

Re-evaluating medical malpractice: A patient safety approach

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OPSOMMING

Herevaluering van mediese wanpraktyke: 'n Pasiënt-veiligheidsbenadering

Toenames in mediese wanpraktykseise en litigasie beïnvloed 'n aantal verskillende rolspelers. Die debat rondom ingrepe en hervorming wentel meestal om die finansiële implikasies daarvan. Koste verbonde aan eise word as 'n bedreiging vir die huidige gesondheidstelsel en die beoogde Nasionale Gesondheid Versekeringskema beskou. Ingrepe wat gemik is op die beperking van kostes word dus tans oorweeg. Hierdie konvensionele ingrepe sal slegs die bestaande mediese aanspreeklikheid- en vergoedingstelsel in 'n mindere mate wysig. Daar is egter kommer oor die doeltreffendheid van die bestaande stelsel. Ongewenste mediese uitkomst is verbasend algemeen en is heel waarskynlik 'n meer gereelde verskynsel in ontwikkelende lande soos Suid-Afrika. Tog stel net 'n fraksie van beseerde pasiënte na so 'n voorval eise in en nóg minder word vergoed. Sommige aanduidings dui daarop dat die sisteem se impak op die voorkoming van ongewenste uitkomst en wanpraktyke maar gering is en dat dit selfs 'n negatiewe effek mag hê op die beoefening van medisyne. Pasiënte, wat die swaarste geraak word deur wanpraktyke, se belange word dikwels nie behoorlik oorweeg nie. Die impak van wanpraktyke op die pasiënt en die geweldige struikelblokke wat oorkom moet word om vergoeding te verkry, noodsaak 'n pasiënt-georiënteerde benadering tot die komplekse kwessies ter sprake. Fundamentele hervorming, wat sowel die doelwitte van die gesondheidstelsel as die mediese aanspreeklikheid- en vergoedingstelsel met mekaar in lyn bring, moet oorweeg word ten einde die gehalte van sorg en pasiënt-veiligheid te bevorder. Konkrete navorsing word benodig om beleid op dié gebied toe te lig.

1 INTRODUCTION

Increases in medical malpractice claims and litigation affect a number of different stakeholders. The debates around interventions and reforms often revolve around the financial implications thereof. Concerns have been raised about escalating insurance premiums and the concomitant consequences.¹ Some have indicated that they have had to change the way in which they practice medicine,

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

by ordering more diagnostic tests or avoiding certain procedures.² Practitioners might even consider leaving certain high risk specialities altogether.³ Inevitably, reforms which seek to limit the number and cost of malpractice claims are proposed by health care providers and their insurers. Typically, these proposed reforms include, amongst others, the capping of non-economic damages and shortening statutes of limitation and repose.⁴ These reforms would merely alter certain aspects of the South African liability and compensation system, but fundamentally it would remain unchanged.

There are however, concerns about the effectiveness of the existing system. Some have suggested a need for more fundamental changes and have proposed a number of alternative measures to deal with malpractice liability and compensation.⁵ Several of these proposals are likely to be met with fierce opposition from the legal profession, who may oppose changes to the existing system on philosophical grounds, or perhaps more likely, due to the monetary consequences thereof. Some proposed changes would fundamentally transform the existing system, reducing litigation and subsequently the income generated thereby.

Medical malpractice reform is, of course, a very complex issue. It is submitted that discussions surrounding the matter should have a strong patient-oriented focus. As patients are the ones who are the most severely affected by malpractice, their interests should be decisive.⁶ It is thus of the utmost importance to consider their perspective.

2 THE PATIENT AND THE CONSEQUENCES OF MEDICAL MALPRACTICE

Patients are often in a vulnerable psychological state when they are diagnosed and have to undergo treatment.⁷ When faced with certain illnesses, severe anxiety or post-traumatic symptoms may be elicited.⁸ Emotional distress may even be present where the diagnosis is clear and treatment has the intended outcome.⁹ Therefore, when all does not go according to plan, the impact is likely to be

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

3 Howarth "The threat of litigation: private obstetric care – *Quo vadis?*" 2011 *SA J of Bioethics and Law* 86; Howarth "The rising cost of litigation; a threat to private obstetric care?" 2013 *Obstetrics and Gynaecology Forum* 35.

4 Barringer *et al* "Administrative compensation of medical injuries: A hardy perennial blooms again" 2008 *J of Health Politics, Policy and Law* 726.

5 Crous "Keuringspanele ('screening panels') as gepaste geskilbeslegtingsmetode ter oplosing van mediese wanpraktyksgeskilte" 2009 *PELJ* 98; Coetzee "The spectre of litigation – A dark cloud on the obstetric horizon" 2010 *Obstetrics and Gynaecology Forum* 111; Pepper and Slabbert 2011 *SA J of Bioethics and Law* 33.

6 Carstens and Pearmain *Foundational principles of South African medical law* (2007) 599. The term "medical malpractice" includes professional negligence and all forms of medical misconduct.

7 See Carstens and Pearmain (2007) 489 where the vulnerability of the patient as a consumer of health care goods and services is discussed.

8 Tedstone and Tarrier "Post-traumatic stress disorder following medical illness and treatment" 2003 *Clinical Psychology R* 409.

9 Vincent "Understanding and responding to adverse events" 2003 *New England J of Medicine* 1054.

particularly distressing.¹⁰ Patients suffer injuries that may have long-term effects on their work, social life and family relationships.¹¹ The immense trauma experienced as a result of the original injury may be aggravated by the manner in which the incident is subsequently handled.¹² Practitioners giving inadequate and evasive explanations of the error may upset patients even further.¹³ Vincent indicates that a patient's initial reaction to a medical injury will, most likely, consist of fear, loss of trust and a feeling of isolation.¹⁴ Not only will the patient have to live with the physical consequences of the injury, which may include permanent impairment, but the subsequent psychological effects could be just as, if not more, traumatic.¹⁵ The devastating consequences of an injury often only become apparent in the long term. Additional surgeries and hospitalisation are likely to be required in most serious cases. The patient may also have to live with chronic pain, disfigurement, disability and depression, which could severely affect his or her quality of life and relationships.¹⁶ The injured individual is not the only one who may be severely affected by a medical error. Family and friends of the patient are also likely to suffer.¹⁷ Such an adverse event could be emotionally and financially devastating to people close to the patient, not to mention the immense trauma and lasting sorrow they may face in the case of the patient's untimely death.¹⁸

3 INCIDENCE OF ADVERSE EVENTS

The devastating consequences of medical malpractice are disconcerting, even more so when one considers the incidence of adverse events.¹⁹ A number of different countries have conducted studies into iatrogenic harm.²⁰ They have

10 Gallagher *et al* "Patients' and physicians' attitudes regarding the disclosure of medical errors" 2003 *JAMA* 1005.

11 Vincent, Phillips and Young "Why do people sue doctors? A study of patients and relatives taking legal action" 1994 *Lancet* 1609.

