AN ANALYSIS OF THE RISING CASES OF MEDICAL MALPRACTICE LITIGATION IN SOUTH AFRICA AND MEANS OF STEMMING THE TIDE

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SUMMARY

South Africa currently faces a crisis in the health care sector, there is a rapid rise in medical malpractice litigation and the value of the claims is increasing yearly,[1] litigation occurs in both the public and private sectors and the resultant effect is that it is negatively impacting on healthcare delivery,[2] more especially in the public sector, in the private sector the major concern is that the cost of health care increases astronomically as physicians begin to find ways of avoiding litigation which will result in patients incurring more cost .

Effort is being made by the different provincial health Departments and the federal Ministry of health to find ways to manage the problem. The study starts by looking at what it takes to prove a case of medical negligence then on to the pointers that there is indeed an increase in the numbers of medical negligence litigation, this is mostly seen in case law and statistics from national treasury regarding amounts spent in settling claims, some of the cases seen across the Provinces are highlighted including the time taken to finalise the them. The possible reasons why we have a sudden rise in these cases is also interrogated , the entities directly affected by this crisis are the Doctor, patient/patient's family and the health care delivery system, the study brings to the fore how these entities are impacted, then an attempt is made on seeking solutions, from preventive measures to actions that can be taken when the error is noted and when the case is actually in Court, other jurisdictions that have been faced with similar crisis in the past like Canada, the United Kingdom and Sweden provided resources in seeking solution

The suggestions that the Study has put forward are a combination of ideas picked up from what other countries have done, legislative and common law changes here in south Africa that should increase the

[1] "medical negligence litigation: undermining South African Health System" https://www.health24.com/News/Public-Health/medical-malpractice-litigation-undermining-south-africas-health-system-20180417 (accessed 21 February 2019)

[2] Malherbe J, "Counting the cost: The consequences of increased medical malpractice litigation in South Africa" .SAMJ [S.l.], v. 103, n. 2, p. 83-84

burden of proof for patients and prevent lawyers from bringing frivolous cases to Court, also some of the legislative changes like in the State Liability Act is aimed at reducing the financial burden on the government so other socio-economic rights can be met. The fact that a few South African Provinces are already actively trying to save cost on settling claims is reviewed and their methods are recommended to other Provinces

Alternate Dispute resolution as a means of avoiding litigation is also explored, data on its success in the United Kingdom is shown and the benefits are also listed, an approach strongly recommended for South Africa.

The Proposition is that all parties involved must make the best of a bad situation, the doctors involved should become better doctors after a bad experience, the patient should be assisted in recovery and the rest of their life should be as comfortable as possible and in the case of death the family left behind should be adequately compensated, while the state should still be able to manage the resources available to it in an equitable manner while settling claims adequately.

CHAPTER 1

INTRODUCTION.

The population of South Africa as at 2018 was about 57.7 million,[3] and majority of this population patronise the public health facilities, in a General Household Survey 2017 conducted by Stats SA it was found that about seven out of every 10 (71.2%) households used public-health facilities as their first point of access when household members needed healthcare services for an illness or injury.[4]With this huge amount of people attending the public health system and the dearth of health care practitioners there is bound to be mishaps from time to time, medicine being a science that seeks to revert a human disease state to normalcy and a process midwifed by humans it would always be subject to human errors and when an error occurs the patient suffers damage, a damage which will require compensation by law.

The patient who is usually the plaintiff would approach a Court of law to seek redress from an error committed by a health care practitioner or the entire hospital, and if the court rules in favour of the patient the compensation may sound in money. This trend is increasing in South Africa and health authorities both in provincial and national levels are getting concerned as this is gradually beginning to threaten quality health care delivery or even worse cripple it.

The problem is not seen only in the public hospitals, private Hospital and doctors working privately have also seen an increase in these cases[5] as noted by the Medical protection society (MPS) one of the private indemnity companies available in the Country. The study seeks reasons for the rise in medical malpractice litigation from the different stakeholders in the health delivery industry, also the impact of this trend on the entire health delivery system , healthcare providers and the patient who suffered damage as a result of negligent health care delivery will be analysed , while finding ways of managing the problems a balance will

[3] www.statssa.gov.va (accessed 21 Feb 2019).

[4]https://www.gov.za/about-sa/health (accessed 21 February 2019).

[5] "medical negligence litigation: undermining South African Health System" https://www.health24.com/News/Public-Health/medical-malpractice-litigation-undermining-south-africas-health-system-20180417 (accessed 21 February 2019)

need to be met in trying to provide remedy for the victims of medical malpractice and ensuring that while paying damages the state does not compromise health care delivery to the rest of the populace.

Case law provides evidence of increasing no of these cases so some of the interesting cases will be looked at and the reasoning in the judgement analysed, some statutes that affect the topic will be referenced, like the Consumer Protection Act, The state Liability Act, the Contingency fee Act, Protection Of Personal Information Act, National Health Act and the most pertinent being the South Africa Constitution.

The approach of other countries that have faced similar problems has formed a huge part of this work, countries like Canada, Sweden, The United states of America, New Zealand are some of the countries in which their methods were researched in other to find solutions for the problem locally.

In South Africa to prove a case of medical negligence the plaintiff must fulfil all the elements of delict , this may prove quite challenging in certain occasions as medicine is not an exact science and the Causation element of delict may be difficult to satisfy because of the several physiological and biochemical factors that come into play in medicine.

CHAPTER 2

PROVING A CASE OF MEDICAL NEGLIGENCE

As stated in the previous chapter a patient seeking to prove medical negligence will have to fulfil all the elements of delict.

Act or Omission, the health care practitioner or hospital must have acted or omitted to act which resulted in harm to the plaintiff (patient)

Wrongfulness, which is when the act breaches a right of the plaintiff.

Fault, there must be fault on the part of the health care practitioner, meaning that there must have been negligence or intent to cause damage, this is possibly the most important element of delict required to find a healthcare professional or a hospital guilty of malpractice, so it is important to be clear on what is required of the doctor. Carstens and Pearmain see it as professional negligence as against the commonly used term medical malpractice where professional negligence will include not only errors in medical or surgical procedures but including breach in confidentiality, lack of consent and all manners of professional misconduct.[6]

Damage, the patient must have suffered harm

And finally

Causation, there must have been a link between the act or omission and the damage suffered, the factual and legal causations must be met and this is often quite difficult for the plaintiff to prove.

Factual causation is said to apply if when the act of the health care practitioner is wished away, then the damage will not have occurred (*condition sine qua non)* also known as "but for" test, so the health care practitioner is said to be the factual cause of the damage. If the damage remains even if the act of the defendant is thought away then the defendant is said not to be responsible for the damage.

[6] Carstens and Pearmain(2007)*Foundational Principles of South African Medical Law* Durban Lexis Nexis 599

Legal Causation is a bit more complex and a few theories are normally used, two are mentioned here

1. The individualization theory: which looks at all the possible factual causes of the damage and then the factual cause which appears most linked to the damage is regarded as the legal cause

2. The theory of adequate causation: if generally the way things are done in life, in the normal flow of events a particular act will normally result in that damage, then that Act is regarded as the legal cause of the damage.

It is important to mention at this stage the doctrine of *res ipsa loquitor* (the thing speaks for itself), that when there is harm the person (doctor) directly involved in the process is presumed negligent does not necessarily apply in South African law of medical negligence, this was made clear by the Court in *Van Wyk v Lewis* 1924.[7] This doctrine will appear to be in favour of the health care practitioners and may dissuade lawyers from bringing medical negligence cases to court but this is not the case as the numbers of litigations against health care practitioners or hospitals has been on the increase.

As soon as a doctor begins to manage the health needs of a patient then a tacit or express contract exists between them, the tacit contract comes into being without been necessarily pronounced or written down, when the patient sees a private doctor in the rooms the contract is tacit most of the time as doctors do not usually insist on a written contract before consultation begins and if the patient is visiting a hospital they may be made to go into an express contract by signing an admission contract and give some form of consent for surgery.

The standard in South Africa is that a doctor or any other healthcare provider should be able to apply reasonable skill and diligence expected of a reasonable doctor of the same discipline, a doctor is therefore liable if this standard is not met. In *Mitchell v Dixon*,[8] the court was clear that the healthcare provider is expected to treat the patient with reasonable care and not necessarily the highest possible care, so a doctor is negligent if that care expected from any other reasonable doctor of the same speciality

[7] *Van Wyk v Lewis* 1924 EDL 37
[8] *Mitchell v Dixon* 1914 AD 519

is not met, If a damage results from negligent care by a doctor or any healthcare practitioner, then the patient may decide to sue the doctor or health facility in contract or delict. Most of the cases getting to South African Courts are based on delict[9] as noted by Carstens and Pearmain and this is probably due to the fact that in delict when damages are paid both Pecuniary and Non pecuniary cost can be awarded to the patient unlike in contract where only pecuniary cost are paid,[10] Non Pecuniary cost include pain, suffering and all sorts of emotional loss and can amount to huge sums of money, this obviously serves as further motivation for attorneys to bring these matters to Court

In the private sector the doctor is sued directly with or without the hospital while Patients may sue public institutions or doctors working in those public facilities based on the contract with the facility in terms of the State liability Act 20 of 1957 which provides in Section 1

1, Claims against the State cognizable in any competent court. Any claim against the State which would, if that claim had arisen against a person, be the ground of an action in any competent court, shall be cognizable by such court, whether the claim arises out of any contract lawfully entered into on behalf of the State or out of any wrong committed by any servant of the State acting in his capacity and within the scope of his authority as such servant.

The claim against the state is usually based on vicarious liability, a Principle in which someone else is held responsible for the mistake of another, an example is an employer held liable for the negligence of the employee. Health care practitioners working in public institutions are employees of the state and are not sued directly, in South Africa every provincial health department is vicariously liable for the negligence committed by its staff, and the case citation will be against the MEC for Health of the affected Province

It is noted that records have shown that South African courts are beginning to see an increase in cases of Medical malpractice[11],

[9] Carstens and Pearmain(2007)284
[10] Coetzee and Carstens(2011)1285
[11] "medical negligence litigation: undermining South African Health System https://www.health24.com/News/Public-Health/medical-malpractice-litigation-undermining-south-africas-health-system-20180417 (accessed 21 Feb 2019

The South Africa teeming population with a huge percentage using a heavily burdened healthcare system should expect medical mistakes and this is happening across the provinces[12] with patients seeking legal redress in delict or contract depending on the legal representatives of the patients.

