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PROJECT 141 MEDICO-LEGAL CLAIMS

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SOUTH AFRICAN LAW REFORM COMMISSION

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REQUEST FOR COMMENTS

The main object of the South African Law Reform Commission (the SALRC) in terms of section 4 of its establishing legislation, the South African Law Reform Commission Act 19 of 1973 (the SALRC Act), is to do research with reference to all branches of the law of the Republic and to study and to investigate all such branches of the law in order to make recommendations for the development, improvement, modernisation or reform thereof.

Pursuant to requests from the Minister of Health and Minister of Justice and Constitutional Development (as the Minister was referred to at the time) to the SALRC to conduct an investigation into medico-legal claims, especially claims against the state, an investigation into this issue was included in the SALRC's research programme. This issue paper is the first document to be published during the course of this investigation. This issue paper aims to announce the SALRC's investigation into medico-legal claims, to elicit comment and suggestions from relevant stakeholders and to disseminate information to the public at large. Its purpose is to initiate and stimulate debate, to seek proposals for reform and to serve as a basis for further deliberation by the Commission. Since this issue paper is the first step in the investigation into medico-legal claims against the state, the paper does not contain clearly defined recommendations for law reform.

The comment of any person on any issue contained in the issue paper or in respect of a related issue which may need inclusion in the debate is sought. Such comment is of vital importance to the Commission, as it will assist in providing direction with regard to the scope and focus of the investigation.

The Commission will assume that respondents agree to the Commission quoting from or referring to comments and attributing comments to respondents, unless representations are marked confidential. Respondents should be aware that the Commission may be required to release information contained in representations under the Promotion of Access to Information Act 2 of 2000.

Respondents are requested to submit written comment, representations or requests to the Commission by no later than 30 September 2017. Respondents are not restricted to the questions posed and issues raised in this paper, and are welcome to draw other matters to the Commission's attention as long as they are related to this topic. The allocated researcher will endeavour to assist with any difficulties and questions related to making submissions. Any request for information and administrative enquiries should be addressed to Ms Ronel van Zyl, the researcher assigned to this project, or to the Secretary of the Commission.

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ACRONYMS

| | Acronym | Explanation |
|-----|----------------|--|
| 1. | CPI | Consumer Price Index |
| 2. | DOH | Department of Health |
| 3. | DOJCD | Department of Justice and Constitutional Development |
| 4. | GDP | Gross Domestic Product |
| 5. | HPCSA | Health Professions Council of South Africa |
| 6. | MEC | Member of the Executive Council |
| 7. | MPS | Medical Protection Society |
| 8. | NDP | National Development Plan |
| 9. | NSDA | Negotiated Service Delivery Agreement |
| 10. | RAF | Road Accident Fund |
| 11. | RCOG | Royal College of Obstetricians and Gynaecologists |
| 12. | SALRC | South African Law Reform Commission |
| 13. | SCA | Supreme Court of Appeal |
| 14. | USA | United States of America |

CHAPTER 1: EVENTS PRECEDING SALRC INVESTIGATION

A Department of Health request for investigation

1.1. After the appointment of the current members of the South African Law Reform Commission (SALRC) in 2013, the Minister of Justice and Constitutional Development (as he was referred to at the time) wrote collegial letters to the other Ministers. The letters invited state departments to submit their suggestions or views on law reform or any aspect of a statute or common law applicable to the mandate of that Ministry for possible inclusion in the Commission's law reform programme.

1.2 On receiving this letter from the SALRC, the Department of Health (DOH) requested the SALRC to include in its programme an investigation into medico-legal claims. This request was made mainly because of the challenges faced by the health sector due to the escalation in claims for damages based on medical negligence and the increasing financial implications thereof for the public health sector.

B Minister of Justice and Correctional Services request for investigation

1.3 The Minister of Justice and Correctional Services (the Minister) wrote to the Chairperson of the SALRC on 16 January 2015. The Minister wrote the said letter in reaction to a request to the Department of Justice and Constitutional Development (DOJCD) for legislation to address the matters raised in the case of *Souls Cleopas and the Premier of Gauteng* unreported case 09/41967, Gauteng South High Court, April 2014 (*Souls Cleopas* case). The case was brought on the basis of negligent medical treatment that the plaintiff had received from staff at Gauteng hospitals.

1.4 The Minister discussed the *Souls Cleopas* case in his letter to the SALRC. He expressed the opinion that the legislation proposed by the Gauteng Department would in effect abolish the common law "once and for all" rule in respect of certain issues, without an in-depth investigation having been conducted into the matter. The Minister was of the view that it would be advisable to await the outcome of such an investigation. The Minister then indicated, in light of the complexity of the matter, it would be appreciated if the SALRC could

give favourable consideration to conducting an in-depth investigation into the matter and then provide the Minister with a report on its findings.

