achieve this goal or how it compares to other possible mechanisms. If South Africa is to invest in health, there should be concrete evidence that the proposed investment will be the most effective option. A complete reform of the health system will be costly and may or may not be effective. It should be considered whether the same outcomes could potentially be achieved, more economically, by improving and investing in the existing system.

One of the major proposals of the NHI is the re-engineering of the Primary Health Care System. A proper functioning system is much needed and has been part of the Department of Health's policy for some time. The inability to get primary health care and the district health system to function properly has contributed significantly to the failure of the health system. District clinical support teams will also be established in order to address high levels of maternal and child mortality and to improve health outcomes. District clinical support teams will include obstetricians and gynaecologists, paediatricians, family physicians, anaesthetists, midwives and primary health care professional nurses. This intervention aims to deliver specialist health care services closer to the patients' home and improve the quality of services rendered at the first level of care by ensuring adherence to treatment guidelines and protocols. Providing specialist support at this level may improve the quality of care and is supported, but a lack of human resources is a concern in this regard.

Very little detail is provided on the benefit package that will be offered under the NHI or how it will be provided. Public hospitals have now been divided into five categories and must be managed in accordance with the newly released national policy. The national policy on the management of hospitals hopes to ensure that skilled and competent managers are appointed who will be trained in leadership, management and governance, that management is decentralised and that accountability frameworks are developed. Many of the problems experienced in the public system are as a result of a lack of proper management and this is a positive development. However, these changes are not dependent on the introduction of the NHI.

The Green Paper contains little concrete information on how quality will be upheld or how liability will be managed in terms of the NHI. From the scarce information available it seems that the government will rely on massive investment in health infrastructure, quality improvement plans and the establishment of the Office of Health Standards Compliance to ensure that quality healthcare services will be provided under the NHI. The public health system is in a desperate state. Improving the quality and standard of care is of critical importance, an enormous and difficult task lies ahead for the Office of Health Standards Compliance. The Office was established as a juristic person, with the object of protecting and promoting the health and safety of health care users. To achieve these objectives the Office will monitor and enforce the compliance of norms and standards in health establishments, as prescribed by the Minister of Health. Furthermore, complaints relating to non-compliance will be considered and investigated in a procedurally fair, economical and expeditious manner. The establishment of the Office is welcomed and a much needed step in ensuring that quality care is provided in the health sector. There are however concerns

about the independence thereof. Political interference may prohibit the proper functioning of the Office and will make it impossible for it to live up to its potential or serve its designated purpose. The Office will impact on many stakeholders in the health sector, which further necessitates its impartiality and independence.

The Green Paper proposes that existing provider payment mechanisms and accountability processes should be changed to ensure effective cost-containment and the future sustainability of the NHI. Very little detail is however provided on matters which are inherently complex and immensely important to the proper functioning of the health system.

The proposed healthcare coding system was also discussed in the chapter. A healthcare coding system is an integral part of any health information system. They are however, very complex to develop and would need to be specifically adapted for the South African context. The existence of some sort of coding system would be a pre-requisite to many of the proposals contained in the NHI submission.

The responsibility of contracting with the NHI to purchase health services will fall upon the District Health Authority, whose contracting unit will be supported by the NHI Fund's sub-national offices in managing contracts with accredited providers. The District Health Authority will have to ensure that services are adequate and accessible for the population in the specified health district. The District Health Authority will also be responsible for monitoring the performance of contracted providers. The reimbursement mechanism will take the performance of contracted providers into account and hopefully health outcomes will improve as a result thereof. Work is apparently underway to develop District Health Authorities. Assessing the costs involved and implications of scaling up are currently an aim of the NHI

pilot districts. It seems that these authorities will function as a management and accountability mechanism in the district health system.

The NHI funding mechanisms are yet to be finalised, but it is apparent that there will be payment in advance and that these funds will then be pooled in order to exercise more control over the purchasing of health services. The Minister of Finance indicated that National Treasury was working with the Department of Health "to examine the funding arrangements and system reforms required for NHI" and that a discussion paper would be made available in 2013. This release has not yet occurred. Any proposed funding mechanism would need to be mindful of the economic realities faced by the country as well as the small, already overburdened tax base. The Green Paper clearly states that NHI membership would be mandatory. This will not mean that medical schemes will cease to exist, but any contribution to a private medical scheme will be voluntary and will require an additional contribution over and above the mandatory contribution already made towards the NHI. Those who choose to continue their medical scheme coverage will also not be eligible for a tax subsidy.

The Green Paper attempts to cost a NHI system that has not yet been adequately defined. There is no indication of what the benefit package will consist of, the profile of persons who will utilise the services or how the system will be administered and governed. National Treasury and the National Department of Health are currently doing more detailed costing work. The NHI pilot districts and other reforms will inform future costing. It may be years before a reliable costing model can be developed. At the moment the Green Paper does not justify the substantial increase in public health expenditure, the public is left in the dark as to which services are changing or why they are changing. This merely comes across as

a budget increase intended to equal medical scheme expenditure. There is however no evidence to suggest that medical scheme members will forego their membership, as the quality of care received in the private sector factors into their decision to spend their disposable income thereon.

The establishment of the NHI Fund was also examined. The Green Paper states that in order to implement the NHI, there will have to be a considerable reconfiguration of all the existing institutions and organisations involved in the funding, pooling, purchasing and provision of health care services in the country. This reconfiguration would see the establishment of a NHI Fund. The NHI Fund will pool resources in order to purchase health services for the entire population from contracted public and private providers. The creation of a single fund that will procure services on behalf of the population raises a number of concerns. Managing a fund of that size will be a huge administrative undertaking and the complexities as well as the consequences of mismanagement should not be underestimated. It is important to note the systemic failures of the public system in this regard. A proper case for such a radical change has not been presented; it needs to be justified by indicating which weaknesses it seeks to address and then convincingly demonstrate that a single fund will be the best option to address those weaknesses.

The need for an integrated and enhanced National Health Information System is emphasised in the Green Paper. South Africa has fragmented systems and a lack of human capacity and experience in health informatics. Many of the systems are still paper based. A number of other challenges have also been identified. The National Department of Health has launched an e-Health strategy to address these problems.

The Green Paper states that the NHI will be phased in over a period of 14 years. It is proposed that changes to the health system be piloted in certain districts in order to evaluate management capacity, the planned service package and the delivery of services through contracted providers. A NHI conditional grant has been allocated to the Department of Health for the development of new systems and capacities in pilot districts and central hospitals. A review presented to parliament, showed that most districts have failed to spend their budgets and that only a third of the primary healthcare facilities were ready to start contracting services from private sector general practitioners.

The migration process will also include the review of existing laws and the preparation of a new Bill to implement the NHI and the NHI fund in South Africa. The long awaited White Paper, which was expected to be released in 2013, is yet to be released.

The introduction of the NHI could have a significant impact on the quality of care patients receive. The little information provided in the Green Paper does not instil confidence that the impact would necessarily be positive. The introduction of the Office of Health Standards Compliance is however a step in the right direction. Again it must be emphasised that the establishment of the Office is not dependent on the introduction of the NHI. There is no evidence to suggest that alternative mechanisms to the proposed NHI were considered or that it would be the most beneficial mechanism to implement. Unfortunately there are too many unanswered questions about the NHI in its current proposed form, not to mention the serious doubts about the financial feasibility thereof.

It is in this context that the medical malpractice system will be considered. It is argued that its objectives should be aligned with that of the health system. The provision of

quality care and the assurance of patient safety should underlie both. The existing malpractice system will thus be analysed accordingly in the following chapter. Escalating costs of claims, especially in the public sector, are a major concern and could have disastrous consequences for the implementation of the NHI, as there are already indications that such a scheme may be unaffordable. Malpractice claims would add to the monetary burden and could potentially cripple such reform. The incidence of adverse events and its effects on patients will be emphasised, as the focus is too often on the financial implications of medical malpractice rather than patient safety.

Chapter Five: Medical Malpractice

Overview

Medical malpractice and its effect on the healthcare system will be evaluated in this chapter. Specifically the role the medical malpractice plays in assuring quality of care and patient safety. Legal liability as it relates to the practitioner will be briefly discussed. In this context the Consumer Protection Act and the effect thereof on medical practice and liability will be considered. Its influence on contracts between patients and healthcare providers will also form part of the discussion. Thereafter the extent of the medical litigation problem in the private as well as the public health sector will be investigated. The consequences of increased medical malpractice litigation will also be discussed. An examination of the possible causes of increased litigation will then be provided. The focus of the chapter will then turn to consider the patients' perspective on medical malpractice and the associated litigation.

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, not to mention our courts.⁸⁸⁰

Not only has there been an increase in the frequency of claims, but the amounts that have been claimed have also risen significantly. In the four years leading up to 2011 the Medical Protection Society (MPS) experienced a 30% increase in the frequency of medical negligence claims reported in South Africa.⁸⁸¹ During the period of 2008-2010 the cost of reported negligence claims rose by 132%.⁸⁸² There are concerns about this development, especially if one considers that the cost of an average claim has virtually doubled every five years.⁸⁸³ 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 in which the neurosurgeon attempted to insert a new ventricular peritoneal shunt. The patient consequently suffered from a number of mobility, speech, memory, visual and cognitive problems. The matter was settled out of court after the Medical Protection Society (MPS) conceded liability and agreed to pay R25 million.⁸⁸⁴

Both the private and public sectors are affected by the considerable increase in litigation. Unfortunately information on the extent of the problem is rather scarce. In June 2013 the Minister of Health, in answering a parliamentary question on the number of claims instituted against the department, declined to give the exact figures. The Minister did however indicate that the escalation of medico-legal claims

⁸⁸⁰ Strauss (1991) 243.

⁸⁸¹ Bown "Counting the cost of litigation" (2012) 20 *Casebook* 9.

⁸⁸² Bateman "Medical negligence pay-outs soar by 132% – subs follow" (2011) 101 *S. Afr. Med. J.* 216.

⁸⁸³ Whitehouse "Counting the costs of GP claims" (2013) 1 *Practice Matters* 8.

⁸⁸⁴ "Brain damage leads to SA's highest-ever medical payout" *Sunday Times* 16 June 2013.

and associated legal costs is a top priority of the Department, in that it poses a serious threat to the survival of both the public and private health systems.⁸⁸⁵ The Minister has previously blamed the high costs of medical litigation on the legal profession, stating that doctors are ‘unmercifully’ being targeted by attorneys.⁸⁸⁶ Stakeholders in the medical fraternity have called for urgent action to be taken to address the issue. They share the view of the Minister that the increase in medical litigation poses a serious threat to the health system as a whole and have suggested that government intervenes by implementing tort reform measures.⁸⁸⁷ A Medico Legal Task Team has been set up by the Minister to investigate the increase in malpractice claims and the causes thereof, in order to make recommendations on policy options.⁸⁸⁸

2. Legal Liability

2.1 Professional Conduct Inquiries

Medical practitioners do not only have to contend with civil claims, they are also held accountable for unprofessional conduct by the Health Professions Council of South Africa (HPCSA).⁸⁸⁹ 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.⁸⁹⁰ This fact is also reflected in the disciplinary powers of

⁸⁸⁵ Parliamentary Question 2013/25A Question Number 627.

⁸⁸⁶ “Motsoaledi wages war against lawyers” Medical Chronicle 10 October 2011.

⁸⁸⁷ “Medical litigation: A national health crisis requiring urgent solutions” Medical Chronicle 7 November 2011.

⁸⁸⁸ Parliamentary Question 2013/25A Question Number 627.

⁸⁸⁹ S 41 Health Professions Act 56 of 1974.

⁸⁹⁰ *Veriava and Others v President, SA Medical and Dental Council, and Others*. Where the court stated that: “The council is thus truly a statutory *custos morum* of the medical profession, the guardian

the professional boards and the penalties that may be imposed by it.⁸⁹¹ If found guilty of improper or disgraceful conduct a registered practitioner will be liable to one or more of the following penalties: a) A caution or a reprimand and a caution; b) suspension for a specified period from practising or performing acts specially pertaining to his or her profession; c) removal of his or her name from the register; d) a prescribed fine⁸⁹²; e) a compulsory period of professional service as may be determined by the professional board; or f) the payment of the costs of the proceedings or a restitution or both. 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 its outcome are used to test the waters for further prospective litigation.

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.⁸⁹³ There are allegations that the Council has been politicised and that management failures have had detrimental consequences.⁸⁹⁴ Practitioners have raised their concerns about the poor service they receive, often having to wait months before they even receive a response from the Council.⁸⁹⁵ Doctors have also voiced their discontent about the patients' rights awareness campaign.⁸⁹⁶ Indicating that they support the patients' right to complain, but have serious trepidations about the possible consequences of such a campaign in the increasingly litigious environment in which they practice.⁸⁹⁷ Patients are also dissatisfied with their

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.”.

⁸⁹¹ S 42(1) Health Professions Act 56 of 1974.

⁸⁹² The maximum fine that may be imposed is R70 000. GN 632 in GG 33385 of 23 July 2010.

⁸⁹³ “Health Professions Council tried to stop exposure of Eastern Cape health crisis” Daily Maverick 5 November 2013.

⁸⁹⁴ Van Niekerk “HPCSA: A mess in the Health Department’s pocket” (2009) 99 *S. Afr. Med. J.* 203. Also see the reply to this editorial comment by the CEO of the HPCSA, Mkhize “HPCSA: A mess in the Health Department's pocket” (2009) 99 *S. Afr. Med. J.* 484.

⁸⁹⁵ “HPCSA and Docs – A relationship on the rocks?” Medical Chronicle 3 September 2012.

⁸⁹⁶ “HPCSA’s ‘Report a Doc’ campaign likely to hike medical costs” Medical Chronicle 7 May 2012.

⁸⁹⁷ *Ibid.*

dealings with the Council.⁸⁹⁸ Many feel that the regulatory body unfairly protects members of the medical profession.⁸⁹⁹ These feelings are exacerbated by the apparent inefficiencies with regard to professional conduct inquiries.⁹⁰⁰ Inquiries often take years to be resolved.⁹⁰¹ This not only affects patients who may have valid complaints, but most certainly the doctors involved as well. Patients want someone to be held responsible in the event of unprofessional conduct and are adversely affected by the delays. As mentioned, the outcome of the inquiry will most likely be a determining factor when it comes to the filing of a civil suit. Practitioners have also felt the impact of the delays, complaining about the time-consuming processes and the stress caused thereby. The Supreme Court of Appeal also addressed the disturbing state of affairs, noting that it reflects badly on the HPCSA and will affect the public confidence in it.⁹⁰²

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

⁸⁹⁸ De Villiers “Protecting the public, the HPCSA or the Profession?” (2000) 22 *South African Family Practice* 2.

⁸⁹⁹ “HPCSA ‘protecting’ hypocritical oafs” Mail & Guardian 2 August 2013; “Health professionals smacked on the wrist” Mail & Guardian 3 January 2014.

⁹⁰⁰ 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. Where the author makes a few proposals, after a detailed analysis of the preliminary investigative system.

⁹⁰¹ *Roux v Health Professions Council of South Africa and Another* at [34].

⁹⁰² *Ibid.*

negligence may underlie both a breach of contract and delict, in which case the conduct will result in liability for both.⁹⁰³ 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.⁹⁰⁴

2.3 The Consumer Protection Act

2.3.1 Introduction

The introduction of the Consumer Protection Act⁹⁰⁵ has also been a significant development in the healthcare context. Patients are regarded as consumers and virtually all dealings between patients and health care providers will qualify as transactions in terms of the Act.⁹⁰⁶ The traditional doctor-patient relationship is likely to be redefined thereby.⁹⁰⁷ The application of the Act is perhaps more suited to commerce and may not be entirely appropriate for the unique healthcare environment.⁹⁰⁸ However, the expansion of patients' rights should be welcomed,

⁹⁰³ Slabbert (2011) 69.

⁹⁰⁴ Strauss (1991) 243.

⁹⁰⁵ Consumer Protection Act 68 of 2008.

⁹⁰⁶ The definitions of "consumer", "service provider", "service", "goods" and "transaction" are all broadly defined in S 1 of the Act.

⁹⁰⁷ Rowe & Moodley "Patients as consumers of health care in South Africa: the ethical and legal implications" (2013) 14 *BMC Medical Ethics* 15. The authors state that viewing patients as consumers may be detrimental to the doctor-patient relationship. The emphasis on patient autonomy may inadvertently lead to the commodification of healthcare, which would result in complex ethical considerations.

⁹⁰⁸ Slabbert *et al* "The application of the Consumer Protection Act in the South African health care context: concerns and recommendations" (2011) 44 *Comparative and International Law Journal of*

especially if one considers the unequal bargaining position patients often find themselves in when dealing with healthcare providers. A potential consequence of this expanded consumer protection, may be an increase in litigation and a constraint of practitioner freedom.

2.3.2 Effect on Medical Practice and Liability

2.3.2.1 Quality Goods and Service

A patient has a right to demand quality service and safe, good quality goods.⁹⁰⁹ The common law remedy for breach of contract is supplemented by the Act, which affirms that the patient has a right to the performance of the services in a manner and quality that persons are generally entitled to expect.⁹¹⁰ Provision is also made for an implied warranty of quality with regard to the supply of goods to the patient.⁹¹¹ Furthermore, liability for damage caused by goods may be incurred irrespective of whether the harm resulted from any negligence on the part of the producer, importer, distributor or retailer.⁹¹² This provision will be particularly useful to patients who suffer damage as result of defective implants, prostheses, pacemakers or unsafe

Southern Africa 202; Van den Heever “Impact of the Consumer Protection Act in the health care context” (2012) *De Rebus* 25.

⁹⁰⁹ S 54 and 55.

⁹¹⁰ S 54(1)(b). If there is a failure to perform a service to the standards contemplated in the Act, the patient may, in accordance with S 54(2), require the healthcare provider to either remedy the defect in the quality of the services performed or goods supplied; or refund him or her a reasonable portion of the price paid for the goods and services. Also see Dinnie “Exposure to the consumer court under the Consumer Protection Act - more litigation for the medical industry?” (2009) 2 *South African Journal of Bioethics and Law* 44 where the author indicates that a patient will likely have to turn to common law remedies if multiple service providers are involved or where the statutory remedy will not be able to adequately compensate all losses suffered by the patient.

⁹¹¹ S 56.

⁹¹² S 61(1). Also see Slabbert & Pepper “The Consumer Protection Act: no-fault liability of health care providers” (2011) 101 *S. Afr. Med. J.* 800.

pharmaceuticals.⁹¹³ Before the Act came into effect a patient who suffered damages as result of a product, would have had to either rely on contractual remedies or institute a delictual claim against the manufacturer.⁹¹⁴ To be successful with the delictual claim, the patient would have needed to prove fault on the part of the manufacturer.⁹¹⁵ The introduction of no-fault liability may open the litigation floodgates, as patients would only need to prove that they suffered harm as a result of the goods being unsafe, defective or hazardous; or that they were not adequately instructed or warned about a hazard which is associated with or arose from the use of the goods.⁹¹⁶ Anyone in the supply chain may be held liable for harm suffered.⁹¹⁷ This means that the health practitioner who administered the treatment may incur strict liability, as he or she would be the most easily identifiable person in the supply chain.⁹¹⁸ The harm for which one could be held liable includes: death or injury, illness, loss or damage to property, and any economic loss resulting from the harm suffered.⁹¹⁹ However, a healthcare provider who supplied the harmful goods can escape liability if it is unreasonable to expect him or her to have discovered the unsafe product characteristic, failure, defect or hazard.⁹²⁰ Seeing that the supplier can rely on this defence, it is unlikely that healthcare providers would experience a surge in litigation. Patients would be wise to rather institute claims against the manufacturer or producer of the harmful goods, to avoid the risk of an adverse cost order should the supplier successfully raise the aforementioned defence.⁹²¹

⁹¹³ Howarth & Davidow "Don't be consumed by new Act" (2010) 18 *Casebook* 13.

⁹¹⁴ Neethling & Potgieter (2010) 335.

⁹¹⁵ *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd* 2003 (4) SA 285 (SCA) 298-300. The court confirmed the fault requirement, stating that if strict liability was to be imposed it would be up to the legislature to do so.

⁹¹⁶ S 61(1)(a)-(c). Also see Slabbert *et al* (2011) 44 *CILSA* 172.

⁹¹⁷ Howarth & Davidow (2010) 18 *Casebook* 12.

⁹¹⁸ Pepper & Slabbert "Is South Africa on the verge of a medical malpractice litigation storm?" (2011) 4 *SAJBL* 32.

⁹¹⁹ S 61(5).

⁹²⁰ S 61(4). A number of other exemptions are included in this section.

⁹²¹ Van den Heever (2012) *De Rebus* 25.