[12]South African Law reform commission issue paper 33 project 141

CHAPTER 3

EVIDENCE OF THE RISE IN MEDICAL MALPRACTICE LITIGATION

The online health news health 24 in an article "medical negligence litigation: undermining South African Health System[13]" the Medical Protection Society (MPS) was said to have settled a claim of almost 24 million Rands on behalf of a member and has also reported a 35% increase in the number of claims brought against health care professionals between 2011 and 2016.

The MPS further reports that claims over 1 million Rands have increased by nearly 550% in the last 5 years compared to those of the last 10 years and that those over R5 million have increased by 900% from 2008 to 2013[14]. The MPS is a private indemnity organization used by many South African doctors

Dr Aaron Motsoaledi, the then South African minister of health while addressing a medico-legal summit in Pretoria in 2015 said the following.

"The nature of the Crisis is that our country is experiencing a sharp increase, actually an explosion in medical malpractice litigation which is not in keeping with the general known trends of negligence"[15]

Statistics from the National treasury indicate that very huge amounts which have increased geometrically over the last few years are paid out to settle judgment debts, it is noted that none of the provinces is exempt. The diagram bellow is culled from The National treasury.

The expenditure of the provinces in settled claims for the stated years is shown in table 1and 2 below

[13] "medical negligence litigation: undermining South African Health System

[14] "medical negligence litigation: undermining South African Health System https://www.health24.com/News/Public-Health/medical-malpractice-litigation-undermining-south-africas-health-system-20180417 (accessed 21 Feb 2019

[15] SAMJ February 2016, Vol. 106, No. 2 ,141

Province	2010/11	2011/12	2012/13	2013/14
Gauteng	R 8 291 000.00	R 30 930 758.24	R 124 846 892.41	R 153 612 355.49
Eastern Cape	R 10 260 049.00	R 25 336 038.35	R 44 743 495.84	R 49 513 108.93
Northern Cape	R 6 810 428.00	R 705 000.00	R -	R 7 107 000.00
KwaZulu Natal	R 22 695 078.06	R 10 762 367.72	R 14 767 477.56	R 205 312 356.94
Western Cape	R 9 210 000.00	R 15 860 000.00	R 11 710 000.00	R 15 680 000.00
Mahikeng	R 12 550 000.00	R 753 602.57	R 7 899 232.50	R 698 940.17
Limpopo	R 8 229 068.81	R 3 457 954.27	R 6 844 259.18	R 21 959 395.55
Free State	R 256 081.57	R 988 604.43	R 327 192.00	R 673 373.00
Mpumalanga	R 17 229 427.00	R 13 252 319.44	R 11 310 058.70	R 44 408 386.64
TOTAL	**R 95 531 132.44**	**R 102 046 645.02**	**R 222 448 608.19**	**R 498 964 916.72**

(Table1)Diagram from the Law reform commission[16]

Department of Health	Annual Report for Year Ending	Contingent liability at year end
Eastern Cape	31/03/206	R13 421 136 000
Western Cape	31/03/2016	R182 025 000
Kwazulu natal	31/03/2016	R9 957 126 000
Mpumalanga	31/03/2015	R1 459 497 000
North west	31/03/2015	R36 157 000
Limpopo	31/03/2015	R1 356 921 000
Northern cape	31/03/2015	R118 064 000
Free state	31/03/2016	R940 545 000
Gauteng	31/03/2016	R13 452 064 000
Total		R40 923 535 000

(Table 2)Diagram from the South Africa law reform commission[17]

[16] South African Law reform commission issue paper 33 project 141

[17] *ibid*

In businesslive. co.za publication by Tamar Khan 19 July 2018, he suggested that the scale of medico-legal claims is staggering and by the end of 2016 -2017 fiscal year Government faced contingent liability the cost if all claims were successful will be about R 56 .1 billion[18] which actually equals about a third of the consolidated health budget for 2016-2017.

Another online source (Risk short term) published on 31 may 2016 noted that medical malpractice claims in excess R5 million is up 900% since 2009[19].

Health 24 also reported that in the year 2017, Gauteng department of health paid out at least 1 billion rand in law suits, while the Eastern Cape is facing pay out of up to R 14 billion.[20]worth mentioning is that technological advances have made the pay outs to patients injured from medical negligence to increase as most of the patients live longer because advanced technology is employed in looking after them,[21] the courts have to factor all these in awarding cost for damages and this has no doubt contributed to the huge awards we see these days

This rise in medical malpractice litigation is a concern to both the public and private hospitals, the rising cost of litigation is eating into the budget for health. The efficiency of health care delivery will plummet as money meant for health care delivery will be spent in settling judgment debts.

A single budget for health caters for purchase of medicine, equipment, paying salaries, training and every other requirement for effective running of a hospital, clearly we are facing a huge crisis if these trends continue.

It is therefore of urgent need for the authorities responsible for health management to make efforts to stem this tide or in not very long time from now we as a nation will experience a total failure of the health care delivery system.

[18] Tamar Khan " its sickening the alarming rise of medical malpractice claims" https://www.businesslive.co.za/fm/features/2018-07-19-its-sickening-the-alarming-rise-of-medical-malpractice-claims/ . (03/09/2019)

[19] Medical malpractice claims above R5m up 900% since 2009.https://www.health24.com/News/Public-Health/medical-malpractice-claims-above-r5m-up-900-since-2009-20160415

[20] Malpractice suits undermining SA health system. https://www.health-e.org.za/2018/04/18/malpractice-suits-undermining-sa-health-system/

[21]Malherbe J, "Counting the cost: The consequences of increased medical malpractice litigation in South Africa" .SAMJ [S.l.], v. 103, n. 2, p. 83-84

In summary most of the evidence of the rise is seen in online publications , newspapers and records kept by the treasury or provinces affected by litigation, the table shown are clear indicators of the rising numbers of medical negligence litigation and financial burden it is putting on the provinces or private insurer like the MPS and by extension the practitioner because as the insurer pays more judgement debts they pass on the cost to the practitioner in their premiums, from 2013 to 2017 premiums paid by obstetricians rose steadily from R250,000 to R850,000 per annum while others may pay as much as R100,000 per month in premiums[22]this was raised by doctors in the pregnancy awareness week held in February 2017 and published in the South African Society for Obstetrics and Gynaecology website (SASOG)

[22]Lisa Isaac, "Litigated out of practice" https://www.iol.co.za/capetimes/news/obstetricians-litigated-out-of-practice-7672343

CHAPTER 4

REASONS FOR THE RISE IN MEDICAL MALPRACTICE LITIGATION.

4.1

Increased awareness of patients of their rights, with the advent of legislation like the Consumer Protection Act (CPA), frequent media discussions on these rights has put the rights of the patients (consumers of Healthcare) in the public domain and people can easily access them on the internet. The CPA gives enormous right to consumers, (patients) especially as regards the nature of the contract they get into with either a doctor or a hospital or any other health facility. In the past contracts skewed in favour of hospitals made it impossible for patients to sue. CPA in section 48 has changed that to a great extent, it states as follows

> (1) A supplier must not— (a) offer to supply, supply, or enter into an agreement to supply, any goods or services— (i) at a price that is unfair, unreasonable or unjust; or (ii) on terms that are unfair, unreasonable or unjust; (b) market any goods or services, or negotiate, enter into or administer a transaction or an agreement for the supply of any goods or services, in a manner that is unfair, unreasonable or unjust; or (c) require a consumer, or other person to whom any goods or services are supplied at the direction of the consumer— (i) to waive any rights; (ii) assume any obligation; or (iii) waive any liability of the supplier, on terms that are unfair, unreasonable or unjust, or impose any such terms as a condition of entering into a transaction. (2) Without limiting the generality of subsection (1), a transaction or agreement, a term or condition of a transaction or agreement, or a notice to which a term or condition is purportedly subject, is unfair, unreasonable or unjust if
>
> (a) it is excessively one-sided in favour of any person other than the consumer or other person to whom goods or services are to be supplied; (b) the terms of the transaction or agreement are so adverse to the consumer as to be inequitable; (c) the consumer relied upon a false, misleading or deceptive representation, as contemplated in section 41 or a statement of opinion provided by or on behalf of the supplier, to the detriment of the consumer; or (d) the transaction or agreement was subject to a term or condition, or a notice to a consumer contemplated in section 49 (1), and— (i) the term, condition or notice is unfair, unreasonable,

unjust or unconscionable; or (ii) the fact, nature and effect of that term, condition or notice was not drawn to the attention of the consumer in a manner that satisfied the applicable requirements of section 49[23].

Section 49 further puts hospitals in difficult positions if they intend to indemnify themselves against damages, it states as follows

. (1) Any notice to consumers or provision of a consumer agreement that purports to— (a) limit in any way the risk or liability of the supplier or any other person; (b) constitute an assumption of risk or liability by the consumer; (c) impose an obligation on the consumer to indemnify the supplier or any other person for any cause; or (d) be an acknowledgement of any fact by the consumer, must be drawn to the attention of the consumer in a manner and form that satisfies the formal requirements of subsections (3) to (5). (2) In addition to subsection (1), if a provision or notice concerns any activity or facility that is subject to any risk— (a) of an unusual character or nature; (b) the presence of which the consumer could not reasonably be expected to be aware or notice, or which an ordinarily alert consumer could not reasonably be expected to notice or contemplate in the circumstances; or (c) that could result in serious injury or death, the supplier must specifically draw the fact, nature and potential effect of that risk to the attention of the consumer in a manner and form that satisfies the requirements of subsections (3) to (5), and the consumer must have assented to that 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. (3) A provision, condition or notice contemplated in subsection (1) or (2) must be written in plain language, as described in section 22. (4) The fact, nature and effect of the provision or notice contemplated in subsection (1) must be drawn to the attention of the consumer— (a) in a conspicuous manner and form that is likely to attract the attention of an ordinarily alert consumer, having regard to the circumstances; and (b) before the earlier of the time at which the consumer— (i) enters into the transaction or agreement, begins to engage in the activity, or enters or gains access to the facility; or (ii) is required or expected to offer consideration for the transaction or agreement. (5)

[23] **Consumer Protection Act**, 68 of 2009,

The consumer must be given an adequate opportunity in the circumstances to receive and comprehend the provision or notice as contemplated in subsection (1)[24].