12 Vincent 2003 *New England J of Medicine* 1054.

13 Gallagher *et al* 2003 *JAMA* 1005.

14 Vincent 2003 *New England J of Medicine* 1054.

15 *Ibid.*

16 *Ibid.*

17 *Ibid.*

18 Vincent and Coulter "Patient safety: What about the patient?" 2002 *Quality and Safety in Healthcare* 78.

19 Vincent *Patient safety* (2010) 52. An adverse event is defined by the author as an "unintended injury caused by medical management rather than by the disease process and which is sufficiently serious to lead to prolongation of hospitalization or to temporary or permanent impairment or disability to the patient at time of discharge or both". The definitions and terminology employed in studies may vary and the author cautions against the misinterpretation of findings on that basis. As such, what constitutes "medical management", "injury" and "error", may differ from one study to the next.

20 Brennan *et al* "Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I" 1991 *New England J of Medicine* 370; Thomas *et al* "Incidence and types of adverse events and negligent care in Utah and Colorado" 2000 *Medical Care* 261; Wilson *et al* "The quality in Australian health care study" 1995 *Medical J of Australia* 458; Davis *et al* "Adverse events in New Zealand public hospitals I: Occurrence and impact" 2001 *New Zealand Medical J* 203; Vincent, Neale and Woloshynowych "Adverse events in British hospitals: Preliminary retrospective record review" 2001 *BMJ* 517; Baker *et al* "The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada" 2004 *Canadian Medical Association J*

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found incidence rates of between 2.9% and 16.6%, depending on the methodology applied. Almost all of the studies indicated that the majority of the adverse events were preventable. The landmark Harvard Medical Practice Study revealed that adverse events occurred in 3.7% of hospitalisations and that 27.6% of the adverse events were due to negligence.²¹ Employing a similar methodology to the Harvard study, researchers found comparable rates of negligence in Utah and Colorado.²² Also of concern is the fact that 2.6% of adverse events caused permanent disabling injuries and 13.6% resulted in the death of the patient.²³ Medical management is thus responsible for a significant amount of injuries and several can be attributed to sub-standard care.²⁴ The study also emphasised that most adverse events are avoidable and that errors in medical practice are common.²⁵ More than half of the adverse events were caused by management errors.²⁶ Adverse events did occur more frequently in certain specialities. However, this was mainly due to the nature of the medical interventions and the risks associated with those specialities.²⁷ Accordingly, thoracic surgery, obstetrics and neurosurgery did account for more adverse events, but the events were not more likely to have been caused by negligence.²⁸

4 ADVERSE EVENTS AND MALPRACTICE CLAIMS

One of the most alarming findings of the Harvard study was the relationship between malpractice claims and adverse events due to negligence.²⁹ Medical records were matched with data on medical malpractice claims in order to identify patients who had filed claims against practitioners and hospitals.³⁰ It was found that 98% of all adverse events due to negligence in the study did not result

1678; Schiøler *et al* "Incidence of adverse events in hospitals. A retrospective study of medical records" 2001 *Ugeskr Laeger* 5370; Michel *et al* "French national survey of inpatient adverse events prospectively assessed with ward staff" 2007 *Quality and Safety in Healthcare* 369; Aranaz-Andrés *et al* "Incidence of adverse events related to health care in Spain: Results of the Spanish national study of adverse events" 2008 *J of Epidemiology and Community Health* 1022; Zegers *et al* "Adverse events and potentially preventable deaths in Dutch hospitals: Results of a retrospective patient record review study" 2009 *Quality and Safety in Healthcare* 297; Mendez *et al* "The assessment of adverse events in hospitals in Brazil" 2009 *Int J for Quality in Health Care* 279; Letaief *et al* "Adverse events in a Tunisian hospital: Results of a retrospective cohort study" 2010 *Int J for Quality in Health Care* 380; Aranaz-Andrés *et al* "Prevalence of adverse events in the hospitals of five Latin American countries: Results of the 'Iberoamerican study of adverse events' (IBEAS)" 2011 *Quality and Safety in Healthcare* 1043.

21 Brennan *et al* 1991 *New England J of Medicine* 371.

22 Thomas *et al* 2000 *Medical Care* 265.

23 Brennan *et al* 1991 *New England J of Medicine* 371.

24 *Idem* 373.

25 Leape *et al* "The nature of adverse events in hospitalized patients: Results of the Harvard Medical Practice Study II" 1991 *New England J of Medicine* 380.

26 *Idem* 381.

27 *Idem* 383.

28 *Ibid*.

29 Localio *et al* "Relation between malpractice claims and adverse events due to negligence: Results of the Harvard Medical Practice Study III" 1991 *New England J of Medicine* 245.