2.3.2.2 Marketing

The Consumer Protection Act will also have an impact on other areas of medical practice. The right to equality in the consumer market is protected by provisions that offer protection against discriminatory marketing.⁹²² In the healthcare context these provisions would ensure that patients do not unfairly receive differential quality care on the basis that they belong to a certain category of persons or that different standards are applied when dealing with patients who belong to a particular benefit option.⁹²³

2.3.2.3 Disclosure

The duty to disclose risks in the healthcare setting is another area of medical practice which is affected by the Act.⁹²⁴ The supplier of any activity or facility that is subject to any: a) risk of an unusual character or nature; b) risk of which a consumer could not reasonably be expected to be aware, or which an ordinarily alert consumer could not reasonably be expected to contemplate, in the circumstances; or c) risk that could result in serious injury or death, must specifically bring that risk to the attention of the patient. Patients need to be warned of the risks, the nature of the risks and the potential effects thereof.⁹²⁵ This form of disclosure differs from the conventional medico-legal one, where a doctor is not required to inform a patient of unusual or remote risks or dangers unless a patient specifically enquires about them or if they are serious and typically found to occur during the proposed intervention.⁹²⁶ Ordinarily a doctor is only obliged to disclose information to a patient where a material risk inherent to the proposed treatment exists. A risk is considered material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would likely attach significance to it; or where the medical

⁹²² S 8-10.

⁹²³ Slabbert *et al* (2011) 44 *CILSA* 176.

⁹²⁴ Slabbert *et al* (2011) 44 *CILSA* 180.

⁹²⁵ S 58(1)

⁹²⁶ Carstens & Pearmain (2007) 885.

practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would likely attach significance to it.⁹²⁷ Section 6 of the National Health Act, which codified the common law duty of disclosure, only requires that health care providers inform patients of the benefits, risks, costs and consequences generally associated with an intervention.⁹²⁸ Patients are to be informed thereof in a language that they understand and in a manner which takes into account their level of literacy.⁹²⁹ The Consumer Protection Act requires in addition that patients be warned of the risks in plain and understandable language in order to allow a patient with average literacy skills and minimal experience as a consumer to understand the warning.⁹³⁰ Healthcare providers are thus burdened with a more demanding standard of disclosure in terms of the consumer orientated statute. Whether this more demanding standard will be adhered to in practice is another matter. Research conducted by Claassen indicates that there is a worrying trend of practitioners not adequately informing their patients with regard to their treatment.⁹³¹ This failure to adequately inform their patients with the consequential absence of informed consent would potentially expose the practitioners to civil or criminal liability.⁹³² It is also interesting to note that the patient's level of literacy and time constraints were the most frequently cited reasons for not providing the required level of disclosure.⁹³³ The problem is exacerbated in the public sector, where patients are often uneducated or unable to understand the practitioner due to a language barrier.⁹³⁴ Coupled with the dramatic time constraints and workloads these practitioners face it

⁹²⁷ *Castell v De Greef* 1994 (4) SA 408 (C) at 426.

⁹²⁸ S 6(1)(c) of the National Health Act 61 of 2003. Also see Carstens & Pearmain (2007) 693.

⁹²⁹ S 6(2).

⁹³⁰ S 49(2) of the Consumer Protection Act 68 of 2008.

⁹³¹ Claassen *Negotiorum Gestio by Geneeskundige Ingrepe* (Unpublished LLD Thesis, 2011 Universiteit van die Vrystaat) 258.

⁹³² Claassen (Unpublished LLD Thesis, 2011 Universiteit van die Vrystaat) 258. The author examines whether legal concept of *negotiorum gestio* could be expanded to the treatment of intellectually challenged patients, which would allow practitioners to treat such patients without first obtaining their informed consent. However, the author concludes that it would require too big of a legal leap to make *negotiorum gestio* applicable to such patients. The defence of legal impossibility would be applicable in such a situation.

⁹³³ Claassen (Unpublished LLD Thesis, 2011 Universiteit van die Vrystaat) 259.

⁹³⁴ *Ibid.*

becomes almost impossible to adequately inform the patients to the standard expected by the law.⁹³⁵ This expected standard of disclosure has now been elevated by the Consumer Protection Act. The healthcare realities in South Africa and the challenges faced, specifically in the public sector, will impact on the practicality of these provisions.

2.3.3 Contracts between Patients and Healthcare Providers

Contracts between healthcare providers and patients are also affected by the Act. The patient has a right to fair, just and reasonable terms and conditions. Healthcare providers must not offer to supply, supply, or enter into an agreement to supply, any goods or services at a price or on terms that are unfair, unreasonable or unjust.⁹³⁶ A patient must also not be required to waive any rights, assume any obligation or waive any liability of the healthcare provider on terms that are unfair, unreasonable or unjust.⁹³⁷ A transaction, agreement, term or condition will be considered to be unfair, unreasonable and unjust if: a) it is excessively one-sided in the favour of the healthcare provider; b) it is adverse to the patient to a point of being inequitable; or c) the patient, to his or her detriment, relied on a false, misleading or deceptive representation or a statement of opinion by the healthcare provider.⁹³⁸

A contract or notice which seeks to limit the risk or liability of a healthcare provider, or constitutes an assumption of risk or liability by the patient, or imposes an obligation on the patient to indemnify the healthcare provider or any other person for any cause must be drawn to the attention of the patient in the prescribed manner.⁹³⁹ In addition, if the contract or notice concerns an activity or facility that is subject to any risk, the patient needs to be made specifically aware of that fact, the nature and

⁹³⁵ *Ibid.*

⁹³⁶ S 48(1)(a).

⁹³⁷ S 48(1)(c). Terms that are unfair, unreasonable or unjust may also not be imposed as a condition of entering into a transaction.

⁹³⁸ S 48(2). Also see Slabbert *et al* (2011) 44 *CILSA* 176.

⁹³⁹ S 49(1). If it is not drawn to the attention of the patient as required by S 49, it would be considered unfair, unreasonable or unjust in terms of S 48(2)(d)(ii).

potential effect of the risk as required by the Act.⁹⁴⁰ The Act requires that the nature and effects of these provisions or notices must be brought to the patient's attention in a conspicuous manner and form that is likely to attract the attention of an ordinarily alert patient, having regard to the circumstances.⁹⁴¹ It must also occur either before the patient enters into the agreement, begins to engage in the activity, enters the facility, or before consideration flowing from the agreement is required, whichever occurs first.⁹⁴² Adequate opportunity must be provided to the patient, under the circumstances, to receive and comprehend the provision or notice, which must be written in plain understandable language.⁹⁴³ Patients are further not allowed to be subjected to contracts that limit or exempt the healthcare provider's liability for loss attributable to the gross negligence of the provider or any person acting for or controlled by the provider.⁹⁴⁴

Hospital admission forms and indemnification clauses are certainly affected by the above provisions.⁹⁴⁵ In terms of the Act contract terms that are unfair, unreasonable or unjust may be set aside by the court.⁹⁴⁶ Furthermore, if certain terms or conditions

⁹⁴⁰ S 49(2). The patient must assent to the provision or notice by signing or initialling the provision, or otherwise acting in a manner consistent with acknowledgement of the notice, awareness of the risk and acceptance of the provision.

⁹⁴¹ S 49(4)(a).

⁹⁴² S 49(4)(b).

⁹⁴³ S 49(5) and (3).

⁹⁴⁴ S 51(1)(c).

⁹⁴⁵ McQuoid-Mason "Hospital exclusion clauses limiting liability for medical malpractice resulting in death or physical or psychological injury: what is the effect of the Consumer Protection Act?" (2012) 5 *SAJBL* 65. The author argues that "as a result of the Act, exclusion clauses that unfairly, unreasonably or unjustly protect hospitals from liability for death or bodily or psychological injury caused by the fault of their staff, may be declared by the courts to be invalid and not binding on consumers. They may also be regarded as unconstitutional". The legal position as stated in *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA) has now been changed by the Act. Also see Carstens & Kok "An assessment of the use of disclaimers by South African hospitals in view of constitutional demands, foreign law and medico-legal considerations" (2003) 18 *SAPL* 430; Naude & Lubbe "Exemption clauses - a rethink occasioned, *Afrox Healthcare Bpk v Strydom*" (2005) 122 *S. Afr. Law J.* 441.

⁹⁴⁶ S 52(3).

are not brought to the patient's attention they may also be severed from the agreement or declared to be without force or effect.⁹⁴⁷

A number of factors are taken into account in assessing whether a contract or provision is unfair, unreasonable or unjust, including: the nature of the parties to that agreement, their relationship to each other and their relative capacity, education, experience, sophistication and bargaining position; whether there was any negotiation between the parties; and the extent to which any documents relating to the agreement satisfied the plain, understandable language requirement.⁹⁴⁸

2.3.4 Remedies

A patient is able to enforce the rights acquired in terms of the Act by referring a complaint to the National Consumer Tribunal, the National Consumer Commission, an alternative dispute resolution agent or a court with jurisdiction if all other available remedies have been exhausted.⁹⁴⁹

3. The Extent of the Medical Litigation Problem

It is near impossible to find any empirical data on medical malpractice in South Africa. The lack of information, in itself poses a problem, the causes and prevalence of medical errors would be much easier to assess and address if the data was readily available. Nonetheless, media and other reports provide a general idea of the current medical malpractice situation.

In 2010 it was reported that nearly 2 000 doctors in both the public and private sectors were facing negligence claims.⁹⁵⁰ Of those claims, 80% stemmed from

⁹⁴⁷ S 52(4).

⁹⁴⁸ S 52(2).

⁹⁴⁹ S 69. Also see Slabbert *et al* (2011) 44 *CILSA* 192.

⁹⁵⁰ "Thousands of doctors 'negligent'" Sunday Times 6 June 2010.

incidents which occurred in the public sector.⁹⁵¹ In the same year, the MPS was assisting 895 members with active negligence claims and had a 1 000 potential claims awaiting assessment.⁹⁵² 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.⁹⁵³ It was reported that almost 70% of all claims are settled out of court.⁹⁵⁴ As previously mentioned, it is clear that both the size and frequency of claims have increased over the last few years.⁹⁵⁵ 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.⁹⁵⁶

The HPCSA has indicated that more than 200 medical practitioners were found guilty in 306 cases of malpractice between 2008 and 2012.⁹⁵⁷ The council issued 283 fines and 137 suspensions to doctors for misconduct during the same period.⁹⁵⁸ Insufficient care and mismanagement of patients roughly doubled, while cases of incompetence also increased in the past year.⁹⁵⁹ According to figures published by the HPCSA, 53 practitioners have been struck from the roll since 2005 due to unprofessional conduct.⁹⁶⁰ The Registrar and Chief Executive Officer of the HPCSA, Dr Mjamba-Matshoba, reportedly said that the increase of medical errors was a big concern and that her office and the health department were investigating the

⁹⁵¹ *Ibid.*

⁹⁵² Correspondence between the Medical Protection Society and their members, regarding membership renewal and subscription rates 2010.

⁹⁵³ *Ibid.*

⁹⁵⁴ "Thousands of doctors 'negligent'" Sunday Times 6 June 2010.

⁹⁵⁵ Bateman (2011) 101 *S. Afr. Med. J.* 216; Bown (2012) 20 *Casebook* 9.

⁹⁵⁶ *Ibid.*

⁹⁵⁷ "248 doctors found guilty of incompetence" Times Live 19 October 2012.

⁹⁵⁸ Health Professions Council of South Africa (2010) Annual Report 2010/2011 27; Health Professions Council of South Africa (2011) Annual Report 2011/2012 33.

⁹⁵⁹ Health Professions Council of South Africa (2011) 34. When compared to the 2010/2011 report, a number of discrepancies in the tables become apparent. This is more than likely due to a typing error in the latest report.

⁹⁶⁰ Health Professions Council of South Africa (2008) Annual Report 2008/2009, read together with the more recent reports.

situation.⁹⁶¹ In March 2012 the HPCSA launched an awareness campaign to educate the public and practitioners on their rights and responsibilities.⁹⁶² This initiative was launched in response to some of the aforementioned developments.⁹⁶³ 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.⁹⁶⁴ These statements have been criticised by the South African Private Practitioners Forum (SAPPF) and the South African Medical Association (SAMA) who have indicated that the awareness campaign would encourage litigation and lead to an increase in the practice of defensive medicine.⁹⁶⁵ The MPS 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.⁹⁶⁶

The systemic challenges faced by the public sector have made it especially vulnerable to malpractice litigation. As a result the respective provincial health departments have had to deal with ever escalating medical malpractice costs. The figures presented below were obtained from the latest available annual reports and media coverage related to the increase in claimed amounts.

Gauteng

The Gauteng health department is facing negligence claims amounting to R1.28 billion for the 2012/2013 financial year.⁹⁶⁷ This is a significant increase from the R665 million and R876 million worth of claims the department faced in the past two

⁹⁶¹ "248 doctors found guilty of incompetence" Times Live 19 October 2012.

⁹⁶² Health Professions Council of South Africa (2012) Media Statement: HPCSA embarks on health and human rights awareness campaign. 19 March 2012.

⁹⁶³ *Ibid.*

⁹⁶⁴ "Patients 'need educating on rights, responsibilities'" Business Day 8 August 2012.

⁹⁶⁵ "HPCSA's 'Report a doc' campaign likely to hike medical costs" Medical Chronicle 7 May 2012.

⁹⁶⁶ Howarth, Bown & Whitehouse "The importance of comprehensive protection in today's healthcare environment" (2013) 103 *S. Afr. Med. J.* 453.

⁹⁶⁷ "Bara facing 86 medical negligence claims – Jack Bloom" Politicsweb 16 January 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 (2012) Annual Report 2012/2013 322. The closing balance of all medico-legal claims up until 31 March 2013 is R2.53 billion.

respective financial years.⁹⁶⁸ There are currently 306 negligence claims in total, of which 155 relate to injuries sustained at birth.⁹⁶⁹ The Chris Hani Baragwanath hospital, by itself, is facing 86 medical malpractice claims equalling roughly R420 million.⁹⁷⁰ These figures are even more troubling when one considers that the department has lost all medical negligence cases in the last three years.⁹⁷¹

KwaZulu-Natal

The KwaZulu-Natal health department is similarly facing negligence related claims exceeding R1.1 billion.⁹⁷² There are currently 515 medical malpractice claims against the department, some of which date back to 2004.⁹⁷³ The department had to spend R376 million on lawsuits in 2008/2009 and R547 million in 2009/2010.⁹⁷⁴

Eastern Cape

The Eastern Cape health department faced claims of R447 million in the 2009/2010 financial year.⁹⁷⁵ The amount increased to R715 million in the 2010/2011 financial year, as the department faced R284 million in additional claims.⁹⁷⁶ Most recent reports indicate that the Eastern Cape health department is currently facing R876 million worth of claims.⁹⁷⁷

⁹⁶⁸ “248 doctors found guilty of incompetence” Times Live 19 October 2012.

⁹⁶⁹ *Ibid.*

⁹⁷⁰ *Ibid.* This amount is the highest for all public hospitals in Gauteng.

⁹⁷¹ “Gauteng DoH faces R3.7bn in legal claims - Jack Bloom” Politicsweb 17 November 2013. 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.

⁹⁷² “KZN health dept sued for R1.1bn” The Times 10 May 2013; KwaZulu-Natal Department of Health (2012) Annual Report 2012/2013 350. The closing balance of all medico-legal claims up until 31 March 2013 is R1.78 billion.

⁹⁷³ “KZN health faces 1 356 legal claims” CityPress 5 September 2013.

⁹⁷⁴ “Botched operations blight SA” The Sunday Independent 2 May 2010.

⁹⁷⁵ Eastern Cape Department of Health (2009) Annual Report 2009/2010 415. The amount encompasses all legal claims against the department and does not indicate the amount of claims specifically related to medico-legal matters.

⁹⁷⁶ Eastern Cape Department of Health (2010) Annual Report 2010/2011. 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 2 September 2011.

⁹⁷⁷ “Hospital horrors costing SA plenty” The Times 17 January 2014.

Limpopo

Reports indicate that the Limpopo health department is dealing with more than 300 malpractice cases, with claims amounting to more than R320 million.⁹⁷⁸

Mpumalanga

In 2010/2011 the Mpumalanga health department spent R21 million on medical negligence claims.⁹⁷⁹ This is up from the R19 million it spent in 2009/2010, and the R666 643 it spent in 2008/2009.⁹⁸⁰ In 2011/2012 the department was facing R160 million worth of claims related to medical negligence and unpaid services.⁹⁸¹

Western Cape

The Western Cape department of health faced R87 million in medico-legal claims in the 2011/2012 financial year.⁹⁸² In 2012/2013 the amount increased to R118 million.⁹⁸³

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 2008/2009.⁹⁸⁴ 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.⁹⁸⁵

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 2010/2011.⁹⁸⁶ However, in November 2013 the department had to pay out R13.3

⁹⁷⁸ "How Limpopo was looted – the inside story" CityPress 14 July 2012.

⁹⁷⁹ "Province pays for negligence" CityPress 17 August 2011.

⁹⁸⁰ "Botched operations blight SA" The Sunday Independent 2 May 2010.

⁹⁸¹ "Province pays for negligence" CityPress 17 August 2011.

⁹⁸² Western Cape Department of Health (2011) Annual Report 2011/2012 342.

⁹⁸³ Western Cape Department of Health (2012) Annual Report 2012/2013 474.

⁹⁸⁴ Free State Department of Health (2008) Annual Report 2008/2009 239.

⁹⁸⁵ Free State Department of Health (2011) Annual Report 2011/2012 168.

⁹⁸⁶ North West Department of Health (2010) Annual Report 2010/2011 145.

million in damages in a single case, after negligent conduct resulted in an infant being blinded.⁹⁸⁷

Northern Cape

In 2005/2006 the Northern Cape health department faced medico-legal claims amounting to R17.7 million.⁹⁸⁸ 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 2007.⁹⁸⁹

4. The Effects of Increased Medical Malpractice Litigation

The figures presented above provide a general idea of the extent of the medical malpractice litigation problem. The available information suggests that the costs involved are immense. This is due to an increase in both the size of malpractice awards and the frequency of claims instituted. The effects of this increase in medical malpractice litigation are already being felt. Although it is clear that doctors and other healthcare providers are directly affected, patients will ultimately have to contend with the indirect consequences caused thereby.⁹⁹⁰

The increase in medical malpractice litigation and the accompanying costs have 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.⁹⁹¹ The specialities with the highest subscription rates are obstetrics, neurosurgery and spinal surgery. Neurosurgeons and spinal surgeons fall in the 'super high risk' category and have an annual

⁹⁸⁷ "Hospital horrors costing SA plenty" The Times 17 January 2014.

⁹⁸⁸ Northern Cape Department of Health (2005) Annual Report 2005/2006 14. This is unfortunately the only information I could obtain from the Northern Cape Department of Health.

⁹⁸⁹ "Botched operations blight SA" The Sunday Independent 2 May 2010.

⁹⁹⁰ Pepper & Slabbert (2011) 4 *SAJBL* 32; Malherbe "Counting the cost: The consequences of increased medical malpractice litigation in South Africa" (2013) 103 *S. Afr. Med. J.* 83.

⁹⁹¹ Bateman (2011) 101 *S. Afr. Med. J.* 216.

subscription rate of R318 190.⁹⁹² Obstetricians have the highest subscription rate and have to pay the MPS an annual subscription rate of R330 000 for indemnity insurance.⁹⁹³ Concerns have been raised about the escalating costs of insurance premiums.⁹⁹⁴ 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 babies.⁹⁹⁵ Not only is it becoming unaffordable to provide indemnity cover, it is becoming unaffordable to purchase indemnity cover.⁹⁹⁶ Obstetricians starting out in private practice will not be able to generate enough income initially to be able to afford the subscription rates.⁹⁹⁷ Whereas, experienced practitioners who perform less deliveries will also not be able to afford the higher premiums and may instead opt to stop practicing obstetrics completely.⁹⁹⁸ 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.⁹⁹⁹

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.¹⁰⁰⁰ 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.¹⁰⁰¹

Medical students and doctors at the start of their careers may even be deterred from practicing in certain specialities due to the costs and potential litigation threat

⁹⁹² MPS (2014) Subscription Rates 1 January – 31 December 2014.

⁹⁹³ *Ibid.* In 2010 the subscription rate was R139 000.

⁹⁹⁴ Coetzee "The spectre of litigation - a dark cloud on the obstetric horizon" (2010) 20 *Obstetrics and Gynaecology Forum* 109.

⁹⁹⁵ "Litigation: a Killer Epidemic with no Cure?" *Medical Chronicle* 6 August 2012.

⁹⁹⁶ Howarth "The threat of litigation: private obstetric care - *quo vadis?*" (2011) 4 *SAJBL* 86.

⁹⁹⁷ Howarth "The rising cost of litigation; a threat to private obstetric care?" (2013) 23 *OBF* 35.

⁹⁹⁸ *Ibid.*

⁹⁹⁹ Howarth (2011) 4 *SAJBL* 86; Howarth, Bown & Whitehouse (2013) 103 *S. Afr. Med. J.* 453.

¹⁰⁰⁰ Malherbe (2013) 103 *S. Afr. Med. J.* 83.

¹⁰⁰¹ *Ibid.*

involved.¹⁰⁰² The South African health system is already facing shortages in specialist care and can ill afford to lose more aspirant specialists.