In section 22 the CPA states that a user has the right to information in plain and understandable language[25],

Information given by hospitals can easily miss out important details that can make them liable to litigation, the complex legalese used in contracts is a ground for litigation when something goes wrong after treatment because most of these contracts may not fulfil the provision of section 22.

4.2

Medical malpractice attorneys regularly advertise both in electronic and print media asking people who have had adverse medical outcomes to come forward, this has encouraged people who previously felt that the doctor was always right to come out and claim against doctors, also because of the likely huge sums of pay out to patients many lawyers in South Africa are going into medical malpractice litigation

4.3

Litigation tends to arise more in cases where there has been lack of communication between the doctor and the patient. Research has shown that a well-informed patient who has good knowledge of his condition and the possible complications that may arise following intervention is less likely to sue his or her doctor,[26] results showed 48% of the families believed that the doctors misled them and 70% said they were not warned of the long term neurodevelopmental problems while 24% recognised a cover up.

In communication gaffes, a root cause of malpractice claims by Beth Hutington BSN et ,it was stated that gross breakdown in communication between patient and physician was the main reason patients file law suits against physicians citing reasons like, the physician will not listen to them, refuse to talk

[24] Consumer Protection Act.
[25] *Ibid*
[26]Hickson GB et al.(1992) 267(10)1359-63 "factors that prompted families to file medical malpractice claims following perinatal **injuries"** Jama 1992 march 11 267(10) 1359- 63

over issues with them or attempted to mislead them or failed to warn them about a possible neurological fall out, doctor deserted them and did not consider their perspective[27].

In its advisory statement document no 1017 of the American Academy of Orthopaedic Surgeons, it described the patient physician relationship as open honest dialogue that builds trust and promotes healing.[28]

Levinson W, et al "the relationship of malpractice claims between primary care physician and Surgeons, it was concluded that certain communication behaviour reduced malpractice claim among certain primary care physician[29]

The summation is that patients are not likely to sue doctors they like and trust because all information has been communicated clearly and honestly to them

4.4

Non-professionalism by healthcare practitioners has been taunted as a possible contributor to the rising numbers of litigation and this cannot be entirely discounted as there has to be a degree of decline on the standard of care for negligence to be on the increase, the important point to raise is that there must be damage for there to be litigation, according to the Health professional Council of South Africa (HPCSA) annual reports 2017/2018[30] the following was recorded

See table 3 below

[27] Hutington BSN et al, "communication gaffes, a root cause of malpractice claims" Baylor University med Centre (2003) 161
[28]"Patient-Physician Communication" American association of Orthopaedic surgeons Statement Document 1017
[29]Levinson W, et al. "the relationship of malpractice claims between primary care physician and Surgeons" (1997) *JAMA.277(7)553-559*
[30] Health Professions Council of South Africa Annual Report 2017/2018(44)

TABLE 3

YEAR	COMPLAINS RECEIVED	CASES FINALISED
2015/2016	2944	1013
2016/2017	2755	1326
2017/2018	1233	1423

4.5

Poorly staffed hospitals is another cause of the increase in medical malpractice litigation,[31] most of the hospitals especially in the public sector do not have sufficient doctors and nurses to manage the huge no of patients that visit the hospitals, this poor staff to patient ratio often lead to delay and patient may not be attended quickly in urgent cases, this is seen in the Khosa and Nstele cases mentioned above.

Norman Mabasa former boss at South African Medical Association, The umbrella body for doctors registered in south Africa noted that Skill shortage is a major issue, and that doctor fatigue is common, junior doctor working without senior doctor overseeing them all contribute to the challenge of increasing medical negligence, part of the problem as he noted is that a huge no of south African doctors are not retained in South Africa as they travel overseas to continue their career.[32]

4.6

Modern diagnostic equipment may not be available in some rural hospitals[33] and patients attending these rural hospitals may have to be transferred to hospitals several distances away which may lead to delay and

[31] Seggie The 'boom' in medical malpractice claims – patients could be the losers. Seggie 2013 SA Medical J 433
[32] https://www.timeslive.co.za/sunday-times/lifestyle/2010-06-06-thousands-of-doctors-negligent/(acceesed 8/6/2019)
[33] Seggie J "The 'boom' in medical malpractice claims – patients could be the losers" 2013 SA Medical J 433.

subsequent severe consequences for the patient, the inadequacy both in staffing and equipment will definitely lead to increase no of litigation.

4.7

Easier access to the Court by the patient will also account for the increase in litigation, most lawyers take on most of the cases on a no win no fee bases, and this will encourage patients to sue since he/she will not be incurring legal fees.

4.8

Contingency Fees Act 66 of 1997[34] which provides in section (1) that the legal Practitioner may if in his or her opinion if there is a reasonable prospects that his or her client will be successful in any proceedings enter into an agreement with such client in which it is agreed that

> A, the legal practitioner shall not be entitled to any fee for service rendered in respect of such proceedings unless such client is successful
>
> B, that the legal practitioner shall be entitled to fees equal to or subject to subsection 2, higher than his or her normal fees, set out in such agreement for any services rendered, if such client is successful to the extent set out in the agreement
>
> (2)Any fees referred to in in subsection (1) b which are higher than the normal fee of the legal practitioner concerned, shall not exceed such normal fees by 100%, provided that in the case of claims sounding in money, the total of any such fees payable by the client to the legal practitioner shall not exceed 25 % of the total amount awarded or any amount obtained by the client in consequence of the proceedings concerned, which amount for the purposes of calculating such excess include cost.,
>
> This act has indeed made medical malpractice litigation flourish as it is very convenient for the clients, and the lawyers are motivated by the prospect of huge settlements by the courts.

[34] Contingency Fees Act 66 of 1997

4.9

The changes in the Road accident fund (RAF).

Following the amendment to the Road accident fund Act in 2008, amendments that made the ability to claim from the Road accident fund more stringent, lawyers that previously benefited from the old Act now realised that they often found it difficult because all the elements as provided for in the Act must be met.[35]

The Road accident act was amended in 2008 resulting in more stringent measures before claims can be successful, apart from the initial six elements that a claim must meet which previously included.

- Third party
- Damage or loss suffered
- Caused by or arising from the driving
- Negligence or wrongful act
- Motor vehicle
- Within the borders of the Republic of South Africa

The Act now requires that non-pecuniary damages (General damages) will not be paid except the injuries are serious[36],

Serious injuries will be determined

As injuries that resulted in 30 per cent or more of whole body damage and if 30 per cent is not attained the injury must lead to

Serious Permanent disfigurement

[35] Malherbe J, "Counting the cost: The consequences of increased medical malpractice litigation in South Africa" .SAMJ [S.l.], v. 103, n. 2, p. 83-84

[36] Road Accident Fund Amendment Act 19 of 2005

Long term impairment or loss of body function

Result in loss foetus

Severe long-term mental impairment or behavioural disturbances.

The settlement of claims will now be calculated with the HPCSA tariffs

All these made The RAF unattractive and most of these lawyers are now migrating to the medical malpractice space, the Road Accident Benefit Scheme is a no-fault system been presently mooted, the scheme if eventually comes in play will operate a no-fault system and may likely entirely cut off lawyers.

4.10

Ready access to information online makes patients aware of legislation and other information that they can rely on to sue, examples are previously decide cases, with access to internet over a cell phone people are able to get information quickly and readily since data fees are reasonable and affordable

4.11

The legislation, certain legislations are very favourable to patients and empower patients to sue health care professionals, the South African constitution has probably influenced our health rights the most and provides veritable grounds for action to be taken by patient-plaintiff against health institutions or healthcare practitioners

The Constitution provides as follow

Section12 (2)[37].

Everyone has the right to bodily and psychological integrity

(b) The right to security and control of their body

Section (10)[38] Right to dignity

Section 14(d)[39] specifically talks about the rights of their communication being infringed

[37] The South African Constitution
[38] *ibid*
[39] *ibid*

Section 12(2) could easily be violated from lack of proper consent before commencing a procedure on a patient, while carelessly leaked information about patients' medical records can easily violate section 14 and section 10, the rights to privacy and dignity respectively

Section 27[40] refers to the right to access to health services including reproductive health, if a patient is denied access to health care or unreasonably delayed specially in public hospitals, section 27 is a ready statute to rely on to sue the department.

Being rude to patient can amount to infringement on their dignity as provided for in section 10 of the constitution

A patient that has not been properly educated about his condition may rely on sec 32 to pursue litigation

Sec 32[41]. Access to information

1. Everyone has the right of access to

a. any information held by the state; and

b. any information that is held by another person and that is required for the exercise or protection of any rights.

2. National legislation must be enacted to give effect to this right, and may provide for reasonable measures to alleviate the administrative and financial burden on the state.

And the Promotion to access of Information Act[42] gives effect to section (32) (2) of the constitution

In section 9 it states that The objects of this Act are- (a) to give effect to the constitutional right of access to- (i) any information held by the State; and

[40] The south African Constitution
[41] *ibid*
[42] Promotion of access to Information Act 2 of 2000

(ii) any information that is held by another person and that is required for the exercise or protection of any rights;

The Medical record of the patient is key to filing a suit in medical negligence; these pieces of legislation come in handy for patients seeking to sue

The National Health Act[43]

Chapter 2 of the National health Act deals with the right and duties of users and health care personnel

Section 6 provides that the user must have full knowledge of the management being offered to him or her

6(b) the range of diagnostic procedure generally available to the user

These are easy grounds for litigation as patient can point out that certain options were not made available to them

6(C) provides that the patient most have information on benefit, risk and cost of the procedure

Omitting to inform patients adequately can infringe many elements of the section and can easily get a health care practitioner to face litigation, in many cases of wrongful birth, these sections can be relied on. In *friedman v Glicksman*,[44] the plaintiff averred that she was not properly advised when she was pregnant about the risk of having a disabled child and had she been well advised she would have terminated the pregnancy, and will not have to be burdened by the cost and emotional trauma of raising a disabled child, the court ruled in favour of the plaintiff.