1.5 The SALRC subjected the requests referred to above to the SALRC's selection criteria for requests for new investigations. After considering the requests and conducting a preliminary investigation, a proposal paper was compiled, which recommended the inclusion of the requests for an investigation into medico-legal claims in the SALRC's programme. The Minister subsequently on 10 September 2015 approved the investigation for inclusion in the SALRC programme of investigations.

C State Attorney's request for review of compensation payable

1.6 An official from the Office of the State Attorney: Johannesburg, requested a meeting with the SALRC via the DOJCD on the increase in claims based on medical negligence against the State. As a result of this meeting the SALRC agreed to look into the manner in which compensation for medical malpractice is determined and paid, the influence of the common law "once and for all rule" on medico-legal claims and lump sum payments as part of an investigation into medico-legal claims against the state.

D Medico-legal Summit of March 2015

1.7 The DOH held a medico-legal summit on 9 and 10 March 2015 to deliberate the growing crisis with regard to medico-legal claims in South Africa. The summit was attended by the Minister of Health; the MECs for health of the various provinces; representatives from the World Health Organisation; representatives from statutory bodies such as the Office of Health Standards Compliance and the Health Professions Council of South Africa; representatives of professional bodies such as the Medical Association of South Africa, the, the Hospital Association of South Africa, the Medical Protection Society and the South African Medico Legal Society; officials from national and provincial Departments of Health; medical practitioners in various fields; hospital managers; medical therapists; pharmacists; nurses; state attorneys from various regions; academics; legal practitioners; actuaries; legal advisers at health care facilities; labour organisations in the health care sector; and others.

1.8 A media report on the summit commented that: “The Minister of Health, addressing the summit, expressed his concern that the lawsuit crisis that South Africa finds itself in is “what led to the collapse of the Australian health system 15 years ago”. He also referred to the “US [that] had a similar crisis in the 1970s and 1980s.”²

1.9 The Minister of Health reportedly made the following remarks at the summit:³

The nature of the crisis is that our country is experiencing a very sharp increase – actually an explosion in medical malpractice litigation – which is not in keeping with generally known trends of negligence or malpractice. ... The cost of medical malpractice claims has skyrocketed and the number of claims increased substantially. ... [T]he crisis we are faced with is not a crisis of public healthcare. It is a crisis faced by everybody in the healthcare profession – public and private.

E Medical Malpractice Workshop of March 2017

1.10 A Medical Malpractice Workshop was held in Johannesburg on 3 March 2017 at the initiative of the Department of Health. The workshop was attended by Ms Naledi Pandor, the Minister of Science and Technology, and Dr Aaron Motsoaledi, the Minister of Health. The workshop brought judges, legal practitioners, legal advisors, medical professionals, actuarial scientists, academics, mediators, the insurance industry and representatives from the Office of the State Attorney, Department of Health, SALRC and Road Accident Fund together to discuss medical malpractice and attempt to propose solutions to dealing with this problem. The workshop took the form of interactive panel discussions with the following topics being discussed:

1. Navigating our way around medical malpractice litigation: Mediation vs litigation
2. A matter of record: Reconciling the Prescription Act relating to minors and the medical practitioner's duty to keep records
3. Contingency fees: The pros and cons
4. The capping of claims and payment of future damages by way of annuities
5. Compulsory professional indemnity insurance for the medical profession

¹ Andile Makholwa “Lawsuits blamed for medical crisis” *Business Day Live* 10 March 2015 available at <http://www.bdlive.co.za/national/health> accessed 16 March 2017.

² Makholwa paragraph 8.

³ Anon “SA’s shocking medical malpractice crisis” *Health24* 10 March 2015 available at <http://www.health24.com/News/Public-Health> accessed 16 March 2017.

F Need for law reform

1.11 No legislation currently exists in South Africa to specifically address legal claims in the medical field, which means that claims based on medical negligence are dealt with under the common law. The escalation in medical negligence litigation, and in particular the increase in the size of the damages sought and awarded, has become a major cause for concern in the public and private health sectors.

1.12 There is an urgent need to undertake reform of the law in order to regulate a system that will become paralysed if no action is taken. It is crucial to cut down on litigation that consumes time and money. Apart from the impact of medical litigation on the public purse, the negative effect of such litigation on the rendering of health services in the private sector must also be considered. Regardless of the nature of the changes, legislation will be required to effect such changes.