30 *Idem* 245.

in malpractice claims.³¹ The negligence to claims ratio was found to be 7.6 to 1.³² This means that claims occur only 13% as often as injuries due to malpractice.³³ Of those patients who do file claims, perhaps half will receive compensation.³⁴

The results of the study suggest that patients who have suffered injuries due to negligence are rarely compensated and that health care providers are hardly ever identified and held accountable for sub-standard medical care.³⁵ The poor correlation between medical negligence and malpractice claims was also present in the Utah and Colorado study.³⁶ Only 3% of patients who suffered injuries due to negligence instituted claims.³⁷ These studies have cast doubt on the malpractice system's ability to deter sub-standard medical practice and compensate negligently injured patients.³⁸

5 INCIDENCE OF ADVERSE EVENTS IN DEVELOPING COUNTRIES

There are almost no published studies on the incidence of adverse events from developing countries. Nearly all studies into adverse events have thus far been conducted by developed nations. However, in 2006, a research project was launched by the WHO World Alliance for Patient Safety in conjunction with the Ministries of Health of Egypt, Jordan, Kenya, Morocco, Tunisia, South Africa, Sudan and Yemen to ascertain the frequency, causes and preventability of adverse events in hospitalised patients in the participating countries.³⁹ A retrospective review of randomly selected medical records from 26 hospitals was undertaken.⁴⁰ The hospitals that formed part of the study were large teaching and urban hospitals, two to six hospitals per country, and consisted of 23 general public hospitals (that included 13 teaching hospitals), one obstetric hospital, one paediatric hospital and one private hospital.⁴¹ Many of the participating hospitals were considered to be amongst the best providers of health care in their respective countries, which serves to emphasise the results and the need for a renewed focus on patient safety.⁴² The results indicated that at least one adverse event occurred in 8.2% of cases, a rate which varied from 2.5% to 18.4% between countries.⁴³ The authors indicate that this is probably an under-estimate of the true rate and that the under-estimate might be quite large.⁴⁴

31 *Idem* 247.

32 *Idem* 248.

33 *Ibid.*

34 *Idem* 249.

35 *Idem* 250.

36 Studdert *et al* "Negligent care and malpractice claiming behaviour in Utah and Colorado" 2000 *Medical Care* 250.

37 *Idem* 255.

38 *Ibid.*

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

40 *Ibid.*

41 *Ibid.*

42 *Ibid.*

43 *Ibid.*

44 *Ibid.*

The finding that 83% of adverse events were highly preventable is significantly higher than previous studies, which estimated that around half were preventable.⁴⁵ A further concern is the fact that 30% of adverse events were associated with the death of the patient, compared to 4% to 15% reported in other studies.⁴⁶ This accounts for nearly 2% of all hospitalised patients in the eight participating countries.⁴⁷ Adverse events also led to 14% of patients sustaining permanent disability.⁴⁸ Adverse events caused by therapeutic error were found to be the most common, followed by diagnostic error and operative errors.⁴⁹ Reviewers identified a number of factors, which they believed contributed towards the adverse events. Inadequate training or supervision of clinical staff was identified as the largest contributor, followed by the absence of or failure to implement a relevant protocol or policy.⁵⁰

The nature of the study with its review of medical records may have placed a focus on individual performance and, therefore, reviewers were less likely to identify systemic failures as contributing factors.⁵¹ These systemic factors often predispose individuals to error and may be particularly prevalent in countries with scarce resources and weak infrastructure.⁵²

6 A FAULTY LIABILITY AND COMPENSATION SYSTEM?

The burden of iatrogenic injury is large. Developing countries, such as South Africa, may suffer more adverse events due to systemic factors. Adverse events associated with management errors cause distress, disability, permanent impairment and death. Many preventable mistakes lengthen hospital stay and result in an increased consumption of health resources. A significant number of patients are injured, many due to the negligent conduct of practitioners and medical personnel, yet there is evidence to suggest that only a fraction of these patients institute claims.

The studies conducted in other countries have raised a number of questions. Why do so few injured patients institute claims, why are fewer still compensated, what are the effects of these injuries on the health care system, and what can be done to address the problem? It is very likely that South Africa faces many of the issues identified by these other countries. It could be that those patients, who lodge malpractice claims locally, represent only a small fraction of patients who were actually injured by negligent treatment and that fewer still will receive compensation. Patients, who go uncompensated, will however still have to live with and bear the physical, psychological and financial burden of those injuries. Research into the prevalence of adverse events, negligence and malpractice in South Africa is required.

45 *Ibid.*

46 *Ibid.*

47 *Ibid.*

48 *Ibid.*

49 *Ibid.*

50 *Ibid.*

51 *Ibid.*

52 *Ibid.*

7 OBSTACLES IN OBTAINING COMPENSATION

Injured patients who do eventually decide to file claims face a number of challenges. Litigation is a costly endeavour and medical malpractice cases often take years to be resolved. Patients who are able to afford litigation, frequently find it very difficult to prove negligence on the part of the practitioners or hospital personnel involved. A number of factors may contribute to the difficulty of the undertaking.

7.1 Burden of proof

In civil cases, the onus of proof lies with the patient. To succeed with a claim, liability needs to be established on a preponderance of probabilities.⁵³ The inherent nature of medicine and the fact that tragic outcomes are often inevitably complicated matters. Practitioners cannot guarantee that treatment will be successful and, consequently, cannot be held accountable for every adverse event or failed intervention.⁵⁴ The mere fact that an injury occurred, does not enable one to conclude that it was necessarily due to sub-standard care.⁵⁵ *Van Wyk v Lewis*⁵⁶ has also functioned as a “protective shield” for practitioners in this regard.⁵⁷ Our law has assumed a rather sheltering attitude towards the medical profession, which is nowhere more apparent than in the *Van Wyk* judgement.⁵⁸ The Appeal Court effectively held that the doctrine of *res ipsa loquitur* does not apply to medical situations.⁵⁹ The maxim thus cannot be invoked to aid the claimant plaintiff in proving his or her case. There can be no inference of negligence, except where the “negligence alleged depends on absolutes”.⁶⁰ This position has been widely discussed and it has been argued that the maxim should be applied in specific circumstances in the medical negligence context, especially if regard is had to principles of procedural equality and certain constitutional considerations.⁶¹

The maxim has again recently come up for judicial consideration, with two differing outcomes. The court in *Ntsele* considered the case to be of an exceptional nature, thus finding that the invocation of the maxim was legally justified if regard was had to section 27 of the Constitution.⁶² In a much more conservative judgement, the court in *Goliath* indicated that it was bound by the principles set out in *Van Wyk*, and that the maxim could therefore not be

53 Claassen and Verschoor *Medical negligence in South Africa* (1992) 26.

54 Giesen *International malpractice law: A comparative study of civil liability arising from medical care* (1988) 512.

55 *Ibid.*

56 1924 AD 438.

57 Strauss *Doctor, patient and the law: A selection of practical issues* (1991) 244.

58 *Ibid.*

59 *Idem* 245.