6(I), the patient right to refuse treatment is provided for in this section. Doctors must realise that even if the treatment is in the best interest of the patients treating them when they have indicated that they do not want to be treated can lead to litigation against them the doctors

[43] The National Health Act 61 0f 2003
[44] *Friedman v Glicksman* 1996 (1) SA 1134 (w*)*

4.12

Action of state attorneys.

Recently in early 2019 the then Minister of health ordered investigation and possible prosecution of some state lawyers who were alleged to be colluding with plaintiffs and their lawyers to bring frivolous cases that lack merit or even those that never occurred to Court and ensuring that the states pay out huge sums to the plaintiff, moneys that they the state lawyers will share from, investigations on these matters are still on going.

A whole lot of factors have led to the rising trends of medical malpractice claims they vary from more access to information by patients, patient friendly legislation, weakness in the health system and the most important without which there will be no negligence , the lack of professionalism by health workers, however it is important to assert that all the above and possibly many more factors not mentioned here will collectively contribute to the huge numbers of medical malpractice claims in South Africa today.

CHAPTER 5

IMPACT OF THE RISE IN MEDICAL MALPRACTICE LITIGATION

5.1

ON THE HEALTH CARE DELIVERY SYSTEM , as for the public health facility, the direct impact of the increasing numbers of medical negligence litigation and the subsequent rising cost of award to patients/plaintiff is that the provinces are not able to maintain equipment, train personnel, buy new equipment, employ staff and generally run their facility better[45] and this is because the provinces have one budget to run the facilities and from the same budget will settle judgment debts, a vicious cycle will ensue as the health delivery system will further deteriorate, which will likely lead to more medical errors and subsequently more litigation, in some of the cases listed below the state was made to pay very huge judgements debts that will impact heavily on the purse of the province.

Khosa v MEC,[46] the Gauteng local division ruled in favour of the plaintiff against the MEC for health, the state was ordered to pay all the proved damages to the plaintiff following poor management during the birth of their child which resulted in the baby born with cerebral palsy

Lushaba v MEC for health,[47] in which case the patient developed abruption placenta, a condition in which blood supply to the child is cut off because the placenta has separated from the uterus, the baby died, the damage was proved 100% and damages awarded to plaintiff

Ntsele v MEC Health.[48] 100% damage was awarded to patient whose child was born with Cerebral palsy

Singh v Ebrahim.[49] a case in the private sector where negligence was proved against the health care practitioner and large amounts paid out to the plaintiffs

[45] Malherbe J, "Counting the cost: The consequences of increased medical malpractice litigation in South Africa" .SAMJ [S.l.], v. 103, n. 2, p. 83-84

[46] *Khoza v MEC for Health, Gauteng* (216/17) [2018] ZASCA 13

[47] *Lushaba v MEC for Health, Gauteng* (17077/2012) [2014] ZAGPJHC 407

[48] *Ntsele v MEC for Health, Gauteng Provincial Government* (2009/52394) [2012] ZAGPJHC 208

[49] *Singh and Another v Ebrahim* (413/09) [2010] ZASCA 145

In the private sector most of the practitioners take private insurance, a very popular private insurer in South Africa is the Medical Protection Society (MPS), with increasing numbers in medical negligence cases, the pay out to clients will no doubt increase and ultimately the premiums paid by doctors will increase especially in the fields that have high litigation rates like Obstetrics, Neurosurgery, Paediatrics and Orthopaedics.

Health experts have raised awareness around an escalating crisis in obstetrics, during a Pregnancy Awareness Week, they say numerous practitioners are leaving active practice due to extremely high indemnity insurance costs which are expected to reach up to R850 000 in 2018[50].

The president of South African Society of Obstetrics and gynaecologist SASOG, Johannes van Waart, said: "This is a real, real crisis. Our indemnity insurance in the last four years has gone from R250 000, to R330 000, to R650 000 last year, to R850 000 this year".[51]

The cost of health care in the private sector is already of big concern and the increasing numbers of medical negligence cases will further increase that cost as doctors who pay huge amounts in premiums will no doubt shift the cost to patient's fees without which remaining in practice will not be economically viable for the doctor

Some doctors may wish to avoid litigation entirely and leave those specialties with high incidence of litigation and younger doctors will refuse to go into those specialties, a vicious cycle also develops in this instance as the few doctors left in the field are overworked and may likely be prone to more mistakes leading to increasing litigation.

The cost of managing patients may further increase because the doctors will also begin to practice defensive medicine,[52] which means that in order to avoid litigation or making errors doctors tend to order test that may not be necessary to arrive at a diagnosis, patients may not be able to afford the private health care as the cost rises and may then cancel their medical aids, this will no doubt put more pressure on the public health system that is already struggling, further increasing the chances of

[49] Lisa Isaac, "Litigated out of practice" https://www.iol.co.za/capetimes/news/obstetricians-litigated-out-of-practice-7672343 (accessed 03/09/2019)
[50] ibid
[51] Claaasen NJB , Verschoor T (1992)3

negligence in the public facilities, another fallout of increasing cost in the private sector is that by middle of the year most subscribers of medical aid would have run out of funds in their medical aid and for the rest of the year they visit public facilities which often times are already struggling to service the huge numbers that visit them yearly.

Because most medico legal claims take very long times to conclude[53] the state will have to retain private counsel (advocates) for that long and this is usually at huge costs as counsels cost lots of money to be retained in South Africa.

5.2

IMPACT ON THE DOCTORS:

Once a doctor has gone through litigation his/her attitude to work will be that of apathy, his morale diminishes, it could lead to depression, a medical condition characterised by insomnia, lack of desire to enjoy life , lack of appetite , sadness and even suicidal ideation, some doctors may also leave the profession entirely,[54] considering that many South African doctors leave the shores of the Country for greener pastures overseas, more doctors leaving the profession because of litigation creates more difficulties to the already struggling health care system, the doctors remaining will have to contend with the huge numbers of patients that visit public facilities daily, which obviously will worsen the crisis.

5.3

ON THE PATIENTS.

Litigation is a long and harrowing experience which is demanding in terms of time and money, in most cases the patient may not be successful and may be made to settle legal cost for the other party making their woes more harrowing. In cases where the alleged negligence may have led to the death of the

[53] the South African Law reforms Issue paper 33 project 141 on Medical claims(2017)22
[54] Malherbe J SAMJ [S.l.], v. 103, n. 2, p. 83-84

patient, the family will not have closure till the end of the case, the bereaved family members' work will be disrupted by time spent in attending either meetings with lawyers or actually going to Court on Court days, to settle a medical malpractice case may take up to 16 years as in the *Ntsele v MEC* for health Gauteng

See table of cases and the average length of time taken to settle the cases[55]

TABLE 4

	CASE	CAUSE OF ACTION	DATE OF INCIDENT	FINAL JUDGEMENT	DURATION OF CASE
1	*Ntsele v MEC for Health Gauteng*	Pre-natal asphyxia resulting in dystonic chid	Sept 1996	Oct 2012	16 years
2	*Lushaba v MEC for Health Gauteng*	Child born with spastic quadriplegic cerebral palsy	June 2000	Oct 2014	14 years 4 months
3	*Rens v MEC for Health Northern cape*	Amputation of left arm from negligent medical treatment	February 1998	April 2009	11 years

[55] the South African Law reforms Issue paper 33 project 141 on Medical claims

4	*Mbhele v MEC for Health*	Still Birth following poor management	Aug 2006	Nov 206	10 years
5	*Molefe v MEC for Health Gauteng*	Child suffering Cerebral Palsy resulting from Perinatal Arterial Ischaemia after falling to the floor during unassisted birth	April 2005	February 2015	9 years 9 months
6	*Links v MEC for Health Northern cape*	Amputation of thumb and loss of use of left arm due to ischaemia	July 2006	March 2016	9 years 8 months
7	*Mshibi obo Sindi v MEC for Health Gauteng*	Child born with cerebral palsy	Aug 2005	Aug 2014	9 years
8	*AD and IB v MEC for Health Western cape*	Child born with athetoid cerebral Palsy due to failure to diagnose and treat jaundice timeously	Jan 2009	Sep 2016	7 years 8 months

	CASE	CAUSE OF ACTION	DATE OF INCIDENT	FINAL JUDGEMENT	DURATION OF CASE
9	*M v MEC for Health Eastern Cape Province*	Death of a Child due to sepsis and dehydration	April 2007	Nov 2014	7 years 7 months
10	*Madida v MEC for Health kwazulu natal*	Chid born with spastic quadriplegic palsy,epilepsy,scoliosis, chest deformity, poor cognitive ability	Jan 2009	March 2016	7 years 2 months
11	*Khoza v MEC for health Gauteng*	Child born with hypoxic ischaemic encephalopathy	May 2008	February 2015	6 years 9 months
12	*Mokheti v MEC for health Gauteng*	Amputation of a childs arm due to negligent medical treatment	May 2007	Sept 2013	6 years 4 months
13	*Smith v MEC for Health Kwazulu Natal*	Patient given Formalin instead of water	May 2010	Aug 2016	6 years 3 months
14	*Hoffman v MEC for Health Eastern Cape*	Still-born due to negligent treatment by hospital staff	Sept 2004	Sept 2009	5 years

	CASE	CAUSE OF ACTION	DATE OF INCIDENT	FINAL JUDGEMENT	DURATION OF CASE
15	*Daniels v Minister of defence*	Patients misdiagnosed, failure to perform certain procedures	August 2011	June 2016	4 years 10 months
16	*Molete v MEC for Health Free State*	Left arm permanently disabled after negligent medical treatment	Dec 2007	June 2012	4 years 6 months
17	*Goliath v MEC for Health*	Gauze swab left in patients abdomen	April 2011	Nov 2014	3 years 7 months

The diagram is culled from the South African Law reforms Issue paper 33 project 141 Medico-legal claims)[56]

From the table above, it can be seen that most of these claims take very long times to settle and one can only imagine the mental and psychological trauma the patient or the family left behind will go through and also the enormous financial resources and time put into the project.