Patients stand to lose the most.¹⁰⁰³ They are the ones who have to contend with the effects of malpractice and may ultimately, in a cruel twist, end up having to face the 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.¹⁰⁰⁴ However, these increased liability costs are eventually passed on to the patient in the form of more expensive healthcare services.¹⁰⁰⁵ Of course there will be practitioners who will not be able to 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.¹⁰⁰⁶ If the trend continues many obstetricians in

¹⁰⁰² Lambert *et al* "Doctors' reasons for rejecting initial choices of specialties as long-term careers" (2003) 37 *Medical Education* 316; Mello & Kelly "Effects of a professional liability crisis on residents' practice decisions" (2005) 105 *Obstetrics & Gynecology* 1287.

¹⁰⁰³ Seggie "The 'boom' in medical malpractice claims – patients could be the losers" (2013) 103 *S. Afr. Med. J.* 433.

¹⁰⁰⁴ 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.

¹⁰⁰⁵ Strauss "Geneesheer, pasiënt en die reg: 'n delikate driehoek" (1987) 1 *Tydskrif vir die Suid-Afrikaanse Reg* 7; Weiler "The case for no-fault medical liability" (1993) 52 *Maryland Law Review* 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) 4 *Journal 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".

¹⁰⁰⁶ "Litigation: a Killer Epidemic with no Cure?" *Medical Chronicle* 6 August 2012.

private practice may be forced to stop practicing or change specialities.¹⁰⁰⁷ With no one in the private sector to deliver their babies, expectant mothers will have to turn to public facilities.¹⁰⁰⁸ With the public sector already under strain, the consequences could be disastrous.¹⁰⁰⁹ 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.¹⁰¹⁰

Medical malpractice litigation could have a devastating effect on the public health sector, which could be exacerbated by the implementation of a NHI mechanism that does not adequately address the underlying problems of the public health system. 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.¹⁰¹¹ 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, and the burden of disease is immense. There has even been judicial recognition that substandard medical treatment could be expected in the public sector.¹⁰¹²

¹⁰⁰⁷ MacLennan *et al* "Who will deliver our grandchildren?: Implications of cerebral palsy litigation" (2005) 294 *JAMA* 1688; Mello *et al* "Effects of a malpractice crisis on specialist supply and patient access to care" (2005) 242 *Annals of Surgery* 621; Howarth "Obstetric risk avoidance: Will anyone be offering obstetrics in private practice by the end of the decade?" (2013) 103 *S. Afr. Med. J.* 513.

¹⁰⁰⁸ Howarth (2011) 4 *SAJBL* 86.

¹⁰⁰⁹ Howarth (2013) 23 *OBF* 35.

¹⁰¹⁰ Malherbe (2013) 103 *S. Afr. Med. J.* 83.

¹⁰¹¹ Seggie (2013) 103 *S. Afr. Med. J.* 433.

¹⁰¹² *S v Tembani* 2007 (1) SACR 355 (SCA) at 367. Also See Carstens (2008) 23 *SAPL* 173 the author welcomes the concrete judicial recognition of the comprised reality of public health care services in the country, but notes that a principled approach should have been followed in adjudicating the matter.

All these factors compromise the standard of care patients receive in the public sector and could potentially lead to more litigation. Seeing that provincial health departments have fixed annual budgets, these claims and the legal costs associated therewith have a direct impact on their ability to finance healthcare.¹⁰¹³ Money spent on medical malpractice claims, cannot be spent on improving the provincial health system.¹⁰¹⁴ This could lead to a further decline in the quality of care provided, which could inevitably lead to even more malpractice litigation.

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.¹⁰¹⁵ Compassion-centred care is being substituted with defensive medicine.¹⁰¹⁶ Defensive medicine has been described as “a deviation from sound medical practice that is induced primarily by a threat of liability”.¹⁰¹⁷ This threat of liability is avoided by engaging in assurance or avoidance behaviour.¹⁰¹⁸ Assurance behaviour includes the over-ordering of diagnostic tests, unnecessary patient referrals and prescribing more medication than medically indicated.¹⁰¹⁹ Apart from being wasteful and expensive, this behaviour may either reduce or improve quality.¹⁰²⁰ Additional care may have some benefits; however it could also expose patients to other risks.¹⁰²¹ It may also raise the expected legal standard of care.¹⁰²² Avoidance behaviour has a negative effect on patient care, high risk patients and interventions are avoided by doctors either

¹⁰¹³ Coetzee (2010) 20 *OBF* 111; Pepper & Slabbert (2011) 4 *SAJBL* 29.

¹⁰¹⁴ Malherbe (2013) 103 *S. Afr. Med. J.* 84.

¹⁰¹⁵ Whitehouse “Counting the costs of GP claims” (2013) 1 *Practice Matters* 8.

¹⁰¹⁶ Pepper & Slabbert (2011) 4 *SAJBL* 32.

¹⁰¹⁷ Studdert *et al* (2005) 293 *JAMA* 2609.

¹⁰¹⁸ *Id* 2612.

¹⁰¹⁹ *Ibid.*

¹⁰²⁰ *Id* 2616.

¹⁰²¹ *Ibid.*

¹⁰²² *Ibid.*

placing restrictions on their practice or stopping practice altogether.¹⁰²³ This behaviour could reduce access to care.¹⁰²⁴

We are seeing the effects of defensive medicine locally. The MPS study revealed that 86% of practitioners now keep more detailed medical records, which is no doubt a positive development.¹⁰²⁵ 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.¹⁰²⁶ 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.¹⁰²⁷ 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 could be diminished.

The threat of medical malpractice litigation affects practitioners both professionally and personally.¹⁰²⁸ 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.¹⁰²⁹ Some groups of symptoms reported correspond with depressive disorders and stress syndromes.¹⁰³⁰ The emotional well-being of practitioners is especially affected if they were more personally involved with the

¹⁰²³ *Id* 2613.

¹⁰²⁴ *Id* 2617.

¹⁰²⁵ Whitehouse (2013) 1 *Practice Matters* 9.

¹⁰²⁶ *Ibid.* This falls into the assurance behaviour category.

¹⁰²⁷ *Ibid.* This can be classified as avoidance behaviour.

¹⁰²⁸ Charles *et al* (1985) 142 *Am. J. Psych.* 437; Forster, Schwartz & DeRenzo "Reducing legal risk by practicing patient-centered medicine" (2002) 162 *Archives of Internal Medicine* 1217; Aasland & Førde "Impact of feeling responsible for adverse events on doctors' personal and professional lives: the importance of being open to criticism from colleagues" (2005) 14 *Quality & Safety in Healthcare* 11.

¹⁰²⁹ Charles *et al* (1985) 142 *Am. J. Psych.* 438.

¹⁰³⁰ *Id* 439.

patient prior to the malpractice claim.¹⁰³¹ It is common for practitioners to feel personally attacked in the event of litigation.¹⁰³² Especially, if they feel that they have performed in the patient's best interest and in accordance with the medically indicated standard of care.¹⁰³³ Many practitioners may consider early retirement and discourage others from entering medicine, which may impact on the availability of healthcare.¹⁰³⁴

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.¹⁰³⁵ However, if errors and adverse events are not reported, nothing can be done to prevent their reoccurrence.¹⁰³⁶ 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.¹⁰³⁷ The absence of adequate communication could lead to and reinforce a decision to litigate.¹⁰³⁸ 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

¹⁰³¹ Shapiro *et al* "A survey of sued and nonsued physicians and suing patients" (1989) 149 *Arch. Intern. Med.* 2190.

¹⁰³² Bark *et al* "Impact of litigation on senior clinicians: implications for risk management" (1997) 6 *Quality in Healthcare* 9.

¹⁰³³ Merenstein "Winners and losers" (2004) 291 *JAMA* 16.

¹⁰³⁴ Charles *et al* (1985) 142 *Am. J. Psych.* 440.

¹⁰³⁵ Gallagher *et al* "Patients' and physicians' attitudes regarding the disclosure of medical errors" (2003) 289 *JAMA* 1001.

¹⁰³⁶ Kohn, Corrigan & Donaldson eds. (2000) *To Err Is Human: Building a Safer Health System* 86.

¹⁰³⁷ Kachalia *et al* "Liability claims and costs before and after implementation of a medical error disclosure program" (2010) 153 *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.

¹⁰³⁸ Beckman *et al* "The doctor-patient relationship and malpractice: lessons from plaintiff depositions" (1994) 154 *Arch. Intern. Med.* 1368.

claims.¹⁰³⁹ 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.¹⁰⁴⁰ 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.¹⁰⁴¹ 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.¹⁰⁴²

5. Causes of Increases in Malpractice Litigation

A number of factors have possibly contributed to the increased malpractice litigation and associated costs. These contributing factors will be arranged into four categories for the purposes of this discussion, namely: the legal profession, the medical profession, increased patient awareness and the healthcare system.

5.1 The 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.¹⁰⁴³ It is likely that many members of the medical

¹⁰³⁹ Levinson *et al* "Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons" (1997) 277 *JAMA* 557.

¹⁰⁴⁰ Levinson *et al* (1997) 277 *JAMA* 557.

¹⁰⁴¹ Vincent, Phillips & Young "Why do people sue doctors? A study of patients and relatives taking legal action" (1994) 343 *Lancet* 1609; Kraman & Hamm "Risk management: extreme honesty may be the best policy" (1999) 131 *Ann. Intern. Med.* 963; Vincent (2003) 348 *N. Engl. J. Med.* 1051.

¹⁰⁴² Kohn, Corrigan & Donaldson eds. (2000) 5, 43, 49.

¹⁰⁴³ "Motsoaledi wages war against lawyers" *Medical Chronicle* 10 October 2011.

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. Nonetheless, if there was no negligence there would be no need for malpractice litigation. The threat of an adverse order of costs also serves to deter meritless claims.¹⁰⁴⁴ 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.¹⁰⁴⁵ Others have indicated that amendments to the Road Accident Fund (RAF) legislation may have driven attorneys to other types of personal injury litigation, such as medical malpractice, since it may be more financially lucrative than RAF claims.¹⁰⁴⁶ The Contingency Fees Act has opened up the possibility of litigation to patients who could previously not have afforded to institute claims.¹⁰⁴⁷ 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.¹⁰⁴⁸ The incentive to inflate claims has no doubt fostered the often justified perception that lawyers are selfish and greedy.¹⁰⁴⁹ The

¹⁰⁴⁴ Strauss (1991) 245. The author describes the threat of an adverse order of costs as the "most powerful deterrent" against litigation in South Africa.

¹⁰⁴⁵ Pepper & Slabbert (2011) 4 *SAJBL* 30.

¹⁰⁴⁶ Road Accident Fund Amendment Act 19 of 2005; *Law Society of South Africa and Others v Minister for Transport and Another* 2011 (1) SA 400 (CC); Malherbe (2013) 103 *S. Afr. Med. J.* 83.

¹⁰⁴⁷ Contingency Fees Act 66 of 1997.

¹⁰⁴⁸ Coetzee (2010) 20 *OBF* 109; Howarth (2011) 4 *SAJBL* 85.

¹⁰⁴⁹ Howarth (2013) 23 *OBF* 33; "Health MEC attacks lawyers" *The Mercury* 7 February 2014.

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 pecuniary interest in the litigation when contingency fee agreements are concluded”.¹⁰⁵⁰

5.2 The Medical Profession

According to comments made by the acting CEO of the HPCSA in 2012 the increase in claims may be due to a decline in professionalism and the standard of care of practitioners.¹⁰⁵¹ The HPCSA has also raised concerns about the increase in the number of complaints they have received.¹⁰⁵² Practitioners have criticised these views and have blamed the increase in litigation on other factors. However, the fact remains, if there was no negligence there would not have been any claims awarded.¹⁰⁵³ Lapses in judgement do occur and even the most vigilant practitioners make mistakes.¹⁰⁵⁴ The focus should perhaps rather be on putting systems in place to avoid preventable mistakes.¹⁰⁵⁵ 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

¹⁰⁵⁰ *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 at [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 not lawful.

¹⁰⁵¹ “Patients 'need educating on rights, responsibilities'” Business Day 8 August 2012.

¹⁰⁵² “HPCSA responds to campaign criticism” Medical Chronicle 4 June 2012.

¹⁰⁵³ Coetzee (2010) 20 *OBf* 111.

¹⁰⁵⁴ Ncayiyana “Compensation for injury from medical treatment is a social justice obligation” (2004) 94 *S. Afr. Med. J.* 304; Gallagher, Studdert & Levinson “Disclosing harmful medical errors to patients” (2007) 356 *N. Engl. J. Med.* 2713.

¹⁰⁵⁵ Reason “Human error: models and management” (2000) 320 *BMJ* 768.

emphasis on education and the enforcement of practice guidelines.¹⁰⁵⁶ Improving the detection of negligent behaviour and instituting appropriate corrective or disciplinary processes would also be constructive.¹⁰⁵⁷

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.¹⁰⁵⁸ Instead it seems that patients' dissatisfaction may be critical.¹⁰⁵⁹ A perceived lack of caring and a breakdown in communication often precedes the decision to litigate.¹⁰⁶⁰ 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.¹⁰⁶¹ Practitioners would thus be wise to adjust their behaviour accordingly. Patients need to comprehend the potential risks involved with their treatment, so that they do not harbour unrealistic expectations. As mentioned before, informed consent is crucial in this regard. It must however, be real informed consent, not those standardised forms which patients are required to sign or a brief technical explanation before the start of treatment. 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 severely affected by such an unfortunate outcome.¹⁰⁶²

5.3 Increased Patient Awareness

¹⁰⁵⁶ Leape *et al* "The nature of adverse events in hospitalized patients: results of the Harvard Medical Practice Study II" (1991) 324 *N. Engl. J. Med.* 383.

¹⁰⁵⁷ Leape *et al* (1991) 324 *N. Engl. J. Med.* 383.

¹⁰⁵⁸ Entman *et al* "The relationship between malpractice claims history and subsequent obstetric care" (1994) 272 *JAMA* 1588.

¹⁰⁵⁹ Levinson *et al* (1997) 277 *JAMA* 553.

¹⁰⁶⁰ Beckman *et al* (1994) 154 *Arch. Intern. Med.* 1365; Hickson *et al* "Patient complaints and malpractice risk" (2002) 287 *JAMA* 2951.

¹⁰⁶¹ Hickson *et al* "Factors that prompted families to file medical malpractice claims following perinatal injuries" (1992) 267 *JAMA* 1359.

¹⁰⁶² Vincent, Phillips & Young (1994) 343 *Lancet* 1609; Vincent (2003) 348 *N. Engl. J. Med.* 1054.

Stakeholders in the medical profession have indicated that the reason for the increasing complaints and litigation is not a decline in standards and care, but rather due to the fact that patients are more aware of their rights.¹⁰⁶³ This is a development that should be welcomed, as patients who have legitimate claims must be compensated.¹⁰⁶⁴ A number of factors may have contributed to improved patient awareness. As mentioned, lawyers may be targeting injured patients by utilising the media more deliberately than before. The HPCSA has also recently launched a patients' rights awareness campaign.¹⁰⁶⁵ Furthermore, the commercialisation of healthcare and the resultant change in the traditional doctor-patient relationship may also be a factor. The Consumer Protection Act broadened the scope of liability in this regard.

5.4 The Healthcare System

Many adverse events can be attributed to systemic factors, rather than purely individual negligence.¹⁰⁶⁶ Errors often occur despite the best intentions and behaviour of the medical personnel involved.¹⁰⁶⁷ The environment in which these practitioners often find themselves and the medical realities they have to contend with need to be considered.¹⁰⁶⁸

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. These weaknesses have been discussed above and include: poor management and maladministration, human and other

¹⁰⁶³ "HPCSA's 'Report a doc' campaign likely to hike medical costs" Medical Chronicle 7 May 2012.

¹⁰⁶⁴ Ncayiyana (2004) 94 S. Afr. Med. J. 303.

¹⁰⁶⁵ Health Professions Council of South Africa (2012) Media Statement: HPCSA embarks on health and human rights awareness campaign. 19 March 2012.

¹⁰⁶⁶ Kohn, Corrigan & Donaldson eds. (2000) 49.

¹⁰⁶⁷ Reason (2000) 320 *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 (1997) *Managing the Risks of Organizational Accidents*.

¹⁰⁶⁸ Carstens & Pearmain (2007) 638.

resource constraints, failing infrastructure and shortages in equipment and the proper maintenance thereof. 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 however, 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.¹⁰⁶⁹ These administrators are the ones who 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.¹⁰⁷⁰

Adverse events occur and it may be more emotionally satisfying to blame individuals rather than institutions or organisations.¹⁰⁷¹ The “person approach” focuses on the unsafe acts of the practitioners and medical personnel who provide healthcare 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.¹⁰⁷² Human behaviour is thus the main focus and error management resources are directed at making individuals less fallible.¹⁰⁷³ This person approach may be inappropriate for 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.¹⁰⁷⁴ Errors are managed, not by targeting the individual, but

¹⁰⁶⁹ Vincent “Research into medical accidents: a case of negligence?” (1989) 299 *BMJ* 1152.

¹⁰⁷⁰ McQuoid-Mason “Establishing liability for harm caused to patients in a resource-deficient environment” (2010) 100 *S. Afr. Med. 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) 124 *S. Afr. Law J.* 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 (2000) *The Legal Liability of Hospitals*.

¹⁰⁷¹ Reason (2000) 320 *BMJ* 768.

¹⁰⁷² *Ibid.*

¹⁰⁷³ *Id* 769.

¹⁰⁷⁴ *Id* 768.

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.¹⁰⁷⁵ 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.¹⁰⁷⁶

6. The Patients' Perspective

Increases in medical malpractice claims and litigation affect a number of different stakeholders. The debates around interventions and reforms often revolve around the financial implications thereof. Those in the medical profession raise concerns about escalating insurance premiums and the concomitant consequences. Many indicate that they have had to change the way in which they practice medicine, by ordering more diagnostic tests or avoiding certain procedures. Some practitioners have even indicated that they might consider leaving certain high risk specialities altogether. Inevitably, reforms which seek to limit the number and cost of malpractice claims are proposed by health care providers and their insurers. Typically these proposed reforms include, amongst others, the capping of noneconomic damages and shortening statutes of limitation and repose.¹⁰⁷⁷ These reforms would merely alter certain aspects of the liability and compensation system, fundamentally it would remain unchanged. There are however, concerns about the effectiveness of the existing system. Some reform advocates have suggested a need for more fundamental changes and have proposed a number of alternative measures to deal with malpractice liability and compensation. Several of these proposals have again been met with fierce opposition from the legal profession, who may oppose changes to the existing system for philosophical reasons, or perhaps more likely, due to the

¹⁰⁷⁵ *Id* 769.

¹⁰⁷⁶ Leape *et al* (1991) 324 *N. Engl. J. Med.* 383.

¹⁰⁷⁷ Barringer *et al* "Administrative compensation of medical injuries: a hardy perennial blooms again" (2008) 33 *Journal of Health Politics, Policy and Law* 726.

financial implications thereof. Some proposed changes would fundamentally transform the existing system, reducing litigation and subsequently the income generated thereby.

This is of course a very complex issue. It is submitted that discussions surrounding the matter should have a strong patient-orientated focus. As patients are the ones who are the most severely affected by malpractice, their interests should be decisive. It is thus of the utmost importance to consider their perspective.

Patients are often in a vulnerable psychological state when they are diagnosed and have to undergo treatment.¹⁰⁷⁸ When faced with certain illnesses, severe anxiety or post-traumatic symptoms may be elicited.¹⁰⁷⁹ Emotional distress may even be present where the diagnosis is clear and treatment has the intended outcome.¹⁰⁸⁰ Therefore, when all does not go according to plan, the impact is likely to be particularly distressing.¹⁰⁸¹ Patients suffer injuries which may have long-term effects on their work, social life and family relationships.¹⁰⁸² The immense trauma experienced as a result of the original injury may be aggravated by the manner in which the incident is subsequently handled.¹⁰⁸³ Practitioners giving inadequate and evasive explanations of the error may upset them even further.¹⁰⁸⁴ Vincent indicates that a patient's initial reaction to a medical injury will most likely consist of fear, loss of trust and a feeling of isolation.¹⁰⁸⁵ Not only will the patient have to live with the physical effects of the injury, which may include permanent impairment, the subsequent psychological effects could be just as, if not more traumatic.¹⁰⁸⁶ The devastating consequences of an injury often only become apparent in the long-term. Additional surgeries and hospitalisation will likely be required in most serious cases.

¹⁰⁷⁸ See Carstens & Pearmain (2007) 489 where the vulnerability of the patient as a consumer of healthcare goods and services is discussed.

¹⁰⁷⁹ Tedstone & Tarrier "Posttraumatic stress disorder following medical illness and treatment" (2003) 23 *Clinical Psychology Review* 409.

¹⁰⁸⁰ Vincent (2003) 348 *N. Engl. J. Med.* 1054.

¹⁰⁸¹ Gallagher *et al* (2003) 289 *JAMA* 1005.

¹⁰⁸² Vincent, Phillips & Young (1994) 343 *Lancet* 1609.

¹⁰⁸³ Vincent (2003) 348 *N. Engl. J. Med.* 1054.

¹⁰⁸⁴ Gallagher *et al* (2003) 289 *JAMA* 1005.

¹⁰⁸⁵ Vincent (2003) 348 *N. Engl. J. Med.* 1054.