60 *Pringle v Administrator, Transvaal* 1990 2 SA 379 (W) 384.

61 Van den Heever *The application of the doctrine of res ipsa loquitur to medical negligence actions: A comparative survey* (LLD thesis UP 2002); Van den Heever and Carstens *Res ipsa loquitur and medical negligence: A comparative survey* (2011) 145.

62 *Ntsele v MEC for Health, Gauteng Provincial Government* 2013 2 All SA 356 (GSJ) [122]–[126]. See also Carstens “Judicial recognition of the application of the maxim *res ipsa loquitur* to a case of medical negligence *Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (unreported as yet, Case Number: 2009/52394 (GSJ) dated 24 October 2012)” 2013 *Obiter* 548 for a discussion of the judgment.

applied.⁶³ Lowe J also stated that the contrary finding in *Ntsele* was incorrect.⁶⁴ Nevertheless, the court did remark that much can be said for revisiting the applicability of the *res ipsa loquitur* maxim in the medical negligence context.⁶⁵

7.2 Expert medical evidence

Medical treatment and interventions have become exceptionally sophisticated. Establishing that harm was caused due to sub-standard care can thus be particularly complicated. This represents another obstacle that patients would need to overcome if they are to prove their case and obtain compensation. Expert medical evidence is generally presented in support of a claim and plays a pivotal role.⁶⁶ This may pose a number of further problems.

Expert witnesses may be reluctant to testify due to the inconvenience it would entail.⁶⁷ Preparations and the trial itself are time-consuming and would likely be financially detrimental to the practitioner. A practitioner called to testify would need to examine the patient, compile reports, consult with attorneys and study the pertinent literature on the aspects that may arise during the case.⁶⁸ The time a practitioner would need to devote to testimony during the actual trial proceedings may be more than expected, due to the nature of our adversarial system and the unpredictability thereof.⁶⁹ Practitioners are entitled to be reasonably remunerated for the examination of the patient and the reports they compile.⁷⁰ Those who have to prepare themselves to testify, are usually paid an agreed-upon qualifying fee.⁷¹

As for the trial itself, a party involved in proceedings may not enter into an agreement with a witness, whereby compensation will be paid if he or she provides evidence.⁷² Such an agreement is *contra bonos mores* and therefore, null and void.⁷³ A witness is only entitled to the fees prescribed in the official tariff of allowances as determined by the Minister.⁷⁴ The new tariff was published in 2008.⁷⁵ It repealed the out-dated tariff, which had been in force

63 *Goliath v MEC for Health in the Province of Eastern Cape* (1084/2012) [2013] ZAECGHC 72 (14 June 2013) [81].

64 *Idem* [121].

65 *Idem* [82].

66 *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 3 SA 1188 (SCA) 1200. The general applicable approach towards expert medical evidence was set out by the court. See also Carstens and Pearmain (2007) 860.

67 Strauss (1991) 433.

68 *Ibid.*

69 *Ibid.*

70 *Idem* 434.

71 *Ibid.* Now more appropriately termed "preparation fees" in the Uniform Rules.

72 *Van Aswegen v Lombard* 1965 3 SA 613 (A).

73 *Transnet Ltd t/a Metrorail v Witter* 2008 6 SA 549 (SCA) 558. The court reiterated and confirmed the position with regard to the costs of expert witnesses.

74 The tariff is prescribed by the Minister for Justice and Constitutional Development, in consultation with the Minister for Finance, under s 51*bis* of the Magistrates' Courts Act 32 of 1944 and s 42 of the Supreme Court Act 59 of 1959. It should be noted that the Supreme Court Act has been repealed by the Superior Courts Act 10 of 2013, which commenced on 23 August 2013. The date of commencement of s 37, which deals with witness fees, is yet to be proclaimed.

75 GN 394 in GG 30953 of 11 April 2008.

since 1991.⁷⁶ The current tariff provides for a subsistence allowance, transport and travelling expenses, and a maximum amount of R1 500 for income forfeited as a consequence of attending the civil trial.⁷⁷ The maximum fee prescribed in the tariff is very low compared to what most practitioners are likely to earn during a day. It is understandable that they might not be too enthusiastic about the financial implications thereof.

The nature of the adversarial system and the rigorous cross-examination expert witnesses often have to endure may deter them from giving evidence in malpractice proceedings. The court room can be confrontational and witnesses are likely to feel that their professional and personal integrity is called into question by opposing counsel.⁷⁸ The method of enquiry applied during proceedings, may also not be analogous to the reasoning employed by members of the medical community. Explaining intricate technical details of specialised procedures and justifying complex theories in terms which the court would be able to comprehend, may present its own set of unique challenges.

Patients often find it extremely difficult to obtain expert medical witnesses who are willing to testify against fellow members of the profession.⁷⁹ Some have even suggested that a “conspiracy of silence” exists amongst practitioners.⁸⁰ It is more likely that a combination of factors mentioned above, many of which relate to the intrinsic nature of our liability and compensation system, contribute to the difficulties experienced in acquiring necessary expert evidence.

7.3 Obtaining compensation from state institutions

Patients injured in the public health sector may institute claims against the executive authority of the particular department for damages incurred as a result of a breach of contract or delict, or both, committed by employees at state health facilities in terms of the State Liability Act.⁸¹ The disconcerting facts in the *Nyathi* case stand to illustrate the difficulty claimants encountered when seeking to recover damages from state institutions.⁸² Section 3 of the Act, which did not allow for execution or attachment against the state, nor an accessible and simple process to secure effective satisfaction of judgement debts sounding in money, has been declared constitutionally invalid.⁸³ The inexcusable prior situation has now been alleviated by the State Liability Amendment Act 14 of 2011.

76 GN 2596 in *GG* 13604 of 1 November 1991. A witness who provided expert evidence was entitled to R50 and other costs incurred for accommodation, as well as subsistence expenses.

77 GN 394 in *GG* 30953 of 11 April 2008.

78 Strauss “The physician’s liability for malpractice: A fair solution to the problem of proof?” 1967 *SALJ* 420.

79 *Ibid.*

80 *Idem* 419. Strauss dismisses this extreme view as a gross over-simplification.

81 State Liability Act 20 of 1957. Practitioners and other medical personnel are employees in public health facilities and, as such, the state can be held vicariously liable.