This chapter espouses the different angles at which the entire health industry in South Africa can be harmed by the increasing numbers of medical malpractice litigation, of great importance is the patient and their relatives whose desire to get some recourse for a damage suffered may end up going into a

[56] the South African Law reforms Issue paper 33 project 141 on Medical claims

long legal battle that may cause more damage to the patient psychologically, the likelihood that a huge portion of the award may go to the attorneys when the case lingers for several years further worsens the plight of the patient, the combination of the effect on doctors, patient and health care delivery will no doubt result to more decline and a very disastrous outcome if not checked.

Some benefits may arise from litigation, healthcare practitioners will be more careful to avoid litigation, some of the reasons negligence happened will be brought to the open during the trial and doctors can learn from that and patient safety is enhanced, The fact that when a doctors' negligence has caused harm that set a patient back in life can be interrogated and openly debated in a court of law is indeed a positive and should be seen as a means to prevent such occurrences, also the fact that a patient that has been injured and suffered damage will be compensated is a bright side to litigation but it is ultimately important that the health care service to the larger population is not compromised.

Having noted the merits of litigation, the disadvantages far outweigh the benefits, it is important that ways must be sought to manage the crisis and create a reasonable balance.

CHAPTER 6

MANAGING THE PROBLEM

The approach towards managing the problem will be to look at the different phases at which intervention could be sought, first, the possibilities of preventing the negligence and after the negligence has occurred what can be done to prevent litigation and if the patient has already sued ways to manage the litigation process and post litigation period, most importantly ways to reasonably save cost for the Department of Health.

6.1

PREVENTING NEGLIGENCE

1. An adequately staffed and well equipped health facility is the point of departure in preventing negligence, errors are more likely if a practitioner is over worked and does not have equipment to work with. The state will most likely prevent errors by their doctors and other health care practitioners if they invest in properly equipping the hospitals and engage in massive recruitment, health care delivery is essentially the quality of the staff, effective and functional equipment they work with. Resuscitation equipment, diagnostic machines should be constantly maintained and be in working conditions at all times.

2. In both undergraduate and post graduate training, special emphasis must be placed on communication skills by the health care practitioners, it is established that the well informed patient is less likely to sue their doctor[57] . The American association of orthopaedics in it 1017 statement document listed some of the ways of improving patient /physician communication to reduce events of litigation and they are include simple things like sitting down during patient encounters, developing an understanding of the patient as an individual, not as a disease or a

[57] Hutington BSN et al, Baylor University med Centre (2003) 161

musculoskeletal condition, clarifying issues and discussing concerns, paying close attention during consultations, showing empathy, answering questions honestly , informing patients about alternative treatments and encouraging second opinions ,making sure patients are involved in decision making, demonstrating sensitivity to patients culture and ethnicity, finally ending consultation by asking if there are any further concerns of the patient.[58]

3. Consent forms provided by the hospitals should be as detailed as possible, forms should also be written in indigenous languages so the patient can truly understand what they have signed , Doctors must also explain in details including possible complications of the surgery,

In *MacDonald v Wroe*,[59] the patient sued the dental surgeon for not informing her of a possible nerve damage that may arise as a complication of the surgery

Section 6 of the National Health Act stipulates that the user must have full knowledge of his or her entire management

While section 7 provides that the patient must give informed consent

Section 8 states that a healthcare user must participate in any decision affecting his or her personal health and treatment, all healthcare providers should be familiar with these legislations.

In *Casteel v De Greef*,[60] the Court found that the Surgeon should have informed the patient about the possible necrosis that may follow the surgery.

It should be made compulsory that the decision to operate should be made by at least two specialists in any given discipline of medicine, a second doctor must read through a summary of the indications to operate and agree with the operating doctor before the operation can take place, and this should apply both in the private and public sectors, when the decision is finally taken the patient should understand the nature of the surgery and all the elements of informed

[58] "Patient-Physician Communication" American Association of Orthopaedics Statement Document 1017(2000)
[59] *MacDonald v Wroe*. (2006) 3 All SA 565 (C).
[60] C*astell v De Greef* 1994 (4) SA 408 (C)

consent should be met as stated in *Christian lawyers association v National minister of Health.*[61] where the Court confirmed that consent must be based on the following elements, knowledge, appreciation and acquiescence, this way doctors do not operate on patients for financial gains only, something patients frown at a lot at this and if discovered later by patients may lead to litigation, obstetricians have been accused of carrying out caesarean sections (Delivering of babies through surgery) where there is no real indication for the caesarean delivery

4 Proper documentation of all that was discussed and agreed on before the surgery is important, In *Casteel v De Greef,*[62] there was a dispute on what the plastic surgeon and the patient agreed on before the procedure, a signed copy of all that was discussed and agreed should be held by the doctor and patient.

5 Empathy and dedication to duty on the part of the doctor will dissuade patients from suing, doctor should be encouraged to see their job more as a call to service than a business

6.2

WHEN THE ERROR HAS OCCURRED

The doctor should honestly explain to patient or the family what has happened, the reason it happened and why and how it happened, this is known to calm the patients down to an extent, absolving the doctor or hospital of the blame when it is clear that the blame should lie with them will most likely anger and frustrate the patient the more and they will usually resolve to find answers

In a study by C. Vincent, A Phillips and M Young "Why do people sue Doctors" A study of patients and relative taking Legal action". It was noted that that litigation was not determined

[61] *Christian lawyers association v National minister of Health.*2004(10)BCLR1086(T)
[62] *Casteel v De Greef*

by only the injury itself but by insensitive and poor communication after the original incident, a show of empathy will no doubt help in reducing litigation by patients[63].

Doctors or hospitals should also do all they can to remedy the effect of a medical error by providing support both psychological support and home based care, every hospital that identifies an error should make sure that the patient is well taken care of thereafter.

The doctors or the hospital should never attempt to cover up their error or deny the mistake as this will further infuriate the patient or family when the truth is eventually discovered, a judge is not likely to award punitive cost against the doctor if there was no attempt to cover up an error, punitive awards are costs meant to directly punish and deter negligent practitioner/defendant

6.3

AFTER THE PATIENT HAS SUED

In South Africa once the patients sues, the full judicial process will ensue with all the challenges that come with it, some other countries have developed models that have yielded positive results in the past, so it will be useful to see if these methods will help in South Africa

6.3.1

APROACH BY OTHER COUNTRIES

1. CANADA

In Canada for instance, they operate a scheme referred to as the Canadian Medical Protection Association (CMPA).[64] The doctors belong to this association and pay membership fee which is heavily subsidised by the provinces, CMPA has about 100,000 physicians as members.[65] When a case arises against a doctor, the CMPA defends the case as vigorously as they can and doctors are generally not penalised by the CMPA , the membership fee of doctors affected does not

[63] Vincent,C et al. (1994) lancet

[64] www.cmpa-acpm.ca(accessed 7/10/2019)

[65] Canadian Medical Protection Association annual report 2018

increase because of litigation, this encourages doctors to remain in the profession even after they have faced litigation, in her book "after the error" speaking out about patient safety to save lives by Susa Mclver and Robin Wyndham, it was noted that between 2005 and 2010 only about 4525 lawsuits were filed against doctors and 3089 were dismissed or abandoned for varied reasons including dismissal by the Court, of about 521 that went to trail only 116 led to judgement in favour of the patient[66].

These results lend credence to the fact that because of the fierce defence by CMPA patients are discouraged from filing lawsuits against doctors. A format of this nature could be looked into for the public sector doctors in South Africa.

The CMPA involvement takes away the burden from the department of health, claims are settled by the Crowd funding of the CMPA. In South Africa the Department of Health employs state attorneys that defend cases of medical negligence and if judgement is passed in favour of the patient, the state will have to pay from the same health budget which as mentioned earlier puts a lot of strain on health care delivery. Another issue of concern is how committed are the state attorneys to putting up a good defence, as stated previously, the Minister of health raised cases were some state attorneys were alleged to have worked secretly with the Patients attorneys to undermine the department of health and make the department pay huge amounts in compensation to patients. The CMPA not only defends its members in Court it also organises seminars and training to keep the members up to date with the laws as it relates to medical negligence.[67]

Capping Compensation

In 1978 the supreme Court of Canada capped to a maximum limit of Canadian $100,000[68] for compensation for non-pecuniary losses such as pain and suffering, loss of amenities, loss of enjoyment of life and loss of life expectancy, this amount increased to about $220,000 in the nineties, the Court however allowed for the amount to be exceeded in extreme cases, this also hugely discourages people from wanting to sue doctors or hospitals. Canadian Courts have

[66] Mclver, S and Wyndham R.(2013) *after the error speaking out about patient safety to save lives*. Canada ECW
[67] Canadian Medical Protection Association Annual Report 2018
[68] Joan M. Gilmour "Overview of Medical Malpractice Law in Canada", 3Annals Health L. 179 (1994) 7

scrapped punitive awards against doctors[69] and this has further reduced what is payable to a plaintiff in medical malpractice litigation, another deterrent from incessant suing of health care practitioners, punitive awards may however be awarded in cases where the healthcare practitioner was malicious, grossly negligent or highly reprehensible in his or her action , punitive cost may also be awarded when the compensatory award which may also be punitive is insufficient to satisfy the objective of putting the patient back to as functional as possible.

The general position in Canadian Courts is to rarely order punitive awards.

Prescription

Medical malpractices cases are subject to the statute of limitation, that is prescribing after a certain period of time, for most Canadian provinces it is a period of 2 years, for some provinces it is 2 years from the first contact with the doctor while others it is from when the damage was established, this is in fact another measure that controls rate of litigation in the medical malpractice space.

2.

THE NATIONAL HEALTH SERVICE LITIGATION AUTHORITY IN THE UNITED KINGDOM

In the United Kingdom the healthcare practitioners are employed by the National Health Service NHS, and when a medical negligence case is instituted against a health care practitioner, the litigation is followed through by the National Health Service Litigation Authority (NHSLA) as vicarious liability through the tort (delict) process,[70] The NHSLA contributes to the Clinical negligence scheme for Trust, which is a voluntary risk pooling programme that functions like an Insurance for the different trusts that contribute to the scheme, awards to patients are made from this fund.