1.13 Developing legislation in this field will aid in furthering the implementation of broader government policy. As explained by Mr Trevor Manual (Minister in the Presidency: National Planning Commission at the time), the National Development Plan (NDP) offers a long-term perspective.⁴ The NDP defines a desired destination and identifies the role different sectors of society need to play in reaching that goal. Chapter 10 of the NDP deals with the promotion of health in South Africa, summarising the key points as follows:⁵

1. Greater intersectoral and inter-ministerial collaboration is central to the Commission's proposals to promote health in South Africa.
2. Health is not just a medical issue. The social determinants of health need to be addressed, including promoting healthy behaviours and lifestyles.
3. A major goal is to reduce the disease burden to manageable levels.
4. Human capacity is key. Managers, doctors, nurses and community health workers need to be appropriately trained and managed, produced in adequate numbers, and deployed where they are most needed.
5. The national health system as a whole needs to be strengthened by improving governance and eliminating infrastructure backlogs.

⁴ National Planning Commission *National Development Plan 2030: Our Future – make it work* 15 August 2012 ISBN: 978-0-621-41180-5.

⁵ *National Development Plan* 329.

6. A national health insurance system needs to be implemented in phases, complemented by a reduction in the relative cost of private medical care and supported by better human capacity and systems in the public health sector.

1.14 The national DOH is responsible for the development and implementation of broader government policy on health in South Africa. The DOH holds overall responsibility for health care, with specific responsibility for the public health care sector.⁶ Provincial health departments provide and manage comprehensive health services through a district-based, public health care model. Authority is delegated to local hospital management for operational issues such as budgeting and human resources, to facilitate quicker responses to local needs.⁷

1.15 The National Health Act 61 of 2003 provides the framework for a single health care system for South Africa, and provides for a number of basic health care rights.⁸ However, the current deluge of medico-legal claims is a serious threat to the ideals set out in the NDP and the existing system of health care. The current policies do not provide guidance for dealing with this problem. Policy direction and the introduction of appropriate legislation are therefore required.

⁶ Brand South Africa “Health care in South Africa” *South African info* available at <http://www.southafrica.info> accessed 16 March 2017.

⁷ Brand South Africa “Health care in South Africa” accessed 16 March 2017.

⁸ Brand South Africa “Health care in South Africa” accessed 16 March 2017.

CHAPTER 2: INVESTIGATION INTO MEDICO-LEGAL CLAIMS

A Scope of problem

2.1 The main object of the SALRC in terms of section 4 of the SALRC Act is to do research with reference to all branches of the law of the Republic and to study and to investigate all such branches of the law in order to make recommendations for the development, improvement, modernisation or reform thereof. It therefore follows that one of the SALRC's tasks is to consider, where applicable, the extent to which the law is unsatisfactory, for example unconstitutional, unduly complex, inaccessible or outdated.

2.2 In applying the principle referred to above to medico-legal claims, especially medico-legal claims against the state, it is necessary to look into such claims in more detail to determine whether the area is problematic and if so, the reasons for and extent of the problem. There has been a raft of delictual claims for damages based on medical negligence instituted in South African courts in recent years, in both the public and private health care sectors. Media reports abound of medical negligence claims instituted against the state for damages suffered in public hospitals; claims instituted against private practitioners and the rising incidence and cost of medical negligence claims.⁹

⁹ Anon "Medical Litigation: A National Health Crisis Requiring Urgent Solutions" *Medical Chronicle* 7 November 2011 www.medicalchronicle.co.za accessed 25 August 2016; Anon "Doctors lose patience as suits spike" *City Press* 7 July 2012 www.city-press.news24.com accessed 15 January 2015; Anon "Six-year-old child awarded R2.8 million for amputated legs" *Times Live* 8 May 2013 www.timeslive.co.za accessed 28 January 2015; Anon "Botched brain ops lead to SA's highest-ever medical payout" *Times Live* 16 June 2013 www.timeslive.co.za accessed 28 January 2015; K Child "Hospital horrors costing SA plenty" *Times Live* 17 January 2014 www.timeslive.co.za accessed 9 February 2015; Anon "Gauteng hospitals face billions in legal claims" *health24* 17 January 2014 www.health24.com accessed 12 March 2015; Z Venter "Negligence case: R17m for two moms" *Pretoria News* 22 August 2014 www.iol.com accessed 5 March 2015; *Legalbrief Today* "Officials blamed for infant's death" Issue 3645 21 November 2014 (Web); Z Venter "Woman seeks R1.5m after hospital ordeal" *Pretoria News* 24 November 2014 www.iol.com accessed 25 November 2014; S Khalane "Eis van R648 m. hang oor departement" *Netwerk24* 23 January 2015 www.netwerk24.com accessed 26 January 2015; Z Venter "Payout for woman in botched op case" *Pretoria News* 30 January 2015 www.iol.com accessed 6 February 2015; *Legalbrief Today* "Woman to get damages after incorrect operation" Issue 3681 6 February 2015 (Web); *Legalbrief Today* "Huge legal costs by EC Health Department questioned" Issue 3685 6 February 2015 (Web); Z Venter "Couple awarded R860 000 for baby" *The Star* 3 March 2015 3 <https://www.highbeam.com> accessed 16 March 2015; Anon "Medical litigation crisis – Motsoaledi" *The Citizen* 9 March 2015 www.citizen.co.za accessed 16 March 2015; Anon "SA's shocking medical malpractice crisis" *health24* 10 March 2015 www.health24.com accessed 12 March 2015; S Fokazi "Lawsuits threaten