82 *Nyathi v MEC for Department of Health, Gauteng* 2008 5 SA 94 (CC). See also Malherbe and Van Eck “The state’s failure to comply with its constitutional duties and its impact on democracy” 2009 *TSAR* 191; Coetzee and Carstens “Medical malpractice and compensation in South Africa” 2011 *Chicago-Kent LR* 1274; Olivier and Williams “State liability for final court orders sounding in money: At long last alignment with the Constitution” 2011 *Obiter* 489.

83 *Nyathi v MEC for Department of Health, Gauteng*. See also Neethling “State (public authority) liability *ex delicto* (1)” 2012 *THRHR* 626.

8 MEDICAL MALPRACTICE AND PATIENT SAFETY

The impact of malpractice on the injured patient and the significant difficulties faced in obtaining compensation have emphasised the need to approach the complex issues with a patient-oriented focus. A large number of patients suffer iatrogenic harm, yet only a small fraction of those patients are compensated.⁸⁴ Avoidable injuries are tragically prevalent, even more prevalent in developing countries such as South Africa.⁸⁵ Many of these injuries are caused by malpractice.⁸⁶ It is argued that, instead of concentrating on reforms that seek to address the financial implications of rising claims, and only indirectly the health care concerns, reforms that seek to reduce sub-standard care should rather be implemented. The role of the compensation and liability system should be re-considered as it relates to patient safety.⁸⁷ It must be determined whether it contributes to, and ensures, a safer health care environment.⁸⁸

The existing compensation and liability system has essentially three social objectives.⁸⁹ It serves to deter sub-standard care, it aims to compensate those patients who were injured as a result of such negligent care and it exacts corrective justice. The deterrence function thereof is particularly relevant to patient safety.⁹⁰ In theory, practitioners would avoid unsafe practices due to the threat of litigation and the consequent emotional and financial costs that would be incurred during a civil trial.⁹¹ Attorneys function as gatekeepers in the system, as they consider the merits of potential claims, along with other factors, when advising their clients to institute claims or not.⁹² If a claim succeeds, indemnity insurance ensures that practitioners are not bankrupted and that patients receive compensation.⁹³ Theoretically, the existing system is adequate and efficient. In reality, however, there are a number of problems.⁹⁴

Studies conducted in the United States have indicated that only a fraction of patients who have suffered injuries institute claims and even fewer receive compensation.⁹⁵ There seems to be a severe divide between injury and litigation.

84 Weiler *et al* *A measure of malpractice: Medical injury, malpractice litigation, and patient compensation* (1993).

85 Wilson *et al* 2012 *BMJ* 344.

86 Localio *et al* 1991 *New England J of Medicine* 245; Studdert *et al* 2000 *Medical Care* 250.

87 Reason "Human error: Models and management" 2000 *BMJ* 768; Bovbjerg, Miller and Shapiro "Paths to reducing medical injury: Professional liability and discipline vs patient safety – and the need for a third way" 2001 *J of Law, Medicine & Ethics* 369.

88 Vincent (2010). See the impressive work by the author, wherein he presents the landscape of patient safety.

89 Miller "Medical malpractice litigation: Do the British have a better remedy" 1985 *American J of Law & Medicine* 435.

90 Schwartz "Reality in the economic analysis of tort law: Does tort law really deter" 1994 *UCLA LR* 377.

91 Calabresi *The cost of accidents: A legal and economic analysis* (1970); Charles *et al* "Sued and non-sued physicians' self-reported reactions to malpractice litigation" 1985 *American J of Psychiatry* 437; Weiler *et al* (1993) 111.

92 Kritzer "Contingency fee lawyers as gatekeepers in the civil justice system" 1997 *Judicature* 22.

93 Howarth, Bown and Whitehouse 2013 *SA Medical J* 453.

94 Studdert, Mello and Brennan "Medical malpractice" 2004 *New England J of Medicine* 284.

95 Localio *et al* 1991 *New England J of Medicine* 245; Studdert *et al* 2000 *Medical Care* 250; Jena *et al* "Malpractice risk according to physician specialty" 2011 *New England J of Medicine* 629.

The malpractice system does, however, capably identify meritorious claims once a suit has been filed.⁹⁶ Nevertheless, as a mechanism for accurately distributing compensation to injured patients it has colossal shortcomings.⁹⁷ This is all exacerbated by the system's inefficiency. The majority of the money spent accessing the system goes towards administrative costs, with legal fees being the predominant expense.⁹⁸

There is little evidence to suggest that the system is effective at deterring sub-standard care.⁹⁹ Evidence suggests that the system's impact on the manner in which practitioners practice medicine, may actually be detrimental.¹⁰⁰ Defensive medicine has led to unnecessary diagnostic tests that consume health resources and increase costs.¹⁰¹ Practitioners may start to avoid certain procedures and patients, thereby restricting access to care.¹⁰² The threat of litigation may even be driving some practitioners out of certain high-risk specialities altogether, further compounding the problem.¹⁰³

As for the costs of claims, there are legitimate concerns. Not all practitioners can afford to pay their indemnity insurance premiums and would thus not be able to provide certain health services.¹⁰⁴ Provincial health department budgets are also severely constrained and large pay-outs will affect their ability to obtain resources, upgrade infrastructure and provide public health services, thereby further reducing the quality of care provided at state facilities and, subsequently, affecting patient safety. However, it is imperative that injured patients must still be compensated.¹⁰⁵

The current liability and compensation system is adversarial and focuses on the individual when assigning blame. Systemic factors are often overlooked and it is almost impossible to identify weaknesses, in order to make the system safer and prevent future errors.¹⁰⁶ Patient safety advocates recognise that faulty

96 Taragin *et al* "The influence of standard of care and severity of injury on the resolution of medical malpractice claims" 1992 *Annals of Internal Medicine* 780; Sloan and Hsieh "Variability in medical malpractice payments: Is the compensation fair?" 1990 *Law & Society R* 997; Studdert, Mello and Brennan 2004 *New England J of Medicine* 285; Studdert *et al* "Claims, errors, and compensation payments in medical malpractice litigation" 2006 *New England J of Medicine* 2024.