The driving principle of the NHSLA is seen on the United Kingdom website Gov.Uk,[71] Is as follows

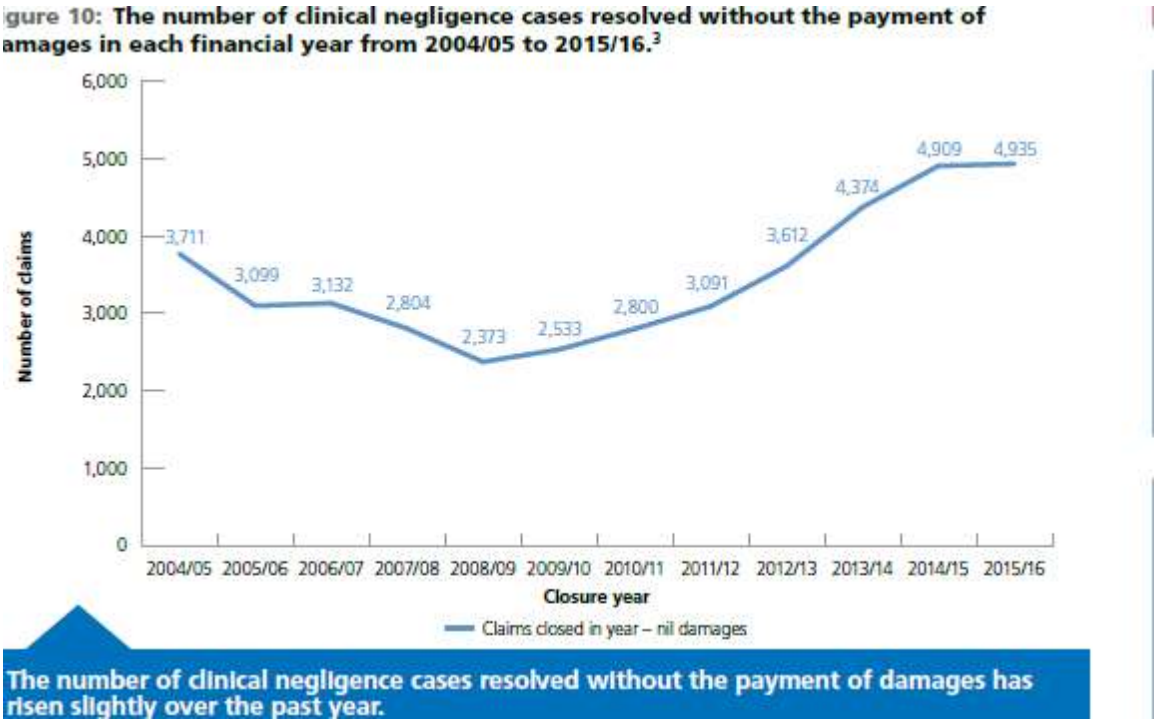
[69] Joan M. Gilmour "Overview of Medical Malpractice Law in Canada", 3Annals Health L. 179 (1994) 7
[70] https://www.gov.uk/government/organisations/nhs-litigation-authority(accessed 20/06/2019)
[71] *ibid*

The NHS Litigation Authority (NHSLA) sole responsibility is to manage cases of negligence and other claims brought against the NHS in England on behalf of its member organizations.

Our aim is to help resolve disputes fairly; share learning about risks and standards in the NHS and help to improve safety for patients and staff".

The NHSLA seeks to evaluate claims and settles out of Court if need be but most importantly to dismiss frivolous claims without settling them, below show how well the NHSLA has fared in that respect from 2004 to 2016

FIGURE 1[72]



From the figure shown above it is clear that the NHSLA has over the years effectively managed litigation against its member bodies

The roles of the NHSLA is enumerated as follow

[72]https://www.gov.uk/government/organisations/nhs-litigation-authority(accessed 20/06/2019)

The NHS LA's role includes[73]:

•proactively working with Members to support their efforts to improve patient safety;

•operating a fair pricing system for indemnity cover, which is responsive to improvements in

A Member's claims and safety profile;

•delivering fair outcomes for patients and healthcare staff through the efficient resolution of valid claims;

•robustly defending invalid or excessive claims and disproportionate legal costs and fees

•resolving concerns about the professional performance of doctors, dentists and pharmacists in a fair, timely, proportionate and defensible way;

•ensuring a prompt and fair resolution of appeals and disputes involving primary care contractors; and

•working collaboratively with others to deliver

In 2015/16 less than 1% of the clinical and non-clinical claims we resolved proceeded to trial, of which 60 per cent were defended successfully[74]

The NHSLA has also tried mediation and a pilot programme was initiated in 2014, of the 49 cases that were accepted into the programme, one case was withdrawn, 1 was settled before the programme started and the rest went through mediation, the outcome of the mediation process was indeed successful as 81% of the cases were settled.[75]

[73] www.Gov.Uk.(Accessed 20/06/2019)
[74] NHLSA annual report and Account 2015/2016
[75] *ibid*

3. THE SWEDISH EXPERIENCE

In Sweden the no fault system of compensation is practiced, where as soon as it is established that an injury has occurred following medical treatment the patient is compensated and the patient does not have to prove negligence on the part of the doctor or the hospital, a body of experts comprising of legal and medical experts evaluate the claim and as long as the causation element of delict is established the patient is compensated. The Patient compensation Insurance (PCI) is responsible for making this payment, the is provided for in

The Patient injury Act in,[76] which states as follows in section 6

Entitlement to patient injury compensation

Section 6

Patient injury compensation is paid for personal injury to patients if the

Injuries with preponderant probability were caused by

1. examination, care, treatment or similar measure provided that the injury could have been avoided either by a different performance of the chosen procedure or by choosing some other available procedure which according to an assessment made retroactively from a medical point of view would have satisfied the need of treatment in a less hazardous way.

2. Defects in the medico-technical products or hospital equipment used in the performance of an examination, care, treatment or similar measure, or improper use thereof.

3. An incorrect diagnosis.

4. Transfer of a contagious substance entailing infection in connection with an examination, care, treatment or similar measure.

[76] Swedish Patient Injury Act

5. Accidents in connection with an examination, care, treatment or similar measure or during a patient transport or in connection with a fire or other damage to health care premises or equipment, or

6. Prescription or provision of pharmaceuticals in contravention of regulations or instructions. When considering the right to compensation in accordance with the first paragraph, items 1 and 3, the guiding principle of action applicable is that of an experienced specialist or other experienced practitioner within the field.

   There is no right to compensation in accordance with item 4 of the first paragraph in those cases where the circumstances are such that the infection must reasonably be tolerated. In that connection regard shall be paid to the nature and degree of severity of the illness or injury which the measure is related to, the patient's health status in other respects and the possibility of anticipating the infection.

It is important to add that a doctor is not directly penalised for negligence in Sweden, there is no connection between the compensation of patient and the doctor or health practitioner who was involved in negligence , there is however a separate body. The Medical responsibility board (MRB) which deals with discipline of doctors.[77]

Some of the advantages of no-fault compensation are considerations of quicker resolution of cases; savings in administrative and legal costs compared to court action, reduced acrimony between health care providers and patients, and the greater willingness by healthcare workers to report errors and adverse events timeously.[78]

The lack of direct punitive measure for doctors whose negligence has led to compensation of patients may give rise to issues of patient safety as there is actually no deterrent that will ensure that doctors are more careful in future and this is the major drawback of the no Fault system as practised in Sweden.

[77]Johansson H. "The Swedish system for compensation of patient injuries". *Ups J Med Sci*. 2010;115(2):88–90.
[78] Weisbrot D and Breen K " A no-fault compensation system for medical injury is long overdue" Med J Aust 2012; 197 (5): 296-298

4. AMERICAN HEALTH COURTS/MEDICAL SCREENING PANELS

Health court as a means of determining liability, in "health courts," judges trained by the medical institutions would decide compensation with the assistance of a panel of medical experts based on pre-determined "one-size-fits-all" benefit schedules for certain injuries.

It expected that the judges may be assisted by medical personnel in making determinations on if the injury was caused by the negligence, also the avoidability standard should be used, i.e. could the injury have been avoided and if not then the patient should be awarded compensation.

It is believed that this approach of health Courts will ease the burden of proof on the patients and cut out lawyers.

One must add that the Health courts still have to establish causation and this may still not have helped the patient a great deal, but this method has been used in some American states and is worthy of mention

Certain American states have adopted the use of medical screening panels before a claim can be accepted in its Courts[79] , the panel consisting of medical and legal experts determine if there are any merits, this is to primarily dissuade overzealous attorneys and prevent overlabouring the court systems, saving defendants legal cost, however in keeping with constitutional requirement of right to courts which states that claimants may still approach the Courts if they wish to ignore the screening panel but must then be made to pay the legal cost of the defendant in all cases if they lose the case.

Certificate of merit, Medical malpractice litigants be made to produce a certificate of merit which establishes if there is negligence and causation, without which they cannot proceed to lay claims. This also eliminates frivolous claims.[80]

5. NEW ZEALAND

[79] Catherine T. Struve "Improving the Medical Malpractice Litigation Process" https://www.healthaffairs.org/doi/full/10.1377/hlthaff.23.4.33 (accessed 20/06/2019)
[80] *ibid*

The system in New Zealand is similar to that of Sweden, The Accident Compensation Corporation settles all cases of accidental injury including malpractice claims,[81] the claimant still needs to prove the causal link

unlike in the case of Sweden, but just like in the Swedish system the health care practitioner involved in the malpractice is not punished directly, his or her premium does not increase.

Studies by Jocelyn Bogdan, "Medical malpractice in Sweden and New Zealand, should their system be replicated in the United states" it was stated in the Study that the New Zealand and Swedish system does not promote patient safety as though the patient is paid but the doctor is not reprimanded or measures have not been taken to prevent the negligent act[82].