¹⁰⁸⁶ *Ibid.*

The patient may also have to live with chronic pain, disfigurement, disability and depression, which could severely affect his or her quality of life and relationships.¹⁰⁸⁷

The injured individual is not the only one who may be severely affected by a medical error. Family and friends of the patient would also likely suffer.¹⁰⁸⁸ Such an adverse event could be emotionally and financially devastating to people close to the patient. Not to mention the immense trauma and lasting sorrow they may face in the case of the patient's untimely death.¹⁰⁸⁹

The devastating consequences of medical malpractice are disconcerting, even more so when one considers the incidence of adverse events. A number of different countries have conducted studies into iatrogenic harm.¹⁰⁹⁰ They have found incidence rates of between 2.9% and 16.6%, depending on the methodology applied. Almost all of the studies also indicated that the majority of the adverse events were preventable. The landmark Harvard Medical Practice Study revealed that adverse

¹⁰⁸⁷ *Ibid.*

¹⁰⁸⁸ *Ibid.*

¹⁰⁸⁹ Vincent & Coulter "Patient safety: what about the patient?" (2002) 11 *Qual. Saf. Health Care* 78.

¹⁰⁹⁰ Brennan *et al* "Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I" (1991) 324 *N. Engl. J. Med.* 370; Thomas *et al* "Incidence and types of adverse events and negligent care in Utah and Colorado" (2000) 38 *Medical Care* 261; Wilson *et al* "The quality in Australian health care study" (1995) 163 *The Medical Journal of Australia* 458; Davis *et al* "Adverse events in New Zealand public hospitals I: occurrence and impact" (2001) 114 *The New Zealand Medical Journal* 203; Vincent, Neale & Woloshynowych (2001) 322 *BMJ* 517; Baker *et al* "The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada" (2004) 170 *Canadian Medical Association Journal* 1678; Schiøler *et al* "Incidence of adverse events in hospitals. A retrospective study of medical records" (2001) 163 *Ugeskr Laeger* 5370; Michel *et al* "French national survey of inpatient adverse events prospectively assessed with ward staff" (2007) 16 *Qual. Saf. Health Care* 369; Aranaz-Andrés *et al* "Incidence of adverse events related to health care in Spain: results of the Spanish National Study of Adverse Events" (2008) 62 *Journal of Epidemiology and Community Health* 1022; Zegers *et al* "Adverse events and potentially preventable deaths in Dutch hospitals: results of a retrospective patient record review study" (2009) 18 *Qual. Saf. Health Care* 297; Mendez *et al* "The assessment of adverse events in hospitals in Brazil" (2009) 21 *International Journal for Quality in Health Care* 279; Letaief *et al* "Adverse events in a Tunisian hospital: results of a retrospective cohort study" (2010) 22 *International Journal for Quality in Health Care* 380; Aranaz-Andrés *et al* "Prevalence of adverse events in the hospitals of five Latin American countries: results of the 'Iberoamerican study of adverse events' (IBEAS)" (2011) 20 *Qual. Saf. Health Care* 1043.

events occurred in 3.7% of hospitalisations and that 27.6% of the adverse events were due to negligence.¹⁰⁹¹ Employing similar methods to the Harvard study, researchers found comparable rates of negligence in Utah and Colorado.¹⁰⁹² Also of concern is the fact that 2.6% of adverse events caused permanent disabling injuries and 13.6% resulted in the death of the patient.¹⁰⁹³ Medical management is thus responsible for a significant amount of injuries and several can be attributed to substandard care.¹⁰⁹⁴ The study also emphasised that most adverse events are avoidable and that errors in medical practice are common.¹⁰⁹⁵ More than half of the adverse events were caused by management errors.¹⁰⁹⁶ Adverse events did occur more frequently in certain specialities. However, this was mainly due to the nature of the medical interventions and the risks associated with those specialities.¹⁰⁹⁷ Accordingly, thoracic surgery, obstetrics and neurosurgery did account for more adverse events, but the events were not more likely to have been caused by negligence.¹⁰⁹⁸

The relation between malpractice claims and adverse events due to negligence is one of the most alarming findings of the study.¹⁰⁹⁹ The medical records were matched with data on medical malpractice claims in order to identify patients who had filed claims against practitioners and hospitals.¹¹⁰⁰ It was found that 98% of all adverse events due to negligence in the study did not result in malpractice claims.¹¹⁰¹ The negligence to claims ratio was found to be 7.6 to 1.¹¹⁰² This means that claims occur only 13% as often as injuries due to malpractice.¹¹⁰³ Of those

¹⁰⁹¹ Brennan *et al* (1991) 324 *N. Engl. J. Med.* 371.

¹⁰⁹² Thomas *et al* (2000) 38 *Med. Care* 265.

¹⁰⁹³ Brennan *et al* (1991) 324 *N. Engl. J. Med.* 371.

¹⁰⁹⁴ *Id* 373.

¹⁰⁹⁵ Leape *et al* (1991) 342 *N. Engl. J. Med.* 380.

¹⁰⁹⁶ *Id* 381.

¹⁰⁹⁷ *Id* 383.

¹⁰⁹⁸ *Ibid.*

¹⁰⁹⁹ Localio *et al* "Relation between malpractice claims and adverse events due to negligence: results of the Harvard Medical Practice Study III" (1991) 325 *N. Engl. J. Med.* 245.

¹¹⁰⁰ Localio *et al* (1991) 325 *N. Engl. J. Med.* 245.

¹¹⁰¹ *Id* 247.

¹¹⁰² *Id* 248.

¹¹⁰³ *Ibid.*

patients who do file claims, perhaps half will receive compensation.¹¹⁰⁴ The results of the study suggest that patients who have suffered injuries due to negligence are rarely compensated and that healthcare providers are hardly ever identified and held accountable for substandard medical care.¹¹⁰⁵ The poor correlation between medical negligence and malpractice claims was also present in the Utah and Colorado study.¹¹⁰⁶ Only 3% of patients who suffered injuries due to negligence instituted claims.¹¹⁰⁷ These studies have cast doubt on the malpractice system's ability to deter substandard medical practice and compensate negligently injured patients.¹¹⁰⁸

There are almost no published studies on the incidence of adverse events from developing countries. All studies into adverse events have thus far been conducted by developed nations. However, in 2006, a research project was launched by the WHO World Alliance for Patient Safety in conjunction with the Ministries of Health of Egypt, Jordan, Kenya, Morocco, Tunisia, South Africa, Sudan and Yemen to ascertain the frequency, causes, and preventability of adverse events in hospitalised patients in the participating countries.¹¹⁰⁹ A retrospective review of randomly selected medical records from 26 hospitals was undertaken.¹¹¹⁰ The hospitals that formed part of the study were large teaching and urban hospitals, two to six hospitals per country, and consisted of: 23 general public hospitals (that included 13 teaching hospitals), one obstetric hospital, one paediatric hospital and one private hospital.¹¹¹¹ Many of the participating hospitals were considered to be amongst the best providers of healthcare in their respective countries, which serves to emphasise the results and the need for a renewed focus on patient safety.¹¹¹² The results indicated that at least one adverse event occurred in 8.2% of cases, a rate which varied from 2.5% to 18.4% between countries.¹¹¹³ The authors indicate that this is probably an

¹¹⁰⁴ *Id* 249.

¹¹⁰⁵ *Id* 250.

¹¹⁰⁶ Studdert *et al* (2000) 38 *Med. Care* 250.

¹¹⁰⁷ *Id* 255.

¹¹⁰⁸ *Ibid.*

¹¹⁰⁹ Wilson *et al* (2012) 344 *BMJ*.

¹¹¹⁰ *Ibid.*

¹¹¹¹ *Ibid.*

¹¹¹² *Ibid.*

¹¹¹³ *Ibid.*

underestimate of the true rate and that the underestimate might be quite large.¹¹¹⁴ The finding that 83% of adverse events were highly preventable is significantly higher than previous studies, which estimated that around half were preventable.¹¹¹⁵ A further finding which is rather concerning, is the fact that 30% of adverse events were associated with the death of the patient, compared to 4% to 15% reported in other studies.¹¹¹⁶ This accounts for nearly 2% of all hospitalised patients in the eight participating countries.¹¹¹⁷ Adverse events also led to 14% of patients sustaining permanent disability.¹¹¹⁸ Adverse events caused by therapeutic error were found to be the most common, followed by diagnostic error and operative errors.¹¹¹⁹ Reviewers identified a number of factors, which they believed contributed toward the adverse events. Inadequate training or supervision of clinical staff was identified as the largest contributor, followed by the absence of or failure to implement a relevant protocol or policy.¹¹²⁰ The nature of the study with its review of medical records may have placed a focus on individual performance and therefore reviewers were less likely to identify systemic failures as contributing factors.¹¹²¹ These systemic factors often predispose individuals to error and may be particularly prevalent in countries with scarce resources and weak infrastructure.¹¹²²

The burden of iatrogenic injury is large. Developing countries, such as South Africa, may suffer more adverse events due to systemic factors. Adverse events associated with management errors cause distress, disability, permanent impairment, and death. Many preventable mistakes lengthen hospital stay and result in an increased consumption of health resources. A significant number of patients are injured, many due to the negligent conduct of practitioners and medical personnel, yet there is evidence to suggest that only a fraction of these patients institute claims.

¹¹¹⁴ *Ibid.*

¹¹¹⁵ *Ibid.*

¹¹¹⁶ *Ibid.*

¹¹¹⁷ *Ibid.*

¹¹¹⁸ *Ibid.*

¹¹¹⁹ *Ibid.*

¹¹²⁰ *Ibid.*

¹¹²¹ *Ibid.*

¹¹²² *Ibid.*

The studies conducted in other countries have raised a number of questions. Why do so few injured patients institute claims, why are fewer still compensated, what are the effects of these injuries on the healthcare system, and what can be done to address the problem? It is very likely that South Africa faces many of the same issues identified by these other countries. It could be that those patients, who lodge malpractice claims locally, represent only a small fraction of patients who were actually injured by negligent treatment and that fewer still will receive compensation. Patients, who go uncompensated, will however still have to live with and bear the physical, psychological and financial burden of those injuries. Research into the prevalence of adverse events, negligence and malpractice in South Africa is necessary. We currently do not even have enough evidence on malpractice to frame the questions raised by other countries and thus proposals for reform, which seek to present answers are particularly premature.

Injured patients who do eventually decide to file claims face a number of challenges. Litigation is a costly endeavour and medical malpractice cases often take years to be resolved. The patients, who are able to afford litigation, frequently find it very difficult to prove negligence on the part of the practitioners or hospital personnel involved. A number of factors may contribute to the difficulty of the undertaking. In civil cases the onus of proof lies with the patient. To succeed with a claim, liability needs to be established on a preponderance of probabilities.¹¹²³ The inherent nature of medicine and the fact that tragic outcomes are often inevitable complicates matters. Practitioners cannot guarantee that treatment will be successful and consequently cannot be held accountable for every adverse event or failed intervention.¹¹²⁴ The mere fact that an injury occurred does not enable one to conclude that it was necessarily due to substandard care.¹¹²⁵ *Van Wyk v Lewis*¹¹²⁶ has also functioned as a “protective shield” for practitioners in this regard.¹¹²⁷ Our law has assumed a rather sheltering attitude towards the medical profession, which is nowhere more apparent

¹¹²³ Claassen & Verschoor (1991) 26.

¹¹²⁴ Giesen (1988) *International Malpractice Law: A Comparative Study of Civil Liability Arising from Medical Care* 512.

¹¹²⁵ Giesen (1988) 512.

¹¹²⁶ 1924 AD 438.

¹¹²⁷ Strauss (1991) 244.

than in the *Van Wyk* judgement.¹¹²⁸ The Appeal Court effectively held that the doctrine of *res ipsa loquitur* does not apply to medical situations.¹¹²⁹ The maxim thus cannot be invoked to aid the claimant plaintiff in proving his or her case. There can be no inference of negligence, except where the “negligence alleged depends on absolutes”.¹¹³⁰ This position has been widely discussed and it has been argued that the maxim should be applied in specific circumstances in the medical negligence context, especially if regard is had to principles of procedural equality and certain constitutional considerations.¹¹³¹ The maxim has again recently come up for judicial consideration, with two differing outcomes. The court in *Ntsele* considered the case to be of an exceptional nature, thus finding that the invocation of the maxim was legally justified if regard is had to section 27 of the Constitution.¹¹³² In a much more conservative judgement the court in *Goliath* indicated that it was bound by the principles set out in *Van Wyk*, and that the maxim could therefore not be applied.¹¹³³ Lowe J also stated that the contrary finding in *Ntsele* was incorrect.¹¹³⁴ Nevertheless, the court did remark that much can be said for revisiting the applicability of the *res ipsa loquitur* maxim in the medical negligence context.¹¹³⁵

Medical treatment and interventions have become exceptionally sophisticated. Consequently, establishing that harm was caused due to substandard negligent care can be particularly complicated. This represents another obstacle that patients would need to overcome if they are to prove their case. Expert medical evidence is

¹¹²⁸ *Ibid.*

¹¹²⁹ *Id* 245.

¹¹³⁰ *Pringle v Administrator, Transvaal.*

¹¹³¹ Van den Heever *The Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Actions: A Comparative Survey* (Unpublished LLD Thesis, 2002 University of Pretoria); Van den Heever & Carstens (2011) *Res Ipsa Loquitur & Medical Negligence: A Comparative Survey* 145.

¹¹³² *Ntsele v Mec for Health, Gauteng Provincial Government* [2013] 2 All SA 356 (GSJ) at [122]-[126]. Also see Carstens “Judicial recognition of the application of the maxim *res ipsa loquitur* to a case of medical negligence *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (unreported as yet, Case Number: 2009/52394 (GSJ) dated 24 October 2012)” (2013) 34 *Obiter* 548 for a discussion of the judgement.

¹¹³³ *Goliath v MEC for Health in the Province of Eastern Cape* (1084/2012) [2013] ZAECGHC 72 (14 June 2013) at [81].

¹¹³⁴ *Id* at [121]

¹¹³⁵ *Id* at [82].

generally presented in support of a claim and plays a pivotal role.¹¹³⁶ This may pose a number of further problems. Expert witnesses may be reluctant to testify due to the inconvenience it would entail.¹¹³⁷ Preparations and the trial itself are time consuming and would likely be financially detrimental to the practitioner. A practitioner called to testify would need to examine the patient, compile reports, consult with attorneys and study the pertinent literature on the aspects which may arise during the case.¹¹³⁸ The time a practitioner would need to devote to testimony during the actual trial proceedings may be more than expected, due to the nature of our adversarial system and the unpredictability thereof.¹¹³⁹ Practitioners are entitled to be reasonably remunerated for the examination of the patient and the reports they compile.¹¹⁴⁰ Those who have to prepare themselves to testify, are usually paid an agreed upon qualifying fee.¹¹⁴¹ As for the trial itself, a party involved in proceedings may not enter into an agreement with a witness, whereby compensation will be paid if he or she provides evidence.¹¹⁴² Such an agreement is *contra bonos mores* and therefor, null and void.¹¹⁴³ A witness is only entitled to the fees prescribed in the official tariff of allowances as determined by the Minister.¹¹⁴⁴ The new tariff was published in 2008.¹¹⁴⁵ It repealed the out-dated tariff, which had been in force since

¹¹³⁶ *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* at 1200. The general applicable approach towards expert medical evidence was set out by the court. Also see Carstens & Pearmain (2007) 860.

¹¹³⁷ Strauss (1991) 433.

¹¹³⁸ *Ibid.*

¹¹³⁹ *Ibid.*

¹¹⁴⁰ *Id* 434.

¹¹⁴¹ *Id* 434. Now more appropriately termed 'preparation fees' in the Uniform Rules.

¹¹⁴² *Van Aswegen v Lombard* 1965 (3) SA 613 (A).

¹¹⁴³ *Transnet Ltd t/a Metrorail and Another v Witter* 2008 (6) SA 549 (SCA) at 558. The court reiterates and confirms the position with regard to the costs of expert witnesses.

¹¹⁴⁴ The tariff is prescribed by the Minister for Justice and Constitutional Development, in consultation with the Minister for Finance, under section 51bis of the Magistrates' Courts Act 32 of 1944 and section 42 of the Supreme Court Act 59 of 1959. It should be noted that the Supreme Court Act has been repealed by the Superior Courts Act 10 of 2013, which commenced on the 23rd of August 2013. The date of commencement of section 37, which deals with witness fees, is yet to be proclaimed.

¹¹⁴⁵ GN 394 in GG 30953 of 11 April 2008.

1991.¹¹⁴⁶ The current tariff provides for a subsistence allowance, transport and travelling expenses, and a maximum amount of R1 500 for income forfeited as a consequence of attending the civil trial.¹¹⁴⁷ The maximum fee prescribed in the tariff is very low compared to what most practitioners are likely to earn during a day. Then again, it is a practitioner's civil duty to provide relevant evidence, but one can understand how they might not be too enthusiastic about the financial implications thereof.

The nature of the adversarial system and the rigorous cross-examination expert witnesses often have to endure may deter them from giving evidence in malpractice proceedings. The court room can be rather confrontational and witnesses are likely to feel that their professional and personal integrity is called into question by opposing counsel.¹¹⁴⁸ The method of enquiry applied during proceedings, may also not be analogous to the reasoning employed by members of the medical community. Explaining intricate technical details of specialised procedures and justifying complex theories in terms which the court would be able to comprehend may present its own set of unique challenges.

Patients often find it extremely difficult to obtain expert medical witnesses who are willing to testify against fellow members of the profession.¹¹⁴⁹ Some have even suggested that a "conspiracy of silence" exists amongst practitioners.¹¹⁵⁰ It is more likely that a combination of factors mentioned above, many of which relate to the intrinsic nature of our liability and compensation system, contribute to the difficulties experienced in acquiring necessary expert evidence.

Patients injured in the public health sector may institute claims against the executive authority of the particular department concerned for damages incurred as a result of a breach of contract or delict, or both, committed by employees at state health

¹¹⁴⁶ GN 2596 in GG 13604 of 1 November 1991. A witness who provided expert evidence was entitled to R50 and other costs incurred for accommodation, as well as subsistence expenses.

¹¹⁴⁷ GN 394 in GG 30953 of 11 April 2008.

¹¹⁴⁸ Strauss "The physician's liability from malpractice: a fair solution to the problem of proof?" (1967) 84 S. Afr. Law J. 420.

¹¹⁴⁹ Strauss (1967) 84 S. Afr. Law J. 420.

¹¹⁵⁰ *Id* 419. Strauss dismisses this extreme view as a gross over-simplification.

facilities.¹¹⁵¹ The disconcerting facts in the *Nyathi* case stands to illustrate the difficulty claimants encountered when seeking to recover damages from state institutions.¹¹⁵² Section 3 of the Act, which did not allow for execution or attachment against the state, nor an accessible and simple process to secure effective satisfaction of judgement debts sounding in money, has been declared unconstitutionally invalid.¹¹⁵³ The inexcusable prior situation has now been alleviated by the State Liability Amendment Act 14 of 2011.

¹¹⁵¹ State Liability Act 20 of 1957. Practitioners and other medical personnel are employees in public health facilities and as such the state can be held vicariously liable.

¹¹⁵² *Nyathi v MEC for Department of Health, Gauteng* 2008 5 SA 94 (CC). Also see Malherbe & Van Eck "The State's failure to comply with its constitutional duties and its impact on democracy" (2009) 1 *TSAR* 191; Coetzee & Carstens "Medical malpractice and compensation in South Africa" (2011) 86 *Chicago-Kent Law Review* 1274; Olivier & Williams "State liability for final court orders sounding in money: at long last alignment with the Constitution" (2011) 32 *Obiter* 489.

¹¹⁵³ *Nyathi v MEC for Department of Health, Gauteng*. Also see Neethling "State (public authority) liability ex delicto (1)" (2012) 75 *THRHR* 626.

Chapter Five: Conclusion

This previous chapter examined different aspects of the medical malpractice system. Recent increases in the frequency of lawsuits and the amounts awarded as damages have raised a number of concerns. Medical malpractice and the subsequent litigation could have a devastating impact on the healthcare system. This impact is felt both financially and by the parties involved. The proposed National Health Insurance scheme may also be threatened by the costs involved.

Healthcare providers may be held liable in a number of different instances. Practitioners can be held accountable for unprofessional conduct by the Health Professions Council in its capacity as the regulatory body of the medical profession. Civil claims against practitioners and hospitals are also becoming a more frequent occurrence. Healthcare providers may incur contractual or delictual liability, depending on the circumstances.

The introduction of the Consumer Protection Act has now broadened the scope of liability. Patients are regarded as consumers and virtually all dealings between patients and health care providers will qualify as transactions in terms of the Act. The Act may however be more suited to commerce than the unique healthcare environment. Patients as consumers of healthcare goods and services are afforded more protection, however doctors may be burdened with more litigation and practitioner freedom may be curtailed. The traditional doctor-patient relationship could be redefined by the Act's effect on medical practice and liability. Patients have a right to demand quality service and safe, good quality goods. Provision is also made for no-fault liability in respect of damage caused by certain harmful goods. Doctors, as suppliers of the goods, may escape liability if it is unreasonable to expect

them to have discovered the unsafe product characteristic, failure, defect or hazard. Patients would thus be wise to rather institute claims against the manufacturer or producer of the harmful goods in such circumstances.