97 Studdert, Mello and Brennan 2004 *New England J of Medicine* 285.

98 Studdert *et al* 2006 *New England J of Medicine* 2024.

99 Schwartz 1994 *UCLA LR* 377; Mello and Brennan "Deterrence of medical errors: Theory and evidence for malpractice reform" 2002 *Texas LR* 1603.

100 Stevenson, Spittal and Studdert "Does litigation increase or decrease health care quality?: A national study of negligence claims against nursing homes" 2013 *Medical Care* 430.

101 Summerton "Positive and negative factors in defensive medicine: A questionnaire study of general practitioners" 1995 *BMJ* 27; Kessler and McClellan "Do doctors practice defensive medicine?" 1996 *Quarterly J of Economics* 353; Studdert *et al* "Defensive medicine among high-risk specialist physicians in a volatile malpractice environment" 2005 *JAMA* 2609.

102 Malherbe 2013 *SA Medical J* 83.

103 Howarth 2013 *Obstetrics and Gynaecology Forum* 35.

104 "No cover for GPs performing foetal anomaly scans" *Medical Chronicle* (2013-06-11) <http://bit.ly/1D5ZX6o> (accessed on 30 April 2014).

105 Ncayiyana "Compensation for injury from medical treatment is a social justice obligation" 2004 *SA Medical J* 303.

106 Reason 2000 *BMJ* 768.

systems, rather than careless individuals, are usually responsible for medical errors.¹⁰⁷ Our system of adjudicating malpractice is ill-suited to such an approach.¹⁰⁸ Transparency is a dominant theme of the patient-safety movement. Errors inevitably occur and in order to prevent future errors, it is necessary to identify and learn from the mistakes.¹⁰⁹ An environment in which these errors can be disclosed and reported, so that they can be addressed, is thus required.¹¹⁰ This conflicts with our existing system, which targets the individual practitioner. There is absolutely no incentive to disclose errors, as doing so may lead to confrontational litigation.¹¹¹ The deterrence of sub-standard care with the threat of litigation, which aims to ensure patient safety, may actually be a greater threat to patient safety in the long run.

If some of the proposed initiatives, such as the disclosure of errors and the reporting of adverse events are introduced, it would most likely result in more malpractice litigation under the existing liability and compensation system.¹¹² The existing system is just not conducive to such an approach and may thus, in a strange contradictory way, be detrimental to the provision of quality health care.¹¹³

9 PROPOSED REFORMS

The problems identified with the existing system have led stakeholders to call for reforms.¹¹⁴ These proposed conventional reforms are almost always directly aimed at the financial implications of malpractice litigation and would merely alter the existing malpractice system. Focusing on the financial implications may indirectly address some of the health care concerns, but this would be insufficient. These reforms will not directly reduce sub-standard care and

107 Kohn, Corrigan and Donaldson (eds) *To err is human: Building a safer health system* (2000); Sage “Medical liability and patient safety” 2003 *Health Affairs* 26.

108 Bovbjerg, Miller and Shapiro 2001 *J of Law, Medicine & Ethics* 369.

109 Reason 2000 *BMJ* 768.

110 Berwick and Leape “Reducing errors in medicine: It’s time to take this more seriously” 1999 *BMJ* 136; Gallagher *et al* 2003 *JAMA* 1001; Kachalia *et al* “Liability claims and costs before and after implementation of a medical error disclosure program” 2010 *Annals of Internal Medicine* 213.

111 Lamb *et al* “Hospital disclosure practices: Results of a national survey” 2003 *Health Affairs* 73.

112 Studdert, Mello and Brennan 2004 *New England J of Medicine* 287. See also Kraman and Hamm “Risk management: Extreme honesty may be the best policy” 1999 *Annals of Internal Medicine* 963 where the authors tentatively indicate that a policy of full disclosure may, in certain instances, not lead to an increase in claims.

113 Gostin “A public health approach to reducing error: Medical malpractice as a barrier” 2000 *JAMA* 1742; Studdert and Brennan “No-fault compensation for medical injuries: The prospect for error prevention” 2001 *JAMA* 217.

114 Ncayiyana 2004 *SA Medical J* 304; Meyer “The ethics of professional indemnity and compensation” 2008 *SA J of Bioethics and Law* 5; Coetzee 2010 *Obstetrics and Gynaecology Forum* 111; “Medical litigation: A national health crisis requiring urgent solutions” *Medical Chronicle* (2011-11-07) <http://bit.ly/1DvRKve> (accessed on 30 April 2014); “HPCSA’s ‘Report a doc’ campaign likely to hike medical costs” *Medical Chronicle* (2012-05-07) <http://bit.ly/1mqsAsJ> (accessed on 30 April 2014); “Litigation: a Killer Epidemic with no Cure?” *Medical Chronicle* (2012-08-06) <http://bit.ly/1yoxzzn> (accessed on 30 April 2014); Parliamentary Question 2013/25A Question Number 627 <http://bit.ly/1tWR4uQ> (accessed on 30 April 2014); “Medical negligence claims threaten NHI” *Mail & Guardian* 2014-04-16.

patients will continue to be injured and face the same, if not more, difficulties in obtaining compensation.

9 1 CONVENTIONAL REFORMS

Conventional reforms can be divided into three categories: (1) reforms that limit access to court; (2) reforms that alter certain liability rules in an attempt to reduce the frequency of claims and the amounts awarded as damages; and (3) reforms that directly address the size of damages awarded.¹¹⁵

9 1 1 *Reforms that limit access to court*

Screening panels determine and make recommendations with regard to the merits of a claim before the matter proceeds to court.¹¹⁶ These panels encourage the expeditious settlement of justifiable claims. Frivolous claims or claims without merit are discouraged in order to avoid costly and lengthy litigation.¹¹⁷ Shortening statutes of limitation and repose would also limit access to court and are also often proposed.¹¹⁸

9 1 2 *Reforms that alter certain liability rules*

Reforms that alter liability rules are aimed at reducing the frequency of claims and the size of the pay-outs. Measures under this category include: eliminating joint-and-several liability, not applying the doctrine of *res ipsa loquitor*, establishing standards for expert witnesses and requiring additional criteria when proving the absence of informed consent.