The study also suggested that in New Zealand and Sweden more patients come up with claims and the Government subsequently pays out little amounts to more people and it may eventual surpass the huge amounts paid out to people that go through litigation in the United states[83]

It is worthy of mention that most of the countries examined in this chapter are countries with much more better economy than South Africa, with better employment indices and that may have influenced the approach they have employed in managing their crisis and adopting them directly into south Africa may not be feasible but the objective is to see in what areas they have been successful and then factor our peculiarity as a nation before applying their methods, some of these countries have had the problem way before South Africa started having these huge numbers we see of late and have gained valuable experience in managing it

[81] https://www.acc.co.nz/(acceesed 10/10/2019)
[82] Bogdan J (2011)2 Centre for Justice and Democracy.
[83] ibid

CHAPTER 7

SUGGESTED REFORMS

Our system here in South Africa is a direct delict system where patient claim against the state or in private practice against the doctor or private Hospital. A system now threatening to cripple the health care system and majority of the claims seen in South Africa are against the state, so it is incumbent on the state to act to properly manage the situation.

7.1

MODIFIED CANADIAN INDEMNITY SYSYTEM

I am of the opinion that a modified approach to the Canadian system where the Canadian Medical Protection Association (CMPA) takes over the role of settling claims and defending physicians[84] may be appropriate for South Africa, the state should create a National Health Professional and Hospital indemnity insurance, so there is a contribution to the fund by all health professionals, and the premiums will be subsidized substantially by the state, the health professional's contribution goes off the salary of healthcare workers monthly and the hospital also contributes monthly.

The scheme will employ doctors whose job will be to analyse every claim from a medical viewpoint working closely with lawyers employed by the scheme to determine the merits of the claim, the decision to settle or head for litigation will be made by the scheme

[84] www.cmpa-acpm.ca (accessed 7/10/2019)

By this method the Department will shift the burden of settling medical malpractice claims to the insurer, a similar system is practiced in the United Kingdom and seems to have worked well in those climes.

The Insurance scheme should not penalise the healthcare practitioner directly if there is a malpractice claim against them, however a negative scoring which is only known to the healthcare practitioner and the scheme is introduced and when the negative score gets to a certain value then disciplinary action will be instituted against the healthcare practitioner.

This method comes with the advantage that the health care practitioner is much more careful to avoid increasing his negative rating with the scheme in the future, and he is not embarrassed as the scoring is not made public, he or she is not likely to suffer psychological setbacks from the event but may actually become a better doctor. The doctors' premium should never be increased due to malpractice claims against him or her

As noted earlier doctors have been known to leave the profession following malpractice claims against them, this approach will no doubt reduce that exodus.

Periodic training for health care practitioners should also be part of the responsibility of the scheme, from the previous cases managed by the scheme , the scheme gains experience on the various kind of negligence and how the Court decided, this will in turn be used for training purposes to prevent negligence in future, this training should be made compulsory to all care workers employed by the state and should form part of the continuous professional development , the training will most appropriately be delivered by both doctor and lawyers

The Indemnity scheme should always consider Alternate dispute resolution as the first line to avoid legal cost as much as possible, the advantages is that the claimant is spared several years of attending court and the fierce acrimony often associated with legal battles is avoided

Another consideration would have been the no Fault system as it is practiced in Sweden but considering the socio-economic situation in South Africa, where a majority of the people using the public health system are indigent, the no fault system may encourage more trivial and irresponsible claims which may open a

floodgate of litigation and the state may not be able to cope. There may however be some modification of the No fault system , Where the state should set up a review board of all the claims and the board must establish causation before the claim is settled, this will no doubt reduce the amount the state pays out as against the Simply no fault settlement.

The claimant will still have the choice to approach a court of law if he or she is not satisfied with the decision of the review board.

In a recent Constitutional Court (CC) judgment delivered by Zondo J on 30 March 2016 in the matter of *Links v Department of Health*[85], the Constitutional Court unanimously upheld an appeal against a judgment and order of the full Bench of the Northern Cape Division of the High Court in Kimberley (the full Bench). The full Bench upheld an earlier judgment by Mamosebo AJ dismissing the applicant's (Links) claim with costs on the basis that his claim against the respondent (the MEC) had become prescribed and with this one may begin to consider changes to some legislation

7.2

CHANGES TO THE LEGISLATION

7.2.1

a, The prescription act

The issue of prescription, is another avenue in which the state can manage the rising numbers in medical malpractice litigation, the Prescription Act 68 of 1969.[86] states as follows in

Section 11

The periods of prescription of debts shall be the following:

(a) thirty years in respect of-

(i) Any debt secured by mortgage bond;

(ii) Any judgment debt;

[85] *Links v Department of Health, Northern [Cape] Province* 2016 (4) SA 414 (CC),
[86] the Prescription Act 68 of 1969

(iii) Any debt in respect of any taxation imposed or levied by or under any law;

(iv) Any debt owed to the State in respect of any share of the profits, royalties or any similar

consideration payable in respect of the right to mine minerals or other substances;

(b) fifteen years in respect of any debt owed to the State and arising out of an advance or loan of money or

A sale or lease of land by the State to the debtor, unless a longer period applies in respect of the debt in question in terms of paragraph (a);

(c) six years in respect of a debt arising from a bill of exchange or other negotiable instrument or from a notarial contract, unless a longer period applies in respect of the debt in question in terms of paragraph (a)

Or (b);

(d) Save where an Act of Parliament provides otherwise, three years in respect of any other debt.

Debts that arise from contracts and delicts which is the category the medical malpractice fall into will prescribe in 3 years, and the time starts counting from when the debtor becomes aware of the debt.

It is suggested that medical malpractice claims should prescribe in 2 years as against the present 3 years for justice to be delivered fairly and accurately for both the defendant and claimant. This is because medical procedures are always complex and details can be easily forgotten especially where the health care practitioner sees several of such cases on a daily basis, with regards to the patient, the injury may have progressed and assumed a totally different form since the procedure, so for justice to be served it is best that a shorter prescription time is used specially for medical malpractice litigation so both claimant and defendant will not unintentionally mislead the Court.

It is important to add that for children or insane people this shorter period should not necessarily obtain given their peculiarities.

7.2.2

b, The State Liability act and Structured Payment

The role of structured payment for successful claims should also be considered, because the primary role of the department of health is to provide health for as many people as possible, settling huge claims at the same time will put immense pressure on the budget and health delivery may be compromised, so if claims are settled in instalments the state can still carry out other responsibilities to ensure that the department does not collapse.

It also offers the patient continuous access to funds to manage the damage resulting from the negligence which may not be the case if the entire fund is paid at once, there is also the possibility that if the funds are paid once off the funds could be mismanaged and it will defeat the real essence of compensating the patient, an example is in the case of a child born with cerebral palsy , a condition in which the child has mental retardation and severe muscular dysfunction and will require continuous and ongoing treatment for their entire life, it will be helpful for the money to be provided as needed for the ultimate benefit of the patient. So funds are made available for special schools when the time arises and most of all the special needs of a cerebral palsy patient.

Instalment payments may dissuade people that sue because of greed and suing the state will not be seen as scheme to get rich, the same will apply to the lawyers who are attracted to medical malpractice litigation because of the huge sums of money that may be paid out.

The State liability amendment bill seeks to incorporate some provisions in line with the above thinking, following the recommendation of the law reform commission the government is advocating for amendments in the state liability act.[87] see bill below

[87] State liability amendment bill

2A. (1) A court must, in a successful claim against the State resulting from wrongful medical treatment that exceeds the amount of R1 million, order that compensation be paid to the creditor in terms of a structured settlement which may provide for—

(a) Past expenses and damages;

(b) Necessary immediate expenses;

(c) The cost of assistive technology or other aids and appliances;

(d) General damages for pain and suffering and loss of amenities of life;

and

(e) Periodic payments for future costs referred to in subsection (2).

(2) (a) Where the State is liable to pay for the cost of future care, future

Medical treatment and future loss of earnings of an injured party, the court

must, subject to subsection (4), order that compensation for the said costs

Be paid—

(i) By way of periodic payments at such intervals, which may not be less

often than once a year;

(ii) Only during the lifetime of the injured party concerned; and

(iii) On such terms as the court considers necessary

(b) The court may—

(i) In lieu of the amount; or

(ii) At a reduced amount,

Of compensation that would have been paid for the future medical treatment of the injured party, order the State to provide such treatment to the injured party at a public health establishment.

(c) Where the State is ordered to provide future medical treatment at a public health establishment, the public health establishment concerned must be compliant with the norms and standards as determined by the Office of Health Standards Compliance established in terms of section 77 of the National Health Act, 2003 (Act No. 61 of 2003).

(d) In circumstances where future medical treatment has to be delivered in a private health establishment, the liability of the State shall be limited to the potential costs that would be incurred if such care was provided in a public health establishment.

(3) The amount payable by way of periodic payments must increase annually in accordance with the average of the consumer price index, as published from time to time by Statistics South Africa established in terms of section 4 of the Statistics Act, 1999 (Act No. 6 of 1999), for the immediately preceding period of 12 months.

(4) The State or creditor referred to in subsection (1) may apply to the court for a variation of the frequency, or amount, of periodic payments, or for a variation of both the frequency and amount of periodic payments, should a substantial change in the condition or the circumstances of the injured party necessitate such a variation.