The Act also impacts on marketing and disclosure in the healthcare context. Provisions in the Act ensure that patients are protected from discriminatory marketing. In practice, this would ensure that patients do not unfairly receive differential quality care on the basis that they belong to a certain category of persons or that different standards are applied when dealing with patients who belong to a particular benefit option.

The duty of disclosure is also significantly altered. Healthcare providers are burdened with a more demanding standard of disclosure. The form of disclosure, in terms of the consumer orientated statute, differs from the conventional medico-legal one, where a doctor is not required to inform a patient of unusual or remote risks or dangers unless a patient specifically enquires about them or if they are serious and typically found to occur during the proposed intervention. The healthcare realities in South Africa and the challenges faced, specifically in the public sector, will impact on the practicality of these provisions. The existing standard of disclosure is already rarely met, thus exposing practitioners to civil and criminal liability. The introduction of a more onerous standard will have significant consequences for healthcare providers.

Contracts between healthcare providers and patients are also affected by the Act. Patients have the right to fair, just and reasonable terms and conditions and must not be required to waive any rights, assume any obligation or waive any liability of a healthcare provider on terms that are unfair, unreasonable or unjust. A contract or notice which seeks to

limit the risk or liability of a healthcare provider, or constitutes an assumption of risk or liability by the patient, or imposes an obligation on the patient to indemnify the healthcare provider or any other person for any cause must be drawn to the attention of the patient in the prescribed manner. Hospital admission forms and indemnification clauses are certainly affected by the Act. Contractual terms that are unfair, unreasonable or unjust may be set aside by the courts. A number of factors are taken into account when assessing whether a contract or provision is unfair, unreasonable or unjust. The Act also provides that certain terms or conditions that are not brought to the patient's attention may be severed from the agreement or declared to be null and void.

The chapter also investigated the extent of the medical litigation problem. There are concerns about the increased litigation in both the private as well as the public health sector. The systemic challenges faced by the public sector have made it especially vulnerable to malpractice litigation. The costs involved could threaten the implementation of the NHI scheme, which is probably unaffordable in any case.

The effects of the increased medical malpractice litigation are already being felt. The increase in medical malpractice litigation and the accompanying costs have had a significant effect on the indemnity insurance premiums of healthcare practitioners. Doctors might opt to leave certain specialities or stop performing high risk procedures and operations. Practitioners in less populated areas may find it financially unviable to continue practicing and would have to relocate their practices to be able to afford indemnity insurance. This will deprive communities of access to care. Aspirant doctors may be discouraged from pursuing medicine as a career and junior doctors may avoid particular specialities due to the threat of litigation. Such a situation would be devastating,

as the country is in desperate need of more doctors and specialists.

Patients stand to lose the most. They are the ones who have to contend with the effects of malpractice and may ultimately, in a cruel twist, end up having to face the consequences of increased malpractice litigation as well. Healthcare costs may increase and there may be a diminution in their access to care.

Medical malpractice litigation could have a devastating effect on the public health sector, which could be exacerbated by the implementation of a NHI mechanism that does not adequately address the underlying problems of the public health system. The systemic problems in the public sector affect the quality of care patients receive. Poor quality care will result in the state incurring more malpractice claims. As provincial health departments have fixed annual budgets, these claims and the legal costs associated therewith have a direct impact on their ability to finance healthcare. Money spent on medical malpractice claims, cannot be spent on improving the provincial health system. This could lead to a further decline in the quality of care provided, which could inevitably lead to even more malpractice litigation. A vicious circle where only the lawyers benefit.

Medical malpractice litigation also affects the way in which medicine is practiced. There is evidence to suggest that doctors will practice medicine defensively in order to avoid the threat of lawsuits. Practitioners engage in assurance or avoidance behaviour to limit their exposure to litigation. This defensive behaviour can have a negative impact on the healthcare system in that it exposes patients to unnecessary risks, increases costs, wastes resources and in some instances it may even diminish access to care. The consequences of

defensive medicine cannot be afforded in an already unaffordable NHI scheme.

The threat of medical malpractice litigation affects practitioners both professionally and personally. It takes a severe emotional toll on the doctor. Practitioners may consider early retirement and discourage others from entering medicine, which may impact on the availability of healthcare services.

The reporting of errors is also less likely to occur in a litigious environment. Practitioners will not be forthcoming with information if it could result in an expensive and arduous civil claim. However, if errors and adverse events are not reported, nothing can be done to prevent their reoccurrence. 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 vital as well. What happened in the preceding and subsequent consultations in the doctor's office, after the adverse event, can be just as important as what happened during treatment. 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.

The chapter also examined the possible causes of increased malpractice litigation. Attorneys have been identified as one of the main drivers of malpractice lawsuits. The Minister of Health has even gone so far as to accuse lawyers of targeting doctors. Whether this is true and that greed is to blame, or that changes in the law have made malpractice litigation a more lucrative venture for the legal profession, does not

change the fact that patients are being injured and require compensation. Lawyers remain the gateway to such redress. 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.

There would be no malpractice claim if there was no adverse event and damages would not have been awarded if the injury was not caused by the negligent conduct of the healthcare providers. The medical profession is thus also responsible for increases in malpractice litigation. The acting CEO of the HPCSA attributed the increased malpractice litigation to a decline in professionalism and the standard of care of practitioners. These comments have been criticised by members of the profession. It is however important, now more than ever, that doctors practice medicine with the necessary care and skill. Education and the enforcement of practice guidelines are critical in this respect. Improving the detection of negligent behaviour and instituting appropriate corrective or disciplinary processes would also be constructive. Studies have indicated that patients' dissatisfaction is a determining factor when it comes to the decision to litigate. Practitioners should adjust their behaviour accordingly.

Patients have become more aware of their rights and this may have contributed to the increased litigation. This is a development that should be welcomed, as patients who have legitimate claims must be compensated. The reasons for this newfound awareness may be related to more aggressive marketing by lawyers or campaigns aimed at educating patients about their rights. The commercialisation of healthcare and the Consumer Protection Act may also have had an effect.

Many adverse events can be attributed to systemic factors, rather than purely individual negligence. Errors often occur despite the best intentions and behaviour of the medical personnel involved. 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. The NHI proposal did not specify what institutional weaknesses exist or how it would address them.

Healthcare practitioners must exercise their duties with the required care and skill, but 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, as they are responsible for the availability of the necessary resources that allow doctors to provide an expected level of care. Health departments and hospital bodies can be held vicariously liable if negligent maladministration or mismanagement resulted in harm being suffered.

Adverse events occur and they will keep occurring. The approach used to deal with these events should change. Our current liability system, which is focussed on individual accountability, follows a "persons approach". It focuses on the unsafe acts of the practitioners and medical personnel who provide healthcare 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. A "systems approach" may be better suited to the complex healthcare environment. Human error and fallibility are regarded as consequences rather than causes, originating not from human nature alone, but rather systemic factors. Errors are managed, not by

targeting the individual, but by implementing programmes that target several different components of the system.

The patients' perspective on the malpractice issue was also considered during the discussion. Many stakeholders are involved and debates as well as proposed reforms are often focussed on the financial implications of increased malpractice. It is submitted that discussions surrounding the matter should have a strong patient-orientated focus. As patients are the ones who are the most severely affected by malpractice, their interests should be decisive.

Patients are in a particularly vulnerable position, even more so if they are injured as a result of medical care. The impact of these injuries could be devastating. The psychological effects associated with an adverse event could be just as, if not more traumatic than the physical injury itself. Patients suffer injuries that may have long-term effects on their work, social life and family relationships. The trauma suffered, may be aggravated by the manner in which the incident is subsequently handled. Additional surgeries and hospitalisation will likely be required in most serious cases. The injured individual is not the only one who may be severely affected by a medical error. Family and friends of the patient would also likely suffer. Such an adverse event could be emotionally and financially devastating to people close to the patient.

The devastating consequences of medical malpractice are disconcerting, even more so when one considers the incidence of adverse events. A number of different countries have conducted studies into iatrogenic harm. They have found incidence rates of between 2.9% and 16.6%, depending on the methodology applied. Almost all of the studies also indicated that the majority of the adverse events were preventable.

The landmark Harvard study into the incidence of adverse events revealed some shocking information. Most adverse events are avoidable and many are caused by negligence. Even more disturbing was the relationship between negligently caused injuries and malpractice claims. It was found that 98% of all adverse events due to negligence in the study did not result in malpractice claims. Of those patients who do file claims, perhaps half will receive compensation. The results of the study suggest that patients who have suffered injuries due to negligence are rarely compensated and that healthcare providers are hardly ever identified and held accountable for substandard medical care. Doubt has been cast on the malpractice system's ability to deter substandard medical practice and compensate negligently injured patients.

In 2006, a research project was launched by the WHO World Alliance for Patient Safety in conjunction with the Ministries of Health of Egypt, Jordan, Kenya, Morocco, Tunisia, South Africa, Sudan and Yemen to ascertain the frequency, causes, and preventability of adverse events in hospitalised patients in the participating countries. The results indicated that at least one adverse event occurred in 8.2% of cases, a rate which varied from 2.5% to 18.4% between countries. The authors indicated that this is probably an underestimate of the true rate and that the underestimate might be quite large. The finding that 83% of adverse events were highly preventable is significantly higher than previous studies into iatrogenic harm, which estimated that around half were preventable. A further finding which is rather concerning, is the fact that 30% of adverse events were associated with the death of the patient, compared to 4% to 15% reported in other studies.

The burden of iatrogenic injury is large. Patients in developing countries, such as South Africa, may suffer more adverse events. Systemic factors and institutional weaknesses

in our health system most likely play a large role. Many preventable mistakes lengthen hospital stay and result in an increased consumption of health resources. This is again an example of a cost consideration that may affect the success of the NHI. A significant number of patients are injured, many due to the negligent conduct of practitioners and medical personnel, yet there is evidence to suggest that only a fraction of these patients institute claims. Patients, who go uncompensated, will however still have to live with and bear the physical, psychological and financial burden of those injuries. Research into the prevalence of adverse events, negligence and malpractice in South Africa is necessary. Only then can informed policy decisions be taken.

Injured patients who do eventually decide to file claims face a number of challenges. Litigation is a costly endeavour and medical malpractice cases often take years to be resolved. The patients, who are able to afford litigation, frequently find it very difficult to prove negligence on the part of the practitioners or hospital personnel involved. Our courts have taken a rather protective attitude towards the medical profession. The Appeal Court effectively held that the doctrine of *res ipsa loquitor* does not apply to medical situations, thus depriving the injured patient of a valuable aid in their attempt to claim compensation. Claimants who attempt to prove their cases also face difficulties with regard to the provision of expert evidence. A combination of factors many of which relate to the intrinsic nature of our liability and compensation system, contribute to the difficulties experienced in acquiring the necessary expert evidence. Patients who have been injured in the public sector didn't just have to contend with these difficulties, but they also had to deal with the inexcusable prior position under the State Liability Act when instituting claims against public

health providers. Some of these challenges have now hopefully been alleviated by the Amendment Act.

Chapter Six: Conclusion

1. Medical Malpractice and Patient Safety

Evidence seems to suggest that claims are instituted more frequently and that costs related to malpractice have consequently increased. The effects and possible causes thereof have also been considered. The impact of malpractice on the injured patient and the significant difficulties faced in obtaining compensation has emphasised the need to approach the complex issues with a patient-orientated focus. A large number of patients suffer iatrogenic harm, yet only a small fraction of those patients are compensated.¹¹⁵⁴ Avoidable injuries are tragically prevalent, even more prevalent in developing countries such as South Africa.¹¹⁵⁵ Many of these injuries are caused by malpractice.¹¹⁵⁶ It is argued that, instead of concentrating on reforms which seek to address the financial implications of rising claims, and only indirectly health care concerns, reforms which seek to reduce substandard care should rather be implemented. The role of the compensation and liability system should be reconsidered as it relates to patient safety.¹¹⁵⁷ It should be determined whether it contributes to and ensures a safer healthcare environment.¹¹⁵⁸

The existing compensation and liability system has essentially three social objectives.¹¹⁵⁹ It serves to deter substandard care, it aims to compensate those patients who were injured as a result of such negligent care and it exacts corrective

¹¹⁵⁴ Weiler *et al* (1993) *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation*.

¹¹⁵⁵ Wilson *et al* (2012) 344 *BMJ*.

¹¹⁵⁶ Localio *et al* (1991) 325 *N. Engl. J. Med.* 245; Studdert *et al* "Negligent care and malpractice claiming behavior in Utah and Colorado" (2000) 38 *Med. Care* 250.

¹¹⁵⁷ Reason (2000) 320 *BMJ* 768; Bovbjerg, Miller & Shapiro "Paths to reducing medical injury: professional liability and discipline vs. patient safety—and the need for a third way" (2001) 29 *The Journal of Law, Medicine & Ethics* 369.

¹¹⁵⁸ Vincent (2010) *Patient Safety*. See the impressive work by the author, wherein he presents the landscape of patient safety.

¹¹⁵⁹ Miller "Medical malpractice litigation: do the British have a better remedy" (1985) 11 *American Journal of Law & Medicine* 435.

justice. The deterrence function thereof is particularly relevant to patient safety.¹¹⁶⁰ In theory practitioners would avoid unsafe practices due to the threat of litigation and the consequent emotional and financial costs that would be incurred during a civil trial.¹¹⁶¹ Attorneys function as gatekeepers in the system, as they consider the merits of potential claims, along with other factors, when advising their clients to institute claims or not.¹¹⁶² If a claim succeeds, indemnity insurance ensures that practitioners are not bankrupted and that patients receive compensation.¹¹⁶³ Theoretically the existing system is adequate and efficient. In reality there are however a number of problems.¹¹⁶⁴

As indicated earlier only a fraction of patients who have suffered injuries institute claims, fewer still receive compensation.¹¹⁶⁵ There seems to be a severe divide between injury and litigation. The system does however capably identify meritorious claims once a suit has been filed.¹¹⁶⁶ Nevertheless, as a mechanism for accurately distributing compensation to injured patients it has colossal shortcomings.¹¹⁶⁷ This is all exacerbated by the system's inefficiency. The majority of the money spent accessing the system goes towards administrative costs, with legal fees being the predominant expense.¹¹⁶⁸

¹¹⁶⁰ Schwartz "Reality in the economic analysis of tort law: does tort law really deter" (1994) 42 *UCLA Law Review* 377.

¹¹⁶¹ Calabresi (1970) *The Cost of Accidents: A Legal and Economic Analysis*; Charles *et al* (1985) 142 *Am. J. Psych.* 437; Weiler *et al* (1993) 111.

¹¹⁶² Kritzer "Contingency fee lawyers as gatekeepers in the civil justice system" (1997) 81 *Judicature* 22

¹¹⁶³ Howarth, Bown & Whitehouse (2013) 103 *S. Afr. Med. J.* 453.

¹¹⁶⁴ Studdert, Mello & Brennan "Medical Malpractice" (2004) 350 *N. Engl. J. Med.* 284.

¹¹⁶⁵ Localio *et al* (1991) 325 *N. Engl. J. Med.* 245; Studdert *et al* (2000) 38 *Med. Care* 250; Jena *et al* "Malpractice risk according to physician specialty" (2011) 365 *N. Engl. J. Med.* 629.

¹¹⁶⁶ Taragin *et al* "The influence of standard of care and severity of injury on the resolution of medical malpractice claims" (1992) 117 *Ann. Intern. Med.* 780; Studdert *et al* (2006) 354 *N. Engl. J. Med.* 2024; Sloan and Hsieh (1990) 24 *Law & Society Review* 997; Studdert, Mello & Brennan (2004) 350 *N. Engl. J. Med.* 285; Studdert *et al* "Claims, errors, and compensation payments in medical malpractice litigation" (2006) 354 *N. Engl. J. Med.* 2024.

¹¹⁶⁷ Studdert, Mello & Brennan (2004) 350 *N. Engl. J. Med.* 285.

¹¹⁶⁸ Studdert *et al* (2006) 354 *N. Engl. J. Med.* 2024.

There is little evidence to suggest that the system is effective at deterring substandard care.¹¹⁶⁹ Evidence on the system's impact on the manner in which practitioners practice medicine, suggests that it may actually not be positive.¹¹⁷⁰ Defensive medicine has led to unnecessary diagnostic tests that consume health resources and increase costs.¹¹⁷¹ Practitioners have also started to avoid certain procedures and patients, thereby restricting access to care. The threat of litigation may even be driving some practitioners out of certain high-risk specialities altogether, further compounding the problem. There are of course commentators who would argue that defensive medicine could be beneficial to some extent.

As for the costs of claims, there are legitimate concerns. Not all practitioners can afford to pay their indemnity insurance premiums and would thus not be able to provide certain health services.¹¹⁷² Provincial health department budgets are also severely constrained and large pay-outs will affect their ability to obtain resources, upgrade infrastructure and provide public health services. Thereby further reducing the quality of care provided at state facilities and subsequently affecting patient safety. However, it is imperative that injured patients still be compensated.¹¹⁷³

As indicated in the previous chapter, the current liability and compensation system is adversarial and focuses on the individual when assigning blame. Systemic factors are often overlooked and it is almost impossible to identify weaknesses, in order to make the system safer and prevent future errors.¹¹⁷⁴ Patient safety advocates recognise that faulty systems rather than careless individuals are usually responsible for medical errors.¹¹⁷⁵ Our system of adjudicating malpractice is ill suited to such an

¹¹⁶⁹ Schwartz (1994) 42 *UCLA Law Review* 377; Mello & Brennan "Deterrence of medical errors: theory and evidence for malpractice reform" (2002) 80 *Texas Law Review* 1603.

¹¹⁷⁰ Stevenson, Spittal & Studdert "Does litigation increase or decrease health care quality?: a national study of negligence claims against nursing homes" (2013) 51 *Med. Care* 430.

¹¹⁷¹ Summerton "Positive and negative factors in defensive medicine: a questionnaire study of general practitioners" (1995) 310 *BMJ* 27; Kessler & McClellan "Do doctors practice defensive medicine?" (1996) 111 *The Quarterly Journal of Economics* 353; Studdert *et al* (2005) 293 *JAMA* 2609.

¹¹⁷² 'No cover for GPs performing fetal anomaly scans' *Medical Chronicle* 11 June 2013.

¹¹⁷³ Ncayiyana (2004) 94 *S. Afr. Med. J.* 303.

¹¹⁷⁴ Reason (2000) 320 *BMJ* 768.

¹¹⁷⁵ Kohn, Corrigan & Donaldson eds. (2000); Sage "Medical liability and patient safety" (2003) 22 *Health Affairs* 26.

approach.¹¹⁷⁶ Transparency is a dominant theme of the patient-safety movement. Errors inevitably occur and in order to prevent future errors, it is necessary to identify and learn from the mistakes.¹¹⁷⁷ An environment in which these errors can be disclosed and reported, so that they can be addressed is thus required.¹¹⁷⁸ This conflicts with our existing system, which targets the individual practitioner. There is absolutely no incentive to disclose errors, as doing so may lead to confrontational litigation.¹¹⁷⁹ The deterrence of substandard care with the threat of litigation, which aims to ensure patient safety, may actually be a greater threat to patient safety in the long run. If some of the proposed initiatives, such as the disclosure of errors and the reporting of adverse events are introduced, it would most likely result in more malpractice litigation under the existing liability and compensation system.¹¹⁸⁰ The existing system is just not conducive to such an approach and may thus in a strange contradictory way be detrimental to the provision of quality healthcare.¹¹⁸¹

2. Proposed Reforms

The problems identified with the existing system have led stakeholders to call for reforms. These proposed conventional reforms are almost always directly aimed at the financial implications of malpractice litigation and would merely alter the existing malpractice system. Focussing on the financial implications may indirectly address some of the healthcare concerns, but this would be insufficient. These reforms will

¹¹⁷⁶ Bovbjerg, Miller & Shapiro (2001) 29 *J. Law Med. Ethics* 369.

¹¹⁷⁷ Reason (2000) 320 *BMJ* 768.

¹¹⁷⁸ Berwick & Leape “Reducing errors in medicine: It’s time to take this more seriously” (1999) 319 *BMJ* 136; Gallagher *et al* (2003) 289 *JAMA* 1001; Kachalia *et al* (2010) 153 *Ann. Intern. Med.* 213.

¹¹⁷⁹ Lamb *et al* “Hospital disclosure practices: results of a national survey” (2003) 22 *Health Aff.* 73.

¹¹⁸⁰ Studdert, Mello & Brennan (2004) 350 *N. Engl. J. Med.* 287. Also see Kraman & Hamm (1999) 131 *Ann. Intern. Med.* 963 where the authors tentatively indicate that a policy of full disclosure may in certain instances not lead to an increase in claims.

¹¹⁸¹ Gostin “A public health approach to reducing error: medical malpractice as a barrier” (2000) 283 *JAMA* 1742; Studdert & Brennan “No-fault compensation for medical injuries: the prospect for error prevention” (2001) 286 *JAMA* 217.

not directly reduce substandard care and patients will continue to be injured and face the same if not more difficulties in obtaining compensation.