9 1 3 *Reforms that directly address the size of damages awarded*

The capping of damages is regularly proposed and is being considered locally. The reforms are specifically directed at the size of malpractice awards.¹¹⁹ These caps may be applied to the total amount or only the non-economic portion of the damages claimed.¹²⁰ As an indirect consequence of caps, malpractice lawsuits may also be less lucrative for attorneys. Income from contingency fee agreements will be considerably less and would deter litigation. Other measures under this category include periodic payments, so that future expenses are paid as they arise, instead of receiving one lump sum and modifications to the collateral source rule.¹²¹

These reforms may reduce claims, costs and, perhaps, indemnity insurance premiums. However, just as more litigation under the existing system will probably not make health care safer, less litigation and smaller awards under a slightly altered version of the existing system will also likely have no impact on patient safety. With regard to the possible indirect effects these reforms may have on health care, such as preventing doctors from leaving certain specialities, avoiding particular patients or practicing in different locations, these reforms

115 Studdert, Mello and Brennan 2004 *New England J of Medicine* 287.

116 Giesen (1988) 501.

117 Weiler *et al* (1993) 136.

118 Giesen (1988) 487; Studdert, Mello and Brennan 2004 *New England J of Medicine* 287.

119 Giesen (1988) 496.

120 Nelson *et al* "Damages caps in medical malpractice cases" 2007 *Milbank Q* 259.

121 Giesen (1988) 496.

may merely preserve the status *quo*. Patient safety and the existing inherent problems will not be addressed.

9 2 Fundamental reforms

It is argued that the role of the compensation and liability system should be reconsidered as it relates to patient safety. The realisation that the malpractice system may not be adequate and efficient in this regard has prompted calls for alternative approaches that would compensate injured patients and make health care safer.

These approaches can also be divided into three categories: (a) alternative dispute resolution mechanisms; (b) no-fault schemes and structures; and (c) enterprise liability.

9 2 1 Alternative dispute resolution mechanisms

These reforms seek to avoid litigation altogether.¹²² Recommendations include structured mediation, administrative tribunals and specialised medical courts.¹²³ Early-offer programs also fall under this category.¹²⁴ These programs attempt to secure early settlements after the occurrence of adverse events by incentivising negotiations between practitioners and patients. The prospect of concluding contracts before treatment, whereby patients agree to alternative dispute resolution mechanisms, have also garnered attention.

9 2 2 No-fault schemes and structures

Reforms in this category eliminate negligence as a requirement for liability and compensation.¹²⁵ Opponents of these schemes fear that by not assigning blame, no-fault schemes will not hold practitioners accountable and would not deter sub-standard care.¹²⁶ Practitioners are opposed to no-fault schemes as they fear that they will incur even more liability if such initiatives are introduced. Although these schemes and structures are commonly referred to as “no-fault”, such a designation may be deceptive. The focus of the investigation in these schemes and structures is not on determining whether an adverse event was negligently caused, but rather whether such an adverse event was avoidable.¹²⁷ This of course has raised concerns about costs, as more injured patients will be

122 *Idem* 505.

123 Johnson *et al* “A fault-based administrative alternative for resolving medical malpractice claims” 1989 *Vanderbilt LR* 1365; Dauer and Marcus “Adapting mediation to link resolution of medical malpractice disputes with health care quality improvement.” 1997 *Law and Contemporary Problems* 185; Studdert, Mello and Brennan 2004 *New England J of Medicine* 289; Mello *et al* “‘Health courts’ and accountability for patient safety” 2006 *Milbank Q* 459.

124 Hersch, O’Connell and Viscusi. “An empirical assessment of early offer reform for medical malpractice.” 2007 *J of Legal Studies* 231; Mello and Gallagher “Malpractice reform – Opportunities for leadership by health care institutions and liability insurers” 2010 *New England J of Medicine* 1353.

125 *Idem* 529.

126 Bovbjerg and Sloan “No-fault for medical injury: Theory and evidence” 1998 *Univ of Cincinnati LR* 53.

127 Kachalia *et al* “Beyond negligence: Avoidability and medical injury compensation” 2007 *Social Science & Medicine* 387.

eligible for compensation.¹²⁸ Considering the large number of patients who are injured but never compensated, these costs could be immense. But, then again, patients should be entitled to compensation and there are patient-safety benefits in determining liability on an avoidability basis, rather than a fault basis.¹²⁹ Proponents argue that costs saved on administrative and legal expenses make these schemes affordable.¹³⁰ But whether that would be the case in South Africa, with our unique social, economic and health care challenges, could not be answered without extensive research into the cost implications.

9.2.3 Enterprise liability

With enterprise liability, litigation is shifted from the individual practitioner to the health care organisation where the patients received treatment.¹³¹ Hospitals are thus held completely liable for all claims brought against allied practitioners. The costs incurred would function as an incentive to implement organisational changes, thereby addressing the systemic factors which contribute towards injuries.¹³²

10 NATIONAL HEALTH INSURANCE AND PATIENT SAFETY

The proposed National Health Insurance system is aimed at improving access to quality health care services and the provision of financial risk protection against catastrophic medical expenses for the entire population.¹³³ Whether the NHI as currently proposed would be the best mechanism to achieve these objectives remains to be seen, but there are numerous concerns. Nevertheless, the Green Paper is correct in conceding that the quality of health care provided to a large majority of the public is poor.¹³⁴ The quality of care provided impacts on patient safety and avoidable errors are most likely a frequent occurrence. These avoidable errors are probably aggravated by the systemic problems in the public health system.

The NHI will attempt to address these quality concerns by investing heavily in the public health sector. There are, however, other reforms that are more specifically directed at quality improvement. In this regard, the Office of Health Standards Compliance will seek to ensure that the quality of care patients receive in health facilities is improved, by monitoring and enforcing norms and standards.¹³⁵ The Office is empowered to investigate and deal with complaints relating to breaches of these prescribed norms and standards and may refuse to

128 Studdert *et al* "Can the United States afford a 'no-fault' system of compensation for medical injury?" 1997 *Law and Contemporary Problems* 32.

129 Studdert and Brennan 2001 *JAMA* 220.

130 Studdert, Mello and Brennan 2004 *New England J of Medicine* 289.

131 Abraham and Weiler "Enterprise medical liability and the evolution of the American health care system" 1994 *Harvard LR* 381.