I strongly suggest that this piece of legislations should be followed through earnestly as it will be of immense help to manage the rising no of litigation against health care practitioners

In the United States some state also may permit a defendant to cease payments if anticipated losses do not occur (e.g., periodic payments for damages other than lost earnings may cease if the plaintiff dies)[88]

[88] Peter P.et al.(2005)11 "Medical Malpractice Law in the United States" for the Henry J. Kaiser Family Foundation The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public

7.2.3

C. The enforcement of section 46 of the national health act 61 of 2003

Obligations of private health establishments. —every private health establishment must maintain insurance cover sufficient to indemnify a user for damages that he or she might suffer as a

Consequence of a wrongful act by any member of its staff or by any of its employees. (Date of commencement of s. 46: 1 March, 2012.)[89]

This act must be enforced to its fullest so the insurer and not the private institution or the doctor bears this burden of settling judgments debt. Presently some doctors working in private hospitals may decide not to take indemnity cover

The Medical Protection Society represents most healthcare practitioners working privately in South Africa, about 30,000 presently,[90] it is suggested that more private insurers should come into this space to ensure more vigorous competition and the cost of premiums will naturally reduce, with more players in this industry it is expected that the defence for doctors and hospital will be more meticulous and aggressive which will most likely translate to more court victories for the healthcare providers and hospitals and dismissal of frivolous claims, the resultant effect is that patients will be discouraged to approach Court for claims that are unlikely to succeed

7.2.4

D, Relooking the contingency fee act

Because of the peculiar nature of the medical negligence cases the contingency fee act should be amended to exclude medical negligence cases, it is argued that lawyers flood the courts with these cases even when the chances of success is slim, but the fact that the settlement is usually huge they will prefer to take their chances, another reason is that the primary purpose of awarding compensation to the patients may be

[89] National Health Act.
[90] https://www.medicalprotection.org/southafrica/home

defeated because these cases go for years and the patient may end up getting a very small fraction of the award as most of the award will go to legal cost.

7.3

ABOLISHING NON-PECUNIARY AWARDS

Placing a cap on non-pecuniary claims like loss of enjoyment of life and emotional stress has been mooted in some quarters or the total cancellation by the legislature, I am of the opinion that if the damage is already being compensated and the damage suffered is gradually being corrected then the emotional pains that developed from the damage will equally be erased as time goes by, the state or defendant paying for emotional loss can be seen as paying twice for the same negligence, I suggest that that non pecuniary loss should be entirely scrapped.

The aim of the court is to compensate the plaintiff and not to enrich them; the legislature should also take into cognisance that the state has a bigger responsibility to the entire population and has a duty to apportion funds equitably to settling claims and ensuring that there are funds for all other of its responsibilities. The state has a constitutional obligation to fulfil the right to health for its citizens and our Courts and the legislature must work with the state to meet those obligations

7.4

COLLATERAL AWARDS

The award granted by the courts could be reduced if the plaintiff has a government sponsored insurance that will pay to the plaintiff following the harm caused by negligence of a state employed healthcare practitioner, some states in the united states practice this (e.g., in Tennessee, payments by government programs or employer-sponsored insurance are considered collateral sources and will be taken off the jury

award, but amounts paid by insurance held directly by the plaintiff do not count to reduce a jury award.)[91] If applied in South Africa will help the state in saving cost, however this suggestion can be further scrutinized to be sure that no laws are broken or rights of the patient breached.

7.5

REVISITING THE REASONABLE DOCTOR TEST

The measure for the standard of care expected of a health care practitioner before he will be said to be negligent in South Africa is to ask if the health care worker acted below what is expected of any other reasonable healthcare worker of the same qualification, i.e. if a reasonable anaesthetist would have acted differently from the defendant if the defendant is an anaesthetist (The reasonable doctor test), to increase the burden of proof of the plaintiff and consequently reduce the barrage of litigation, factors like the facility in which the doctor works should be considered, doctors working in rural South Africa without much support should not be accessed like a doctor in a first class facility in Johannesburg. In public hospitals because of lack of personnel the doctors are meant to work very long hours, this should also be a consideration by the courts in determining if the doctor in their personal capacity acted negligently

Another factor that will increase the burden of proof for the plaintiff is to consider that amount of support a defendant doctor had in terms of other medical personnel that are able to support the doctor when the negligence occurred and if the doctor was acting in the best interest of the patient because waiting for other specialist to arrive without doing anything would have worsened the case of the patient. In *Mitchell v Dixon*,[92]the Court asserted that the highest level of care is not expected of doctors. While In *S v Burger*,[93] the Court in reference to fault stated

"One does not expect of a *diligens paterfamilias* any extremes such as Solomonic wisdom, prophetic foresight, chameleonic caution, headlong haste, nervous timidity, or the trained reflexes of a racing driver. In short, a *diligens paterfamilias* treads life's pathway with moderation and prudent common sense".

[91] Peter P. et al "Medical Malpractice Law in the United States"

[92] *Mitchell v Dixon*

[93] *S v Burger* 1975 (4) SA 877 (A)

In developing our common law and future adjudication in Medical malpractice cases the reasoning of the Courts in *Mitchel V Dixon* , *S v Burger* and *Van Wyk v Lewis* should constantly guide our Courts as it can be seen that medical negligence is peculiar.

7.6

ACTION TAKEN BY SOME PROVINCES IN SOUTH AFRICA

Some of the different provincial Departments of health are beginning to take action to minimize the loses from medical negligence litigation, in the Eastern Cape for example given the poor outcome of defence of medical malpractice cases by state attorneys, the department recently engaged the services of a private law firm Smith Tabata and Norton Rose Fulbright and between 2017 and early 2018, the law firm saved the department about 45 million Rands, with the state attorneys the state was only able to successfully defend about 2% of the cases brought against it from 2014 till the law firm took over[94].

In the Western Cape. In order to mitigate the loses and dissuade attorneys from arbitrarily suing the department of health and bringing frivolous claims, the department has organized an in house team that accesses every claim and vigorously defends all claims,[95] and if they realise that the department was negligent they settle immediately thereby eliminating prolonged legal battle that will no doubt result to huge legal cost to department.

Also the Department now has introduced Trust for children that suffered damage from medical negligence in its hospitals, the fund pays for the continuous maintenance of the children but returns the fund to the department in the event of death, this deviates from the previous practice of once off payment, as the children are often times seen to return to the same provincial institutions for treatment after the money paid is not judiciously managed by the parents or guardian of the child.

These practices in some of the provinces should be examined and all the positives taken out to try and create a national approach to solving the problem of increasing medical malpractice litigation.

[94] Tamar Khan, Financial times 19 July 2018
[95] *ibid*

7.7

SPECIALIST DOCTORS FOR RURAL AREAS

There is no doubt that there is a dearth of specialist doctors in rural south Africa, the Provincial governments should embark on recruitment of specialists to rural South Africa because some of the medical negligence cases seen in rural South Africa will normally arise from errors made by medical officers because of lack of specialist support. The provinces can attract specialist to rural South Africa by huge incentives like better rural allowance and accommodation. Specialist doctors can be sourced from Eastern Europe because the salary paid to doctors here in South Africa will be competitive to what obtains in Eastern Europe.

It is believed that some of the errors arising in rural hospitals will be reduced if there is an increase in the no of specialists in different fields of medicine practicing in rural South Africa

7.8

A CASE FOR MEDIATION.

As an alternative to litigation and the attending costs associated with litigation, mediation may be an alternative method to vigorously pursue. The evidence of its success in the United Kingdom can be a motivation to adopt same in South Africa.

The merits of mediation include

1. It saves time , from table 4 shown above it can be seen that Litigation can run into years, while mediation can be completed in in one day, waiting for trail days are completely eliminated

2. It cost a lot less to the state and the plaintiff, attorney fees are reduced or even eliminated , and if the state or hospital has to settle out of Court it is without legal cost , the normal contingency fee that amount to 25% is eliminated
3. Mediation creates an atmosphere of confidentiality, where the participants feel safe and free to tell the truth and since it is carried out without prejudice, the parties may have their attorneys attend so they may feel more confident not to be undermined.
4. Mediation is less acrimonious and the relationship between the parties does not deteriorate as they do not necessarily become adversaries, as much as possible mediation is conducted in an atmosphere to promote psychological healing.
5. In Mediation the very complex issues that may have brought about the injury are spelt out and if there is any lack of understanding on the part of the patient it is explained to the patient.
6. Mediation is voluntary and not binding, any party may decide to withdraw at any stage and seek to go to litigation, and this further encourages both parties to be as open as possible.

Singapore has reported over 93% success rate from mediation in the year 2000.[96]

[96] Claassen N. *(2016)* South African journal for Bioethics and law 9(1):7-10.

CHAPTER 8.

CONCLUSION

Both the private and public sectors have become aware of the dangers posed by the increasing numbers of medical negligence litigation to health care delivery and efforts are being sort to manage the crisis , it is believed that all the suggested reforms depending on what suits the sector should be employed in attempts at managing the situation

The overall aim is to reduce negligence as much as possible and defend frivolous claims vigorously, the hospitals should be a place to get healed and not to get worse, but when damages inevitably occur from medical negligence, the state or the private institution involved should create functional systems that can compensate the victim, but a balance should be created so that the ultimate goal of caring for more people is not compromised as we see now in provincial hospitals.

South Africa has recently introduced the National Health Insurance scheme (NHI), the objective being to provide universal health coverage for all its' citizens, as the program is still relatively new it is hoped that the authorities will make effort to consider the rising trends in medical malpractice litigation in rolling out this programme.

It is expected that more people will have access to hospitals and the already heavily burdened public health system will be under enormous strain, this I expect should have been some of the factors considered in the

planning stages of the NHI and measures must have been put in place to manage the possible fall outs of this increase access to hospital one of which is likely further increase in medical malpractice litigation.

Amendments in legislation especially the State liability act is encouraged, our Courts should be encouraged to develop the common law considering on one hand the welfare of patients who have suffered damage from medical negligence and also the healthcare needs of the larger population that require the state to provide them with excellent medical care, in keeping with the duty of the
government to meet the Constitutional socio-economic rights to Health of the people as provided for in section 27 of the South African constitution.

The methods used in other countries that have proven to be successful and seen to have saved the healthcare authorities cost and at same time adequately rewarded deserving patients who have suffered damages from medical negligence should also be introduced. The Canadian system where the Canadian Medical Protection Association represents member physicians in medical malpractice litigation, pays out claims to deserving patients and also trains physicians on how to minimise negligence and subsequently litigation[97] is highly recommended

Where alternate dispute resolution is believed to be the most feasible approach, then it should be used.

Singapore's experience[98] with overwhelming success in alternate dispute resolution is worthy of further exploring

As mentioned earlier some provinces in South Africa have already begun experimenting on different methods to try and solve the problem, where success has been recorded, other provinces should emulate the initiating provinces.

It is believed that managing the explosion of medical malpractice litigation and the consequences that come with it is a continuous process and at all times health authorities and policy makers should build on whatever is applicable to better manage the situation.

[97] www.cmpa-acpm.ca

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