2.1 Conventional Reforms

Conventional reforms can be divided into three categories: 1) reforms that limit access to court; 2) reforms that alter certain liability rules in an attempt to reduce the frequency of claims and the amounts awarded as damages; and 3) reforms that directly address the size of damages awarded.¹¹⁸²

2.1.1 Reforms that Limit Access to Court

Screening panels determine and make recommendations with regard to the merits of a claim before the matter proceeds to court.¹¹⁸³ These panels encourage the expeditious settlement of justifiable claims. Frivolous claims or claims without merit are discouraged in order to avoid costly and lengthy litigation. Shortening statutes of limitation and repose would also limit access to court and are also often proposed.¹¹⁸⁴

2.1.2 Reforms that Alter certain Liability Rules

These reforms are aimed at reducing the frequency of claims and the size of the pay-outs. Measures under this category include: eliminating joint-and-several liability, not applying the doctrine of *res ipsa loquitor*, establishing standards for expert witnesses and requiring additional criteria when proving the absence of informed consent.

¹¹⁸² Studdert, Mello & Brennan (2004) 350 *N. Engl. J. Med.* 287.

¹¹⁸³ Giesen (1988) 501.

¹¹⁸⁴ *Id* 487.

2.1.3 Reforms that Directly Address the Size of Damages Awarded

The capping of damages is regularly proposed and is being considered locally. The reforms are specifically directed at the size of malpractice awards.¹¹⁸⁵ These caps may be applied to the total amount or only the non-economic portion of the damages claimed. As an indirect consequence of caps, malpractice lawsuits may also be less lucrative for attorneys. Income from contingency fee agreements will be considerably less and would deter litigation. Other measures under this category include periodic payments, so that future expenses are paid as they arise, instead of receiving one lump sum and modifications to the collateral source rule.¹¹⁸⁶

These reforms may reduce claims, costs and perhaps indemnity insurance premiums. However, just as more litigation under the existing system will probably not make health care safer, less litigation and smaller awards under a slightly altered version of the existing system will also likely have no impact on patient safety. With regard to the possible indirect effects these reforms may have on health care, such as preventing doctors from leaving certain specialities, avoiding particular patients or practicing in different locations, these reforms may merely preserve the status quo. Patient safety and the existing inherent problems will not be addressed.

2.2 Fundamental Reforms

It is argued that the role of the compensation and liability system should be reconsidered as it relates to patient safety. The realisation that the malpractice system may not be adequate and efficient in this regard has prompted calls for alternative approaches that would compensate injured patients and make health care safer.

¹¹⁸⁵ *Id* 496.

¹¹⁸⁶ *Ibid.*

These approaches can also be divided into three categories: 1) alternative dispute resolution mechanisms; 2) no-fault schemes and structures; and 3) enterprise liability.

2.2.1 Alternative Dispute Resolution Mechanisms

These reforms seek to avoid litigation altogether.¹¹⁸⁷ Recommendations include structured mediation, administrative tribunals and specialised medical courts. Early-offer programs also fall under this category. These programs attempt to secure early settlements after the occurrence of adverse events by incentivising negotiations between practitioners and patients. The prospect of concluding contracts before treatment, whereby patients agree to alternative dispute resolution mechanisms, have also garnered attention.

2.2.2 No-Fault Schemes and Structures

Reforms in this category eliminate negligence as a requirement for liability and compensation.¹¹⁸⁸ Opponents of these schemes fear that by not assigning blame, no-fault schemes will not hold practitioners accountable and would not deter substandard care. Practitioners are opposed to no-fault schemes as they fear that they will incur even more liability if such initiatives are introduced. Although these schemes and structures are commonly referred to as “no-fault”, such a designation may be deceptive. The focus of the investigation in these schemes and structures are not on determining whether an adverse event was negligently caused, but rather whether such an adverse event was avoidable. This of course has raised concerns about costs, as more injured patients will be eligible for compensation. Considering the large number of patients who are injured but never compensated, these costs could be immense, but then again patients should be entitled to compensation and there are patient-safety benefits in determining liability on an avoidability rather than

¹¹⁸⁷ *Id* 505.

¹¹⁸⁸ *Id* 529.

fault basis. Proponents argue that costs saved on administrative and legal expenses make these schemes affordable. But if that would be the case in South Africa with our unique social, economic and healthcare challenges could not be answered without extensive research into the cost implications, it does however seem unlikely that it would.

2.2.3 Enterprise Liability

With enterprise liability, litigation is shifted from the individual practitioner to the healthcare organisation where the patients received treatment. Hospitals are thus held completely liable for all claims brought against allied practitioners. The costs incurred would function as an incentive to implement organisational changes, thereby addressing the systemic factors which contribute towards injuries.

3. The National Health Insurance Response

The proposed National Health Insurance system is aimed at improving access to quality healthcare services and the provision of financial risk protection against catastrophic medical expenses for the entire population. Whether the NHI as currently proposed would be the best mechanism to achieve these objectives remains to be seen, there are however numerous concerns, as highlighted in a previous chapter. Nevertheless, the Green Paper is correct in conceding that the quality of healthcare provided to a large majority of the public is poor. The quality of care provided impacts on patient safety and avoidable errors are most likely a frequent occurrence. These avoidable errors are probably aggravated by the systemic problems in the public health system.

The National Health Insurance will attempt to address these quality concerns by investing heavily in the public health sector. There are however other reforms that are more specifically directed at quality improvement. In this regard the newly

established Office of Health Standards Compliance will seek to ensure that the quality of care patients receive in health facilities is improved, by monitoring and enforcing norms and standards. The Office is empowered to investigate and deal with complaints relating to breaches of these prescribed norms and standards and may refuse to certify, as well as penalise establishments that do not comply therewith. The Office may also recommend that persons who are responsible for the non-compliance be referred to the relevant authority, which may then institute disciplinary proceedings. Other measures aimed at improving norms and standards are also envisioned. The establishment of the Office is welcomed. It indicates that there is a willingness to intervene and hopefully rectify some of the issues faced by our health system. There are however concerns about the independence thereof, political interference may well impede its functioning and hinder the potential impact it may have on patient safety.

The introduction of the Green Paper and the developments since, suggest that there is a political impetus for change in order to achieve the objectives of the proposed NHI. The current medical malpractice system, viewed as a threat to healthcare delivery and the successful implementation of the NHI will most likely also be reformed. There are already indications that reforms are being deliberated. Comments made by the Minister and the establishment of a Medico Legal Task Team, which is currently investigating the malpractice situation, are indicative thereof. The limitations of our current malpractice system need to be reconsidered if changes are to be affected. Conventional reforms that merely seek to alter the existing system may not be aligned with the objectives of the proposed NHI or the health system in its current state. Conventional reforms will not assist in improving the quality of care received or prevent injured patients from incurring catastrophic costs in the form of damages suffered due to inadequate medical management. Most injured patients are rarely compensated under the existing malpractice system. Patients may even be compensated less if certain conventional reforms, such as caps are introduced and would be severely burdened by the harm suffered and the expenses incurred as a result thereof.

Opponents of the existing malpractice system contend that it places too much emphasis on the individual, when medical errors are in fact much more complex and likely predominately caused by systemic factors. These systemic factors are

particularly prevalent in our under-resourced public health system. By its inherent nature and design, the existing malpractice system does not concern itself with these causes, as it explicitly targets and attributes blame to the individual practitioner. Proponents of the system argue that this serves to deter unsafe practices. There are however doubts about its efficiency in this regard. It also needs to be considered whether patient safety is sufficiently promoted thereby, since there is evidence to suggest that alternative approaches could be more constructive.

4. Final Remarks

Is our existing malpractice system the best mechanism with which to promote quality healthcare by ensuring patient safety? Medical errors should be prevented by recognising that mistakes are inevitable. If a more transparent atmosphere is fostered, these errors could be more readily identified, thus enabling providers to implement systems to avoid the occurrence of future adverse events. The existing malpractice system is not conducive to such an approach.

Fundamental reforms should perhaps be considered to align the objectives of the health care system with those of the malpractice system. However, this will not be an easy task. The different stakeholders involved all have conflicting interests and to find a proposition everyone will be able to agree on will be an immense if not impossible undertaking. Therefore, a patient-orientated focus should be central to any policy decisions, patients' interests thus being decisive.

Any policy decisions on possible malpractice system reforms should be based on concrete research. Information on South Africa's health system as it relates to the burden of iatrogenic injury, the causes and avoidability thereof should be studied. The malpractice system should also be scrutinised, reliable data is necessary on the number of malpractice claims filed, causes of increased claims, costs involved with litigation and the difficulties experienced in obtaining compensation. Policy decisions that would improve the quality of care provided and patient safety, while adequately compensating patients must be informed by the necessary inquiries.

Bibliography

Table of Abbreviations

<i>Am. J. Psych.</i>	<i>The American Journal of Psychiatry</i>
<i>Ann. Intern. Med.</i>	<i>Annals of Internal Medicine</i>
<i>Arch. Intern. Med.</i>	<i>Archives of Internal Medicine</i>
<i>Bull. World Health Organ.</i>	<i>Bulletin of the World Health Organization</i>
CILSA	<i>Comparative and International Law Journal of Southern Africa</i>
<i>Health Aff.</i>	<i>Health Affairs</i>
<i>J. Health Polit. Policy Law</i>	<i>Journal of Health Politics, Policy, and Law</i>
<i>J. Law Med. Ethics</i>	<i>The Journal of Law, Medicine & Ethics</i>
JAMA	<i>JAMA: The Journal of the American Medical Association</i>
<i>Lancet</i>	<i>The Lancet</i>
LAWSA	<i>The Law of South Africa</i>
<i>Med. Care</i>	<i>Medical Care</i>
<i>Med. J. Aust.</i>	<i>The Medical Journal of Australia</i>
<i>N. Engl. J. Med.</i>	<i>The New England Journal of Medicine</i>
OGF	<i>Obstetrics and Gynaecology Forum</i>
<i>Qual. Saf. Health Care</i>	<i>Quality & Safety in Health Care</i>
<i>S. Afr. Law J.</i>	<i>South African Law Journal</i>
<i>S. Afr. Med. J.</i>	<i>South African Medical Journal</i>
SAHR	<i>South African Health Review</i>
SAJBL	<i>South African Journal of Bioethics and Law</i>
SAJHR	<i>South African Journal on Human Rights</i>
SAPL	<i>SA Public Law</i>
THRHR	<i>Tydskrif vir Hedendaagse Romeins-Hollandse Reg</i>
TSAR	<i>Tydskrif vir die Suid-Afrikaanse Reg</i>

Primary Sources of Law

South African Legislation

Children's Act 38 of 2005

Compensation for Occupational Injuries and Diseases Act 130 of 1993

Constitution of the Republic of South Africa, 1996

Consumer Protection Act 68 of 2008

Contingency Fees Act 66 of 1997

Department of Health (1997) White Paper for the Transformation of the Health System in South Africa. Government Notice 667 published in *Government Gazette* 17910 of 16 April 1997

Department of Health (2011) Policy on National Health Insurance. Government Notice 657 published in *Government Gazette* 34523 of 12 August 2011

Health Professions Act 56 of 1974

Magistrates' Courts Act 32 of 1944

Medical Schemes Act 131 of 1998

National Health Act 61 of 2003

Occupational Diseases in Mines and Works Act 78 of 1973

Promotion of Access to Information Act 2 of 2000

Promotion of Administrative Justice Act 3 of 2000

Road Accident Fund Amendment Act 19 of 2005

State Liability Act 20 of 1957

Sterilisation Act 44 of 1998

Superior Courts Act 10 of 2013

Supreme Court Act 59 of 1959

South African Case Law

Accident and Guarantee Corporation Ltd v Koch 1963 (4) SA 147 (A)

Administrateur, Transvaal v Van der Merwe 1994 (4) SA 347 (A)

Administrator, Natal v Edouard [1990] 2 All SA 374 (A)

Afrox Healthcare Bpk v Strydom 2002 (6) SA 21 (SCA)

Alley Cat Clothing (Pty) Ltd v De Lisle Weare Racing [2002] 1 All SA 129 (D)

Allot v Paterson & Jackson 1936 SR 221

Applicant v Administrator, Transvaal 1993 (4) SA 733 (W)

Argus Printing & Publishing Co Ltd v IFP 1992 (3) SA 579 (A)

Behr v Minister of Health 1961 (1) SA 629 (SR)

Bester v Calitz 1982 (3) SA 864 (O)

Bester v Commercial Union Versekeringsmaatskappy van SA Bpk 1973 (1) SA 769 (A)

Blyth v Van der Heever 1980 (1) SA 191 (A)

Borgin v De Villiers 1980 (3) SA 556 (A)

Botha v Rompel 1955 TPD 719 (unreported)

Broude v McIntosh 1998 (3) SA 60 (SCA)

Buls v Tsatsarolakis 1976 (2) SA 891 (T); [1976] 2 All SA 89 (T)

Burger v Administrator, Kaap 1990 (1) SA 483 (C)

Buys v Lennox Residential Hotel 1978 (3) SA 1037 (C)

Cape Town Municipality v Bakkerud 1997 (4) SA 356 (C)

Cape Town Municipality v Paine 1923 AD 207

Carmichele v Minister of Safety & Security 2001 (1) SA 489 (SCA)

Carmichele v Minister of Safety & Security (Centre for Applied Legal Studies Intervening) 2001 (4) SA 938 (CC)

Castell v De Greef 1993 (3) SA 501 (C)

Castell v De Greef 1994 (4) SA 408 (C); [1994] 4 All SA 63 (C)

Clarke v Hurst 1992 (4) SA 630 (D)

Clinton-Parker v Administrator, Transvaal; Dawkins v Administrator, Transvaal 1996 (2) SA 37 (W)

Coetzee & Sons v Smit 1955 (2) SA 553 (A)

Collins v Administrator, Cape 1995 (4) SA 73 (C)

Colman v Dunbar 1933 AD 141

Coppen v Impey 1916 CPD 309

Correira v Berwind 1986 (4) SA 60 (ZH)

Dantex Investment Holdings (Pty) Ltd v Brenner 1989 (1) SA 390 (A)

Dale v Hamilton 1924 WLD 184

D'Ambrosi v Bane 2006 (5) SA (K)

Da Silva v Coutinho 1971 (3) SA 123 (A)

De Beer v Health Professions Council of South Africa 2005 (1) SA 332 (T)

De La Rouviere v SA Medical and Dental Council 1977 (1) SA 85 (N)

De Vos v Suid-Afrikaanse Eagle Versekeringsmaatskappy Bpk 1984 (1) SA 724 (O)

Dippenaar v Shield Insurance Co Ltd 1979 (2) SA 904 (A)

Dube v Administrator Transvaal 1963 (4) SA 260 (W)

Dukes v Marthinusen 1937 AD 12

Edouard v Administrator, Natal 1989 (2) SA 368 (D); [1989] 4 All SA 309 (D)

Esterhuizen v Administrator Transvaal 1957 (3) SA 710 (T)

Ex Parte Dixie 1950 (4) SA 748 (W)

Farmer v Robinson Gold Mining Co Ltd 1917 AD 501

First National Bank of South Africa Ltd v Duvenhage 2006 (5) SA 319 (SCA)

Fowlie v Wilson 1993 (N) (unreported)

Friedman v Glicksman 1996 (1) SA 1134 (W)

Goliath v MEC for Health in the Province of Eastern Cape (1084/2012) [2013] ZAECGHC 72

Gordon v Da Mata 1969 (3) SA 285 (A)

Government of the Republic of South Africa v Ngubane 1972 (2) SA 601 (A)

Griffiths v Netherlands Insurance Co of SA Ltd 1976 (4) SA 691 (A)

Groenewald v Groenewald 1998 (2) SA 1106 (SCA)

Guardian National Insurance Co Ltd v Van Gool NO 1992 (4) SA 61 (A)

Hammerstrand v Pretoria Municipality 1913 TPD 374

Health Professions Council of SA v De Bruin [2004] 4 All SA 392 (SCA)

Herschel v Mrupe 1954 (3) SA 464 (A)

Hewat v Rendel 1925 TPD 679

Hoffa NO v SA Mutual Fire & General Insurance Co Ltd 1965 (2) SA 944 (C)

International Shipping Co (Pty) Ltd v Bentley 1990 (1) SA 680 (A)

Jacobson v Carpenter-Kling 1998 TPD (unreported)

Jansen van Vuuren and Another NNO v Kruger 1993 (4) SA 842 (A)

Joffe & Co Ltd v Hoskins; Joffe & Co Ltd v Bonamour 1941 AD 431

Johannesburg Consolidated Investment Co Ltd v Langleigh Construction (Pty) Ltd
1991 (1) SA 576 (A)

Jones v SANTAM Bpk 1965 (2) SA 542 (A)

Kadir v Minister of Law & Order 1992 (3) SA 737 (C)

Kakamas Bestuusraad v Louw 1960 (2) SA 202 (AD)

Kantey & Templer (Pty) Ltd and Another v Van Zyl NO 2007 (1) SA 610 (C)

Kgobane v Minister of Justice 1969 (3) SA 365 (A)

*Khosa and Others v Minister of Social Development and Others; Mahlaule and
Another v Minister of Social Development and Others* 2004 (6) BCLR 569 (CC)

Knop v Johannesburg City Council 1995 (2) SA 1 (A)

Kovalsky v Krige (1910) 20 CTR 822

Kruger v Coetzee 1966 (2) SA 428 (A)

Lampert v Hefer 1955 (2) SA 507 (A)

Law Society of South Africa and Others v Minister for Transport and Another 2011
(1) SA 400 (CC)

Layton and Layton v Wilcox and Higginson 1944 SR 48

Lillicrap, Wassenaar & Partners v Pilkington Bros (SA) (Pty) Ltd 1985 (1) SA 475 (A)

Local Transitional Council of Delmas and Another v Boshoff 2005 (5) SA 514 (SCA)

Louwrens v Oldwage 2006 (2) SA 161 (SCA)

Lymbery v Jefferies 1925 AD 236

Magware v Minister of Health NO [1981] 4 All SA 531 (Z)

Marais v Interim Nasionale Mediese en Tandheelkundige Raad van Suid-Afrika en 'n Ander [1997] 4 All SA 260 (O)

Marais v Richard 1981 (1) SA 1157 (A)

Matlou v Makhubedu 1978 (1) SA 946 (A)

May v Udwin 1981 (1) SA 1 (A)

McCallum v Hallen 1916 EDL 74

McDonald v Wroe [2006] 3 All SA 565 (C)

mCubed International (Pty) Ltd and Another v Singer and Others NNO 2009 (4) SA 471 (SCA)

Meyer v SA Medical and Dental Council and Others 1982 (4) SA 450 (T)

Michael v Linksfield Park Clinic (Pty) Ltd 2001 (3) SA 1188 (SCA)

Minister of Correctional Services v Lee 2012 (3) SA 617 (SCA)

Minister of Justice v Hofmeyr 1993 (3) SA 131 (A)

Minister of Police v Skosana 1977 (1) SA 31 (A)

Minister of Safety and Security and Another v Carmichele 2004 (3) SA 305 (SCA)

Minister of Safety and Security and Another v Rudman and Another 2005 (2) SA 16 (SCA)

Minister of Safety and Security v Van Duivenboden 2002 (6) SA 431 (SCA)

Minister van Polisie v Ewels 1975 (3) SA 590 (A); [1975] 3 All SA 599 (A)

Mistry v Interim National Medical and Dental Council of South Africa 1998 (4) SA 1127 (CC)

Mitchell v Dixon 1914 AD 519

Mkhatswa v Minister of Defence 2000 (1) SA 1104 (SCA)

Mtetwa v Minister of Health 1989 (3) SA 600 (D)

Mukheiber v Raath 1999 (3) SA 1065 (SCA)

Muller v Mutual and Federal Insurance Co Ltd and Another 1994 (2) SA 425 (C)

Myers v Abramson 1951 (3) SA 438 (C); [1951] 3 All SA 82 (C)

Napier v Collett and Another 1995 (3) SA 140 (A)

Neuhaus v Bastion Insurance Co Ltd 1968 (1) SA 398 (A)

Ngubane v South African Transport Services 1991 (1) SA 756 (A)

NM and Others v Smith and others (Freedom of Expression Institute as Amicus Curiae) 2007 (5) SA 250 (CC)

Ntsele v Mec for Health, Gauteng Provincial Government [2013] 2 All SA 356 (GSJ)

Nyathi v MEC for Department of Health, Gauteng 2008 5 SA 94 (CC)

Nydoo v Vengtas 1965 (1) SA 1 (A)

Oates v Niland 1914 CPD 976

Ocean Accident & Guarantee Corporation Ltd v Koch 1963 (4) SA 147 (A)

Oldwage v Louwrens [2004] 1 All SA 532 (C)

Olitzki Property Holdings v State Tender Board 2001 (3) SA 1247 (SCA)

Pakendorf v De Flamingh 1982 (3) SA 146 (A)

Phathela v Chairman, Disciplinary Committee, SA Medical & Dental Council 1995 (3) SA 179 (T)