132 Sage, Hastings and Berenson "Enterprise liability for medical malpractice and health care quality improvement" 1994 *American J of Medicine* 12.

133 Department of Health *Policy on National Health Insurance* GN 657 in GG 34523 of 12 August 2011.

134 *Idem* 6.

135 S 78 of the National Health Act 61 of 2003. The date of commencement for the establishment of the Office is yet to be proclaimed.

certify, as well as penalise, establishments that do not comply therewith.¹³⁶ The Office may also recommend that persons who are responsible for the non-compliance be referred to the relevant authority, which may then institute disciplinary proceedings.¹³⁷ Other measures aimed at improving norms and standards are also envisioned. The establishment of the Office is welcomed. It indicates that there is a willingness to intervene and, hopefully, rectify some of the issues faced by our health care system. There are nevertheless concerns about the independence thereof, because political interference may well impede its functioning and hinder the potential impact it may have on patient safety.

The introduction of the Green Paper and the subsequent developments suggest that there is a political impetus for change in order to achieve the objectives of the proposed NHI. The current medical malpractice system, viewed as a threat to health care delivery and the successful implementation of the NHI, will most likely also be reformed.¹³⁸ There are already indications that reforms are being deliberated. Comments made by the Minister and the establishment of a Medico Legal Task Team, which is currently investigating the malpractice situation, are indicative thereof.¹³⁹

The limitations of our current malpractice system need to be reconsidered if changes are to be affected. Conventional reforms that merely seek to alter the existing system may not be aligned with the objectives of the proposed NHI or the health system in its current state. Conventional reforms will not assist in improving the quality of care received or prevent injured patients from incurring catastrophic costs in the form of damages suffered due to inadequate medical management. Most injured patients are rarely compensated under the existing malpractice system. Patients may even be compensated less if certain conventional reforms, such as caps, are introduced and would be severely burdened by the harm suffered and the expenses incurred as a result thereof.

The existing malpractice system places too much emphasis on the individual, when medical errors are in fact much more complex and likely predominantly caused by systemic factors. These systemic factors are particularly prevalent in our under-resourced public health system. By its inherent nature and design, the existing malpractice system does not concern itself with these causes, as it explicitly targets and attributes blame to the individual practitioner. Proponents of the system argue that this serves to deter unsafe practices.¹⁴⁰ There are, however, doubts about its efficiency in this regard.¹⁴¹ It also needs to be considered whether patient safety is sufficiently promoted thereby, since there is evidence to suggest that alternative approaches could be more constructive.

11 CONCLUSION

Is our existing malpractice system the best mechanism with which to promote quality health care by ensuring patient safety? Medical errors should be prevented

136 S 82A.

137 S 82(4)(c).

138 "Medical negligence claims threaten NHI" *Mail & Guardian* 2014-04-16; <http://bit.ly/1kxRfl7> (accessed on 30 April 2014).

139 Parliamentary Question 2013/25A Question Number 627.

140 Schwartz 1994 *UCLA LR* 397

141 Mello and Brennan 2002 *Texas LR* 1606.

by recognising that mistakes are inevitable. If a more transparent atmosphere is fostered, these errors could be more readily identified, thus enabling providers to implement systems to avoid the occurrence of future adverse events. The existing malpractice system is not conducive to such an approach.

Fundamental reforms should perhaps be considered to align the objectives of the health care system with those of the malpractice system. However, this will not be an easy task. The different stakeholders involved all have conflicting interests and to find a proposition that everyone will be able to agree upon, will be an immense, if not impossible, undertaking. Therefore, a patient-oriented focus should be central to any policy discussion. The interests of patients should be decisive.

Any policy decisions on possible malpractice system reforms should be based on concrete research. Information on South Africa's health system as it relates to the burden of iatrogenic injury, the causes and avoidability thereof, should be studied. The malpractice system should also be scrutinised. Reliable data is required on the number of malpractice claims filed, causes of increased claims, costs involved with litigation and the difficulties experienced in obtaining compensation. Policy decisions that would improve the quality of care provided and patient safety, while adequately compensating patients, must be informed by the necessary inquiries.

Family mediation in South Africa: Developments and recommendations

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OPSOMMING

Gesinsbemiddeling in Suid-Afrika: Ontwikkelinge en aanbevelings

Die artikel handel oor die toekoms van gesinsbemiddeling in Suid-Afrika. 'n Omskrywing van en oorsig oor die beginsel van gesinsbemiddelaars in Suid-Afrika word verskaf. Die bepalinge van die Kinderwet 38 van 2005 met betrekking tot bemiddeling word uiteengesit. Onlangse hofbeslissings wat handel oor gesinsbemiddeling word kortliks verduidelik. Voorstelle word gemaak met betrekking tot gesinsbemiddeling in Suid-Afrika, soos dat daar sentrums vir bemiddeling gestig moet word wat verskeie rolle moet speel, byvoorbeeld as onderrig- en leersentrum vir bemiddelaars en 'n verskaffer van bekostigbare bemiddeling. Die sentrums kan byvoorbeeld verbonde wees aan regshulpklinieke en universiteite. Dit is noodsaaklik dat gesinsbemiddeling aanhou groei in Suid-Afrika en dat die behoeftes van alle Suid-Afrikane in ag geneem word.

1 INTRODUCTION

This article provides an overview of the development in South African law of the concept “mediation”¹ as well as recommendations regarding the future practising of family mediation in South Africa. A definition and an overview of the concept of mediation, and an explanation of what family mediators are,² in South Africa will be provided. The provisions of the Children’s Act with regard to mediation as well as similar alternative dispute resolution mechanisms³ will be explained. Recent court decisions dealing with family mediation and the rules of court dealing with mediation will be discussed. A comparison between African-style mediation and Western-style mediation will be made. Thereafter, Family Relationship centres in Australia will be discussed. In conclusion, recommendations will be made with regard to family mediation in South Africa.

2 FAMILY MEDIATION

Family mediation is defined as

“a process in which the mediator, an impartial third party who has no decision-making power, facilitates the negotiations between disputing parties with the object of getting them

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1 Within the realms of family law.

2 As well as their qualifications.

3 Such as family group conferences.