Phillips v De Klerk 1983 TPD (unreported)

Pop v Revelas 1999 W (unreported)

Preddy and Another v Health Professions Council of South Africa 2008 (4) SA 434 (SCA)

Premier, Western Cape v Faircape Property Developers (Pty) Ltd 2003 (6) SA 13 (SCA)

Pringle v Administrator, Transvaal 1990 (2) SA 379 (W)

Protea Assurance Co Ltd v Lamb 1971 (1) SA 530 (A)

Prowse v Kaplan 1933 EDL 257

R v Van der Merwe 1953 (2) PH H 124 (W)

Ramsay v Minister van Polisie 1981 (4) SA 802 (A)

Recsei's Estate v Meine 1943 EDL 277

Rex v Umfaan 1908 TS 62

Reyneke v Mutual & Federal Insurance Co Ltd 1991 (3) SA 412 (W)

Richter and Another v Estate Hammann 1976 (3) SA 226 (C)

Road Accident Fund v Sauls 2002 (2) SA 55 (SCA)

Rompel v Botha 1953 TPD (unreported)

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

Roux v Health Professions Council of South Africa and Another [2012] 1 All SA 49 (SCA)

S v Binta 1993 (2) SACR 553 (C)

S v Counter 2003 (1) SACR 143 (SCA)

S v Daniëls en 'n Ander 1983 (3) SA 275 (A)

S v Kiti 1994 (1) SACR 14 (E)

S v Kramer 1987 (1) SA 887 (W)

S v Mkwetshana 1965 (2) SA 493 (N)

S v Mokgethi en Andere 1990 (1) SA 32 (A)

S v Nel 1987 TPD (unreported)

S v Sikunyana 1961 (3) SA 549 (E)

S v Tembani 2007 (1) SACR 355 (SCA)

S v V 1972 (3) SA 611 (A)

S v Van As 1967 (4) SA 594 (A)

Santam Versekeringsmaatskappy Bpk v Byleveldt 1973 (2) SA 146 (A)

SA Uitsaaikorporasie v O'Malley 1977 (3) SA 394 (A)

Sea Harvest Corporation (Pty) Ltd v Duncan Dock Cold Storage (Pty) Ltd 2000 (1) SA 827 (SCA)

Shiels v Minister of Health [1974] 3 All SA 116 (RA)

Silva's Fishing Corporation (Pty) Ltd v Maweza 1957 (2) SA 256 (AD)

Siman & Co (Pty) Ltd v Barclays National Bank Ltd 1984 (2) SA 888 (A)

SM Goldstein & Co (Pty) Ltd v Cathkin Park Hotel (Pty) Ltd 2000 (4) SA 1019 (SCA)

Smit v Abrahams 1992 (3) SA 158 (C)

Smit v Abrahams 1994 (4) SA 1 (A)

Smit v SA Vervoerdienste 1984 (1) SA 246 (C)

Soobramoney v Minister of Health, KwaZulu-Natal [1998] 1 All SA 268 (CC)

South African Medical and Dental Council v McLoughlin 1948 (2) SA 355 (A)

Standard Chartered Bank of Canada v Nedperm Bank Ltd 1994 (4) SA 747 (A)

Standard General Insurance Co Ltd v Dugmore 1997 (1) SA 33 (A)

Steenkamp NO v Provincial Tender Board, Eastern Cape 2007 (3) SA 121 (CC)

Stoffberg v Elliot 1923 CPD 148

Sutherland v White 1911 EDL 407

Telematrix (Pty) Ltd t/a Matrix Vehicle Tracking v Advertising Standards Authority SA 2006 (1) SA 461 (SCA)

Thompson v Thompson 2002 (5) SA 541 (W)

Thoroughbred Breeders' Association of SA v Price Waterhouse 2001 (4) SA 551 (SCA)

Tödt v Ipser 1993 (3) SA 577 (A)

Transnet Ltd v Sechaba Photoscan (Pty) Ltd 2005 (1) SA 299 (SCA)

Transnet Ltd t/a Metrorail and Another v Witter 2008 (6) SA 549 (SCA)

Transvaal Provincial Administration v Coley 1925 AD 24

Transvaal & Rhodesian Estates Ltd v Golding 1917 AD 18

Tuck v Commissioner for Inland Revenue 1988 (3) SA 819 (A)

Tucker and Another v SA Medical and Dental Council and Others [1980] 3 All SA 632 (T)

Tulloch v Marsh 1910 TPD 453

Union Government (Minister of Railways & Harbours) v Warneke 1911 AD 657

Universiteit van Pretoria v Tommie Meyer Films (Edms) Bpk 1977 (4) SA 376 (T)

Van Aswegen v Lombard 1965 (3) SA 613 (A)

Van der Merwe v Road Accident Fund and Another (Women's Legal Centre Trust as Amicus Curiae) 2006 (4) SA 230 (CC)

Van Eeden (formerly Nadel) v Minister of Safety & Security 2003 (1) SA 389 (SCA)

Van Wyk v Lewis 1924 AD 438

Verhoef v Meyer 1976 A (unreported)

Veriava v President, SA Medical and Dental Council, and Others 1985 (2) SA 293 (T)

Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd 2003 (4) SA 285 (SCA)

Weber v SANTAM Versekeringsmpy Bpk 1983 (1) SA 381 (A)

Whittaker v Roos & Bateman; Morant v Roos & Bateman 1912 AD 92

Williams v Oosthuizen 1981 (4) SA 182 (C)

Secondary Sources of Law

Books

Bilchitz D (2006) 'Health' in Woolman S & Bishop M (eds) *Constitutional Law of South Africa* Cape Town: Juta

Boberg PQR (1984) *The Law of Delict: Aquilian Liability* Cape Town: Juta

Burchell JM (1993) *Principles of Delict* Cape Town: Juta

Calabresi G (1970) *The Cost of Accidents: A Legal and Economic Analysis* New Haven CT: Yale University Press

Carstens PA & Pearmain DL (2007) *Foundational Principles of South African Medical Law* Durban: LexisNexis

Claassen NJB & Verschoor T (1992) *Medical Negligence in South Africa* Pretoria: Digma

Cronjé-Retief M (2000) *The Legal Liability of Hospitals* Boston: Kluwer Law International

Dada MA & McQuoid-Mason DJ (eds) (2001) *Introduction to Medico-Legal Practice* Durban: Butterworths

Dhai A & McQuoid-Mason DJ (2011) *Bioethics, Human Rights and Health Law: Principles and Practice* Cape Town: Juta

Erasmus HJ & Gauntlett JJ (2004) 'Damages' in Joubert WA (ed) *The Law of South Africa* Durban: LexisNexis

Giesen D (1988) *International Malpractice Law: A Comparative Study of Civil Liability Arising from Medical Care* Dordrecht: Martinus Nijhoff Publishers

Gordon I, Turner R & Price TW (1953) *Medical Jurisprudence* Edinburgh: Livingston

International Labour Organisation (1999) *Modelling in Health Care Finance: A Compendium of Quantitative Techniques for Health Care Financing* Geneva: International Labour Office

Kohn LT, Corrigan JM & Donaldson MS (eds) (2000) *To Err Is Human: Building a Safer Health System* Washington DC: National Academy Press

Neethling J & Potgieter JM (2010) *Deliktereg* Durban: LexisNexis

Mcquoid-Mason DJ (2008) 'Medical Professions and Practice' in Joubert WA (ed) *The Law of South Africa*: LexisNexis

Midgley JR & Van Der Walt JC (2005) 'Delict' in Joubert WA (ed) *The Law of South Africa* Durban: LexisNexis

Nadasen S (2000) *Public Health Law in South Africa: An Introduction* Durban: Butterworths

Pearmain D (2008) *The Law of Medical Schemes in South Africa* Cape Town: Juta

Reason J (1997) *Managing the Risks of Organizational Accidents* Aldershot: Ashgate

Slabbert MN 'South Africa' in Blanpain R & Nys H (eds) (2011) *International Encyclopaedia of Laws: Medical Law* Netherlands: Kluwer Law International

Strauss SA (1991) *Doctor, Patient and the Law: A Selection of Practical Issues* Pretoria: Van Schaik

Strauss SA & Strydom MJ (1967) *Die Suid-Afrikaanse Geneeskundige Reg* Pretoria: Van Schaik

Van den Heever P & Carstens PA (2011) *Res Ipsa Loquitur & Medical Negligence: A Comparative Survey* Cape Town: Juta

Van der Walt JC & Midgley JC (2005) *Principles of Delict* Durban: LexisNexis

Van Rensburg (2004) *Health and Health Care in South Africa* Pretoria: Van Schaik

Verschoor T & Alberts RW (1990) *Verdicts of the Medical Council* Pretoria: Digma

Verschoor T & Oosthuizen H (1990) *Handbook of the Rules and Regulations for Medical Practitioners and Dentists* Pretoria: Digma

Vincent C (2010) *Patient Safety* West Sussex: Wiley-Blackwell

Visser PJ & Potgieter JM (2003) *Law of Damages* Landsdowne: Juta

Weiler PC, Hiatt HH, Newhouse JP, Johnson WG, Brennan TA & Leape LL (1993) *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* Cambridge MA: Harvard University Press

Academic Articles

Aasland OG & Førde R "Impact of feeling responsible for adverse events on doctors' personal and professional lives: the importance of being open to criticism from colleagues" (2005) 14 *Quality and Safety in Health Care* 13

Aranaz-Andrés JM, Aibar-Remón C, Limón-Ramírez R, Amarilla A, Restrepo FR, Urroz O, Sarabia O, García-Corcuera LV, Terol-García E, Agra-Varela Y, Gonseth-García J, Bates DW & Larizgoitia I “Prevalence of adverse events in the hospitals of five Latin American countries: results of the ‘Iberoamerican study of adverse events’ (IBEAS)” (2011) 20 *Quality and Safety in Healthcare* 1043

Aranaz-Andrés JM, Aibar-Remón C, Vitaller-Murillo J, Ruiz-López P, Limón-Ramírez, R & Terol-García E “Incidence of adverse events related to health care in Spain: results of the Spanish National Study of Adverse Events” (2008) 62 *Journal of Epidemiology and Community Health* 1022

Baker GR, Norton PG, Flintoft V, Blais R, Brown A, Cox J, Etchels E, Ghali WA, Hébert P, Majumdar SR, O’Beirne M, Palacios-Derflinger L, Reid RJ, Sheps S & Tamblyn R “The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada” (2004) 170 *Canadian Medical Association Journal* 1678

Bark P, Vincent C, Olivieri L & Jones A “Impact of litigation on senior clinicians: implications for risk management” (1997) 6 *Quality in Health Care* 7

Barringer PJ, Studdert DM, Kachalia AB & Mello MM “Administrative compensation of medical injuries: a hardy perennial blooms again” (2008) 33 *Journal of Health Politics, Policy and Law* 725

Bateman C “Medical negligence pay-outs soar by 132% – subs follow” (2011) 101 *The South African Medical Journal* 216

Bateman C “Will our public healthcare sector fail the NHI?” (2012) 102 *The South African Medical Journal* 817

Bates DW, Spell N, Cullen DJ, Burdick E, Laird N, Petersen LA, Small SD, Sweitzer BJ & Leape LL “The costs of adverse drug events in hospitalized patients” (1997) 277 *JAMA: The Journal of the American Medical Association* 307

Beckman HB, Markakis KM, Suchman AL & Frankel RM “The doctor-patient relationship and malpractice: lessons from plaintiff depositions” (1994) 154 *Archives of Internal Medicine* 1365

Berwick DM “Payment by capitation and the quality of care” 335 *The New England Journal of Medicine* 1227

Berwick DM & Leape LL “Reducing errors in medicine: It’s time to take this more seriously” (1999) 319 *BMJ* 136

Bovbjerg RR, Miller RH & Shapiro DW “Paths to reducing medical injury: professional liability and discipline vs. patient safety—and the need for a third way” (2001) 29 *The Journal of Law, Medicine & Ethics* 369

Bown S “Counting the cost of litigation” (2012) 20 *Casebook* 9

Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, Newhouse JP, Weiler PC & Hiatt HH “Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I” (1991) 324 *The New England Journal of Medicine* 370

Carrin G, Mathauer I, Xu K & Evans DB “Universal coverage of health services: tailoring its implementation” (2008) 86 *Bulletin of the World Health Organization* 857.

Carstens PA “Judicial recognition of substandard medical treatment in South African public hospitals: the slippery slope of policy considerations and implications for liability in the context of criminal medical negligence” (2008) 23 *SA Public Law* 168

Carstens PA “Judicial recognition of the application of the maxim *res ipsa loquitur* to a case of medical negligence *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (unreported as yet, Case Number: 2009/52394 (GSJ) dated 24 October 2012)” (2013) 34 *Obiter* 548

Carstens PA “The locality rule in medical practice” (1990) *De Rebus* 421

Carstens PA & Kok A “An assessment of the use of disclaimers by South African hospitals in view of constitutional demands, foreign law and medico-legal considerations” (2003) 18 *SA Public Law* 430

Charles SC, Wilbert JR & Franke KJ “Sued and nonsued physicians' self-reported reactions to malpractice litigation” (1985) 142 *The American Journal of Psychiatry* 437

Chopra M, Lawn JE, Sanders D, Barron P, Abdool Karim SS, Bradshaw D, Jewkes R, Abdool Karim Q, Flisher AJ, Mayosi BM, Tollman SM, Churchyard GJ & Coovadia H “Achieving the health Millennium Development Goals for South Africa: challenges and priorities” (2009) 374 *The Lancet* 1023

Coetzee EJ “The spectre of litigation - a dark cloud on the obstetric horizon” (2010) 20 *Obstetrics and Gynaecology Forum* 109

Coetzee LC & Carstens PA “Medical malpractice and compensation in South Africa” (2011) 86 *Chicago-Kent Law Review* 1263

Coovadia H, Jewkes R, Barron P, Sanders D & McIntyre D “The health and health system of South Africa: historical roots of current public health challenges” (2009) 374 *The Lancet* 817.

Davis PB, Lay-Yee R, Briant RH, Ali W, Scott AJ & Schug S “Adverse events in New Zealand public hospitals I: occurrence and impact” (2002) 115 *New Zealand Medical Journal*

De Villiers P “Protecting the public, the HPCSA or the Profession?” (2000) 22 *South African Family Practice* 2

Dinnie D “Exposure to the consumer court under the Consumer Protection Act - more litigation for the medical industry?” (2009) 2 *South African Journal of Bioethics and Law* 43

Du Toit K & Carnelley M “ICD diagnostic codes and the constitutional rights of patients” (2007) 28 *Obiter* 537

Engelbrecht B & Crisp N “Improving the performance of the health system” (2010) *South African Health Review* 195

Entman SS, Glass CA, Hickson GB, Githens PB, Whetten-Goldstein K & Sloan FA “The relationship between malpractice claims history and subsequent obstetric care” (1994) 272 *JAMA: The Journal of the American Medical Association* 1588

Forster HP, Schwartz J & DeRenzo E “Reducing legal risk by practicing patient-centered medicine” (2002) 162 *Archives of Internal Medicine* 1217

Gallagher TH, Studdert D & Levinson W “Disclosing harmful medical errors to patients” (2007) 356 *The New England Journal of Medicine* 2713

Gallagher TH, Waterman AD, Ebers AG, Fraser VJ & Levinson W “Patients' and physicians' attitudes regarding the disclosure of medical errors” (2003) 289 *JAMA: The Journal of the American Medical Association* 1001

Gostin L (2000) “A public health approach to reducing error: medical malpractice as a barrier” (2000) 283 *JAMA: The Journal of the American Medical Association* 1742

Heywood M “Crumbling provincial health departments cost lives and will affect NSP outcomes” (2012) 5 *NSP Review* 1

Hickson GB, Clayton EW, Githens PB & Sloan FA “Factors that prompted families to file medical malpractice claims following perinatal injuries” (1992) 267 *JAMA: The Journal of the American Medical Association* 1359

Hickson GB, Federspiel CF, Pichert JW, Miller CS, Gauld-Jaeger J & Bost P “Patient complaints and malpractice risk” (2002) 287 *The Journal of the American Medical Association* 2951

Howarth G “Obstetric risk avoidance: Will anyone be offering obstetrics in private practice by the end of the decade?” (2013) 103 *The South African Medical Journal* 513

Howarth G “The rising cost of litigation; a threat to private obstetric care?” (2013) 4 *Obstetrics and Gynaecology Forum* 33

Howarth G “The threat of litigation: private obstetric care - *quo vadis?*” (2011) 4 *South African Journal of Bioethics and Law* 85

Howarth G, Bown S & Whitehouse S “The importance of comprehensive protection in today’s healthcare environment” (2013) 103 *The South African Medical Journal* 453

Howarth G & Davidow R “Don’t be consumed by new Act” (2010) 18 *Casebook* 12

Jena AB, Seabury S, Lakdawalla D & Chandra A “Malpractice risk according to physician specialty” (2011) 365 *The New England Journal of Medicine* 629

Kachalia A, Kaufman SR, Boothman R, Anderson S, Welch K, Saint S & Rogers MA “Liability claims and costs before and after implementation of a medical error disclosure program” (2010) 153 *Annals of Internal Medicine* 213

Kessler D & McClellan M “Do doctors practice defensive medicine?” (1996) 111 *The Quarterly Journal of Economics* 353

Khumalo F “Health management information systems” (2006) *South African Health Review* 65

Klaaren J “Non-citizens and equality” (1998) 14 *South African Journal on Human Rights* 286.

Kraman SS & Hamm G “Risk management: extreme honesty may be the best policy” (1999) 131 *Annals of Internal Medicine* 963

Kritzer HM “Contingency fee lawyers as gatekeepers in the civil justice system” (1997) 81 *Judicature* 22

Lagomarsino G, Garabrant A, Adyas A, Muga R & Otoo N “Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia” (2012) 380 *The Lancet* 933

Lamb RM, Studdert DM, Bohmer RM, Berwick DM & Brennan TA “Hospital disclosure practices: results of a national survey” (2003) 22 *Health Affairs* 73

Lambert TW, Davidson JM, Evans J & Goldacre MJ “Doctors' reasons for rejecting initial choices of specialties as long-term careers” (2003) 37 *Medical Education* 312

Leape LL, Brennan TA, Laird N, Lawthers AG, Localio AR, Barnes BA, Hebert L, Newhouse JP, Weiler PC & Hiatt H “The nature of adverse events in hospitalized patients: results of the Harvard Medical Practice Study II” (1991) 324 *The New England Journal of Medicine* 377

Letaief M, El Mhamdi S, El-Asady R, Siddiqi S & Abdullatif A “Adverse events in a Tunisian hospital: results of a retrospective cohort study” (2010) 22 *International Journal for Quality in Health Care* 380

Levinson W, Roter DL, Mullooly JP, Dull VT & Frankel RM “Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons” (1997) 277 *JAMA: The Journal of the American Medical Association* 553

Localio AR, Lawthers AG, Brennan TA, Laird NM, Hebert LE, Peterson LM, Newhouse JP, Weiler PC & Hiatt HH “Relation between malpractice claims and adverse events due to negligence: results of the Harvard Medical Practice Study III” (1991) 325 *The New England Journal of Medicine* 245

MacLennan A, Nelson KB, Hankins G & Speer M “Who will deliver our grandchildren?: Implications of cerebral palsy litigation” (2005) 294 *JAMA: The Journal of the American Medical Association* 1688

Malherbe J “Counting the cost: The consequences of increased medical malpractice litigation in South Africa” (2013) 2 *The South African Medical Journal* 83

Malherbe R & Van Eck M “The State's failure to comply with its constitutional duties and its impact on democracy” (2009) 2 *Tydskrif vir die Suid-Afrikaanse Reg* 209

Matshidze P & Hanmer L “Health information systems in the private health sector” (2007) *South African Health Review* 89

Matsoso MP & Fryatt R “National Health Insurance: the first 18 months: legislation and financing” (2012) *South African Health Review* 21

McQuoid-Mason D “Establishing liability for harm caused to patients in a resource-deficient environment” (2010) 100 *The South African Medical Journal* 573

McQuoid-Mason D “Hospital exclusion clauses limiting liability for medical malpractice resulting in death or physical or psychological injury: what is the effect of the Consumer Protection Act?” (2012) 5 *South African Journal of Bioethics and Law* 65

Mello MM & Brennan TA “Deterrence of medical errors: theory and evidence for malpractice reform” (2001) 80 *Texas Law Review* 1595

Mello MM & Kelly CN “Effects of a professional liability crisis on residents' practice decisions” (2005) 105 *Obstetrics & Gynecology* 1287

Mello MM, Studdert DM, DesRoches CM, Peugh J, Zapert K, Brennan TA & Sage WM “Effects of a malpractice crisis on specialist supply and patient access to care” (2005) 242 *Annals of Surgery* 621

Mello MM, Studdert DM, Thomas EJ, Yoon CS & Brennan T “Who pays for medical errors? An analysis of adverse event costs, the medical liability system, and incentives for patient safety improvement” (2007) 4 *Journal of Empirical Legal Studies* 835

Mendes W, Martins M, Rozenfeld S & Travassos C “The assessment of adverse events in hospitals in Brazil” (2009) 21 *International Journal for Quality in Health Care* 279

Meng Q, Yuan B, Jia L, Wang J, Yu B, Gao J & Garner P “Expanding health insurance coverage in vulnerable groups: a systematic review of options” (2011) 26 *Health Policy and Planning* 93

Merenstein D “Winners and losers” (2004) 291 *JAMA: The Journal of the American Medical Association* 15

Michel P, Quenon JL, Djihoud A, Tricaud-Vialle S & de Sarasqueta AM “French national survey of inpatient adverse events prospectively assessed with ward staff” (2007) 16 *Quality and Safety in Health Care* 369

Miller FH “Medical malpractice litigation: do the British have a better remedy” (1985) 11 *American Journal of Law & Medicine* 433

Mills A, Ally M, Goudge J, Gyapong J & Mtei G “Progress towards universal coverage: the health systems of Ghana, South Africa and Tanzania” (2012) 27 *Health Policy and Planning* i4

Mkhize B “HPCSA: A mess in the Health Department's pocket” (2009) 99 *The South African Medical Journal* 484

Naude T & Lubbe G “Exemption clauses - a rethink occasioned, *Afrox Healthcare Bpk v Strydom*” (2005) 122 *South African Law Journal* 441

Ncayiyana DJ “Compensation for injury from medical treatment is a social justice obligation” (2004) 95 *The South African Medical Journal* 304

Neethling J “State (public authority) liability ex delicto (1)” (2012) 75 *Tydskrif vir Hedendaagse Romeins-Hollandse Reg* 622

Ngwena C “The historical development of the modern South African health-care system: from privilege to egalitarianism” (2004) 2 *De Jure* 290

Olivier NJJ & Williams C “State liability for final court orders sounding in money: at long last alignment with the Constitution” (2011) 32 *Obiter* 489

Pepper MS & Slabbert MN “Is South Africa on the verge of a medical malpractice litigation storm?” (2011) 4 *South African Journal of Bioethics and Law* 29

Pieterse M “Foreigners and socio-economic rights: Legal entitlements or wishful thinking?” (2000) 63 *Tydskrif Vir Hedendaagse Romeins-Hollandse Reg* 51

Pieterse M “Health care rights, resources and rationing” (2007) 124 *South African Law Journal* 514

Reason J “Human error: models and management” (2000) 320 *BMJ* 768

Rowe K & Moodley K “Patients as consumers of health care in South Africa: the ethical and legal implications” (2013) 14 *BMC Medical Ethics* 15

Sacket DL, Rosenberg WM, Gray JA, Haynes RB & Richardson WS “Evidence based medicine: what it is and what it isn't” (1996) 312 *BMJ* 71

Sage WM “Medical liability and patient safety” (2003) 22 *Health Affairs* 26

Schiøler T, Lipczak H, Pedersen BL, Mogensen TS, Bech KB, Stockmarr A, Svenning AR & Frølich A “Incidence of adverse events in hospitals. A retrospective study of medical records” (2001) 163 *Ugeskr Laeger* 5370

Schwartz GT “Reality in the economic analysis of tort law: does tort law really deter” (1994) 42 *UCLA Law Review* 377

Seggie J “The 'boom' in medical malpractice claims – patients could be the losers” (2013) 103 *The South African Medical Journal* 433

Shapiro RS, Simpson DE, Lawrence SL, Talskie AM, Sobocinski KA & Schiedermayer DL “A survey of sued and nonsued physicians and suing patients” (1989) 10 *Archives of Internal Medicine* 2190

Shuping S & Kabane S “Public-private partnerships: A case study of the Pelonomi and Universitas hospital co-location project” (2007) *South African Health Review* 151

Slabbert MN, Maister B, Botes M & Pepper MS “The application of the Consumer Protection Act in the South African health care context: concerns and recommendations” (2011) 44 *Comparative and International Law Journal of Southern Africa* 168

Slabbert MN & Pepper MS “The Consumer Protection Act: no-fault liability of health care providers” (2011) 101 *The South African Medical Law Journal* 800

Sloan FA & Hsieh CR “Variability in medical malpractice payments: is the compensation fair?” (1990) 24 *Law & Society Review* 997

Steenekamp TJ “The progressivity of personal income tax in South Africa since 1994 and directions for tax reform” (2012) 16 *Southern African Business Review* 39

Stevenson DG, Spittal M J & Studdert DM “Does litigation increase or decrease health care quality?: a national study of negligence claims against nursing homes” (2013) 51 *Medical Care* 430

Strauss SA “Geneesheer, pasiënt en die reg: 'n delikate driehoek” (1987) 1 *Tydskrif vir die Suid-Afrikaanse Reg* 1

Strauss SA “The physician’s liability form malpractice: a fair solution to the problem of proof?” (1967) 84 *The South African Law Journal* 419

Studdert DM & Brennan TA “No-fault compensation for medical injuries: the prospect for error prevention” (2001) 286 *JAMA: The Journal of the American Medical Association* 217

Studdert DM, Mello MM & Brennan TA “Medical Malpractice” (2004) 350 *The New England Journal of Medicine* 283

Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, Puopolo AL & Brennan TA "Claims, errors, and compensation payments in medical malpractice litigation" (2006) 354 *The New England Journal of Medicine* 2024

Studdert DM, Mello MM, Sage WM, DesRoches CM, Peugh J, Zapert K & Brennan TA "Defensive medicine among high-risk specialist physicians in a volatile malpractice environment" (2005) 293 *JAMA: The Journal of the American Medical Association* 2609

Studdert DM, Thomas EJ, Burstin HR, Zbar BI, Orav EJ & Brennan TA "Negligent care and malpractice claiming behavior in Utah and Colorado" (2000) 38 *Medical care* 250-260

Summerton N "Positive and negative factors in defensive medicine: a questionnaire study of general practitioners" (1995) 310 *BMJ* 27

Taitz JR "Review of the disciplinary proceedings of the Medical and Dental Council" (1988) 105 *South African Law Journal* 25

Taitz JR "The disciplinary powers of the South African Medical and Dental Council" (1988) *Acta Juridica* 40

Taragin MI, Willett LR, Wilczek AP, Trout R & Carson JL "The influence of standard of care and severity of injury on the resolution of medical malpractice claims" (1992) 117 *Annals of Internal Medicine* 780

Tedstone JE & Tarrier N "Posttraumatic stress disorder following medical illness and treatment" (2003) 23 *Clinical Psychology Review* 409

Thomas EJ, Studdert DM, Burstin HR, Orav EJ, Zeena T, Williams EJ, Howard KM, Weiler PC & Brennan TA "Incidence and types of adverse events and negligent care in Utah and Colorado" (2000) 38 *Medical Care* 261

Van den Heever A "A financial feasibility review of National Health Insurance proposals for South Africa" (2010) *South African Health Review* 157

Van den Heever P "Impact of the Consumer Protection Act in the health care context" (2012) *De Rebus* 22

Van Niekerk JP “HPCSA: A mess in the Health Department’s pocket” (2009) 99 *The South African Medical Journal* 203

Van Oosten FFW “*Castell v De Greef* and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy” (1995) *De Jure* 164.

Vincent C “Research into medical accidents: a case of negligence?” (1989) 299 *BMJ* 1150

Vincent C “Understanding and responding to adverse events” (2003) 348 *The New England Journal of Medicine* 1051

Vincent C & Coulter A “Patient safety: what about the patient?” (2002) 11 *Quality and Safety in Healthcare* 76

Vincent C, Neale G & Woloshynowych M “Adverse events in British hospitals: preliminary retrospective record review” (2001) 322 *BMJ* 517

Vincent C, Phillips A & Young M “Why do people sue doctors? A study of patients and relatives taking legal action” (1994) 343 *The Lancet* 1609

Wadee H & Khan F “Human resources for health” (2007) *South African Health Review* 141

Weiler PC “The case for no-fault medical liability” (1993) 52 *Maryland Law Review* 908

Welz D “The boundaries of medical-therapeutic privilege” (1999) 116 *South African Law Journal* 299

Wilson M “When is a risk of medical treatment material?” (2006) *De Rebus* 22

Wilson RM, Michel P, Olsen S, Gibberd RW, Vincent C, El-Assady R, *et al* “Patient safety in developing countries: retrospective estimation of scale and nature of harm to patients in hospital” (2012) 344 *BMJ*

Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD “The quality in Australian health care study” (1995) 163 *Medical Journal of Australia* 458

Whitehouse S “Counting the costs of GP claims” (2013) 1 *Practice Matters* 9

Whittaker S, Shaw C, Spieker N & Linegar A “Quality standards for healthcare establishments in South Africa” (2011) *South African Health Review* 59

Wolfaardt G, Van Niftrik J, Beira B, Mapham W & Stander T “The role of private and other non-governmental organisations in primary health care” (2008) *South African Health Review* 223

Zegers M, De Bruijne MC, Wagner C, Hoonhout LHF, Waaijman R, Smits M, Hout FAG, Zwaan L, Christiaans-Dingelhoff I, Timmermans DRM, Groenewegen PP & van der Wal G “Adverse events and potentially preventable deaths in Dutch hospitals: results of a retrospective patient record review study” (2009) 18 *Quality and Safety in Health Care* 297

Reports and Official Publications

Actuarial Society of South Africa (2010) Discussion Document: Burden of Disease: Actuarial Society of South Africa NHI Model. 8 March 2010

African National Congress (1994) A National Health Plan for South Africa. 30 May 1994

African National Congress (2009) National Health Insurance Policy Proposal. 22 June 2009

African National Congress (2010) General Council: Additional Discussion Documents. 20-24 September 2010

Centre for Development and Enterprise (2011) Reforming Healthcare in South Africa: What Role for the Private Sector? November 2011

Council for Medical Schemes (2009) Annual Report 2008-2009

Council for Medical Schemes (2011) Annual Report 2010-2011

Council for Medical Schemes (2012) Annual Report 2012-2013

Development Bank of South Africa (2008) A Roadmap for the Reform of the South African Health System

Eastern Cape Department of Health (2009) Annual Report 2009/2010

Eastern Cape Department of Health (2010) Annual Report 2010/2011

Econex (2010) Health Reform Note 6: Provider Payment Systems. September 2010

Econex (2010) Health Reform Note 7: Updated GP and Specialist Numbers for SA. October 2010

Econex (2011) Health Reform Note 15: National Health Systems: Public Service vs. Insurance-Based Models. September 2011

Econex (2012) Research Note 27: Public vs. Private Health Sector Rationing Mechanisms: Theoretical and Practical Considerations. April 2012

Econex (2013) The South African Private Healthcare Sector: Role and Contribution to the Economy. November 2013

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

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

Gauteng Department of Health (2012) Annual Report 2012/2013

Gupta S, Davoodi HR & Tiongson ER (2000) Corruption and the Provision of Health Care and Education Services. IMF Working Paper. June 2000

Health Professions Council of South Africa (2008) Annual Report 2008/2009

Health Professions Council of South Africa (2010) Annual Report 2010/2011

Health Professions Council of South Africa (2011) Annual Report 2011/2012

Health Professions Council of South Africa (2012) Media Statement: HPCSA embarks on health and human rights awareness campaign. 19 March 2012

Health Systems Trust (2012) National Health Care Facilities Baseline Audit: National Summary Report. September 2012

KwaZulu-Natal Department of Health (2012) Annual Report 2012/2013

McLeod H, Grobler P & Van den Berg S (2010) Preliminary Estimate of NHI Costing in 2009 Rand Terms: Methodology and Assumptions: A briefing paper prepared for National Treasury. 18 February 2010

National Committee for Confidential Enquiries in Maternal Deaths (2012) Saving Mothers 2008–2010: Fifth report on the confidential enquiries into maternal deaths in South Africa. 15 April 2011

National Department of Health (2010) National Strategic Plan 2010/11-2012/13

National Department of Health (2010) Negotiated Service Delivery Agreement (NSDA) 2010-2014

National Department of Health (2011) National Health Insurance Conference: Lessons for South Africa. National Consultative Health Forum (NCHF). Johannesburg, South Africa. 7-8 December 2011

National Department of Health (2012) eHealth Strategy South Africa 2012/13-2016/17

National Department of Health (2011) Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17. 11 October 2011

National Department of Health (2011) National Core Standards for Health Establishments in South Africa

National Perinatal Morbidity and Mortality Committee (2011) Triennial Report 2008-2010. June 2011

National Planning Commission (2012) National Development Plan 2030: Our Future - Make It Work

National Treasury (2012) Budget Speech, delivered by the Minister of Finance, Pravin Gordhan. 22 February 2012

National Treasury (2012) GEMS Annual Symposium: Financing NHI and Pilot Districts. Sandton, South Africa. 15-16 August 2012

National Treasury (2013) Budget Speech, delivered by the Minister of Finance, Pravin Gordhan. 27 February 2013

National Treasury & South African Revenue Service (2013) Tax Statistics 2013

Northern Cape Department of Health (2005) Annual Report 2005/2006

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

Parliamentary Question 2013/25A Question Number 627

Section27 (2013) Monitoring Our Health: An Analysis of the Breakdown of Health Care Services in selected Gauteng Facilities: A Report for the Period January - December 2012. 4 March 2013

Task Team on National Health Insurance (2009) National Health Insurance Plan for South Africa. 16 February 2009.

Treatment Action Campaign and Section27 (2013) Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System. 11 September 2013.

Van den Heever (2011) Evaluation of the Green Paper on National Health Insurance. 20 December 2011

Vital Wave Consulting (2009) Health Information Systems in Developing Countries: A Landscape Analysis. May 2009

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

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

World Health Organisation (1987) Declaration of Alma Ata. International Conference on Primary Health Care. Alma-Ata, USSR. 6-12 September 1978

World Health Organization (1992) International Classification of Diseases and Related Health Problems 10th Revision

World Health Organisation (2000) The World Health Report 2000: Health Systems: Improving Performance

World Health Organisation (2005) *The World Health Report 2005: Make Every Mother and Child Count*

World Health Organisation (2010) *The World Health Report 2010: Health Systems Financing: The Path to Universal Coverage*

World Health Organisation (2013) *World Health Statistics 2013*

Theses

Carstens PA (1996) *Die Straftelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid* (Unpublished LLD Thesis, University of Pretoria)

Claassen NJB (2011) *Negotiorum Gestio by Geneeskundige Ingrepe* (Unpublished LLD Thesis, Universiteit van die Vrystaat)

Lerm H (2008) *A Critical Analysis of Exclusionary Clauses in Medical Contracts* (Unpublished LLD Thesis, University of Pretoria)

Pearmain DL (2004) *A Critical Analysis of the Law on Health Service Delivery in South Africa* (Unpublished LLD Thesis, University of Pretoria)

Redelinghuys IF (2005) *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, University of Pretoria)

Van den Heever P (2002) *The Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Actions: A Comparative Survey* (Unpublished LLD Thesis, University of Pretoria)

Van Oosten FFW (1989) *The Doctrine of Informed Consent in Medical Law* (Unpublished LLD Thesis, UNISA)

Foreign Case Law

Greenland v Chaplin (1850) 5 Ex 243

In re Polemis v Furness, Withy & Co Ltd 1921 3 KB 560 (CA)

Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co Ltd [1961] AC 388 (PC)

Rigby v Hewitt (1850) 5 Ex 240

Smith v London & South Western Railway Co (1870) LR 6 CP 14

Weld-Blundell v Stephens 1920 AC 956

Newspaper Reports

Child K “Hospital horrors costing SA plenty” *The Times* 17 January 2014

Gernetzky K “Patients 'need educating on rights, responsibilities'” *Business Day* 20 March 2012

Govender P “Brain damage leads to SA's highest-ever medical payout” *Sunday Times* 16 June 2013

Naidoo S “Thousands of doctors ‘negligent’” *Sunday Times* 6 June 2010

Skiti S “EC pays R50m in health claims” *Daily Dispatch* 2 September 2011

Internet Sources

“248 doctors found guilty of incompetence” Times Live 19 October 2012.

<http://www.timeslive.co.za/Feeds/inethealth/article6946309.ece>

African National Congress (2007) 52nd National Conference: Resolutions. 20 December 2007. <http://www.anc.org.za/show.php?id=2536#social>

African National Congress (2009) ANC Today (Vol. 9 No. 3). National Health Insurance: A revolution in health care. 23-29 January 2009. <http://www.anc.org.za/docs/anctoday/2009/at03.htm>

“Bara facing 86 medical negligence claims – Jack Bloom” Politicsweb 16 January 2014.

<http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71616/page71654?oid=512696&sn=Detail&pid=71654>

“Botched operations blight SA” The Sunday Independent 2 May 2010.

<http://www.iol.co.za/news/south-africa/botched-operations-blight-sa-1.482422>

Correspondence between the Coordinator of the NEC Subcommittee for Education and Health and the Secretary General of the ANC. 13 July 2009. <http://www.health-e.org.za/wp-content/uploads/2013/05/5b5e24462cdf6e214072c2e3f92ab1b9.pdf>

“Gauteng DoH faces R3.7bn in legal claims - Jack Bloom” Politicsweb 17 November 2013.

<http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=457441&sn=Detail&pid=71619>

“How Limpopo was looted – the inside story” CityPress 14 July 2012.

<http://www.citypress.co.za/politics/how-limpopo-was-looted-the-inside-story-20120714/>

“Health professionals smacked on the wrist” Mail & Guardian 3 January 2014.

<http://mg.co.za/article/2014-01-02-health-professionals-smacked-on-the-wrist>

“Health Professions Council tried to stop exposure of Eastern Cape health crisis” Daily Maverick 5 November 2013. <http://www.dailymaverick.co.za/article/2013-11-05-health-professions-council-tried-to-stop-exposure-of-eastern-cape-health-crisis/>

“HPCSA and Docs – a Relationship on the Rocks?” Medical Chronicle 3 September 2012. <http://www.medicalchronicle.co.za/hpcsa-and-docs-a-relationship-on-the-rocks/>

“HPCSA 'protecting' hypocritical oafs” Mail & Guardian 2 August 2013. <http://mg.co.za/article/2013-08-02-00-hspca-protecting-hypocritical-oafs>

“HPCSA’s ‘Report a doc’ campaign likely to hike medical costs” Medical Chronicle 7 May 2012. <http://www.medicalchronicle.co.za/hpcsa%E2%80%99s-%E2%80%98report-a-doc%E2%80%99-campaign-likely-to-hike-medical-costs/>

“HPCSA responds to campaign criticism” Medical Chronicle 4 June 2012. <http://www.medicalchronicle.co.za/hpcsa-responds-to-campaign-criticism/>

“KZN health faces 1 356 legal claims” CityPress 5 September 2013. <http://www.citypress.co.za/news/kzn-health-faces-1-356-legal-claims/>

“Litigation: a Killer Epidemic with no Cure?” Medical Chronicle 6 August 2012. <http://www.medicalchronicle.co.za/litigation-a-killer-epidemic-with-no-cure/>

“Medical litigation: A national health crisis requiring urgent solutions” Medical Chronicle 7 November 2011. <http://www.medicalchronicle.co.za/medical-litigation-a-national-health-crisis-requiring-urgent-solutions/>

“Medical schemes move to address regulatory backlog” Business Day 20 August 2013. <http://www.bdlive.co.za/business/healthcare/2013/08/20/medical-schemes-move-to-address-regulatory-backlog>

“Most districts in NHI study have failed to spend their budgets” Business Day 24 July 2013. <http://www.bdlive.co.za/national/health/2013/07/24/most-districts-in-nhi-study-have-failed-to-spend-their-budgets>

“Motsoaledi wages war against lawyers” Medical Chronicle 10 October 2011. <http://www.medicalchronicle.co.za/motsoaledi-wages-war-against-lawyers/>

MPS (2014) Subscription Rates 1 January – 31 December 2014.
<http://www.medicalprotection.org/southafrica/membership/subscription>

“National Health Insurance ‘not the end’ of medical schemes industry” Business Day 20 August 2013. <http://www.bdlive.co.za/national/health/2013/08/20/national-health-insurance-not-the-end-of-medical-schemes-industry>

“No cover for GPs performing fetal anomaly scans” Medical Chronicle 11 June 2013. <http://www.medicalchronicle.co.za/no-cover-for-gps-performing-fetal-anomaly-scans/>

“Primary healthcare will be heartbeat of NHI, says health minister” Business Day 16 October 2013. <http://www.bdlive.co.za/national/health/2013/10/16/primary-healthcare-will-be-heartbeat-of-nhi-says-health-minister>

“Province pays for negligence” CityPress 17 August 2011. <http://www.citypress.co.za/news/province-pays-for-negligence-20110817/>

“Public, private hospital costs ‘similar’” Business Day 29 October 2013. <http://www.bdlive.co.za/national/health/2013/10/29/public-private-hospital-costs-similar>

“Treasury’s NHI discussion document nearly ready” Business Day 23 October 2013. <http://www.bdlive.co.za/national/health/2013/10/23/treasurys-nhi-discussion-document-nearly-ready>

Uniform Patient Fee Schedule: Explanation of the current policy regarding the classification of patients for the determination of fees. <http://www.health.gov.za/docs/programes/2012/appendixH.pdf>