2.3 The 2016 mid-year estimate of the population of South Africa was nearly 56 million people.¹⁰ The public health sector delivers services to about 80% of the population, thus more than 40 million people.¹¹ The sheer number of people using public health care gives an

SA specialists" *Daily News* 12 March 2015 www.iol.com accessed 13 March 2015; Z Venter "Woman who lost arm to get R3.6m" *Pretoria News* 20 April 2015 www.iol.com accessed 21 April 2015; D Lotriet "Free State hospitals swamped by malpractice cases" *news24* 20 May 2015 www.news24.com accessed 14 July 2015; Z Venter "R5.6m payout for brain-damaged boy" *Pretoria News* 8 June 2015 www.iol.com accessed 11 June 2015; T Setana "Claims cost Health dearly" *news24* 10 June 2015 www.news24.com accessed 14 July 2015; Anon "DA NW: Chris Hattingh says Health dept. spends R70 million on malpractice lawsuits in 4 years" *Polity.org.za* 22 July 2015 www.polity.org.za accessed 22 July 2015; *Legalbrief Today* "Gauteng health lawsuits now top R10bn" Issue 3834 10 September 2015 (Web); *Legalbrief Today* "Brain-damaged baby case settled for R14m" Issue 3837 15 September 2015 (Web); *Legalbrief Today* "Province reels under weight of medical negligence claims" Issue 3859 16 October 2015 (Web); K Child "Docs' nightmare is being sued" *Times Live* 12 November 2015 www.timeslive.co.za accessed 12 January 2016; *Legalbrief Today* "Mothers claim R76m for medical negligence" Issue 3882 18 November 2015 (Web); R Human "Mediese nalatigheid – al meer eise teen dokters" *Netwerk24* 29 November 2015 www.netwerk24.com accessed 30 November 2015; S Peters "Department of Health sued for R11.8m" *Daily News* 3 December 2015 www.iol.co.za accessed 26 January 2016; S Peters "Man sues Margate Hospital for R20 million" *Daily News* 20 January 2016 www.iol.co.za accessed 28 January 2016; *Legalbrief Today* "Mother seeks R14m for blind baby" Issue 3919 29 January 2016 (Web); A Umraw "Man sues for R10m over botched leg amputation" *The Witness* 2 February 2016 www.news24.com accessed 1 March 2016; *Legalbrief Today* "R19m claimed for brain damaged son" Issue 3923 4 February 2016 (Web); Z Venter "MEC to pay R28.5m for care of brain-damaged boy" *Pretoria News* 25 February 2016 www.iol.co.za accessed 9 March 2016; *Legalbrief Today* "Judge warns Health MEC on malpractice claims" Issue 3951 15 March 2016 (Web); S Peters "Father sues KZN Health for R23m" *Daily News* 16 March 2016 www.iol.com accessed 17 March 2016; Anon "Mother sues KZN health MEC for millions over premature baby's blindness" *news24* 7 April 2016 www.news24.com accessed 13 April 2016; S Peters "R26m claim for girl left disabled after surgery" *Daily News* 9 June 2016 www.iol.co.za accessed 8 July 2016; *Legalbrief Today* "Mthatha Hospital face R3bn in claims" Issue 4021 29 June 2016 (Web); *Legalbrief Today* "Hospital pays for giving woman formalin to drink" Issue 4046 4 August 2016 (Web); *Legalbrief Today* "Department forks out R23m medical negligence settlement" Issue 4053 16 August 2016 (Web); Anon "MEC gives victim's family a job to avoid R20m lawsuit" *African News Agency* 28 September 2016 www.iol.com accessed 25 January 2017; Zelda Venter "Duo claim R9.7m over botched ops" *Pretoria News* 8 October 2016 www.iol.com accessed 19 January 2016; Zelda Venter "Woman claims R28m after liver fails" *Pretoria News* 13 October 2016 www.iol.com accessed 14 October 2016; Shain Germaner "Why the Gauteng Health Department is coughing up in court" *The Star* 20 October 2016 www.iol.com accessed 25 January 2017; Zelda Venter "Woman sues surgeon after blade left in throat" *Pretoria News* 29 October 2016 www.iol.com accessed 25 January 2017; Yolisa Tswanya "Maternity wards in danger of shutdown" *Cape Argus* 29 November 2016 www.iol.com accessed 30 January 2017; Nomahlubi Jordaan "Court lambasts hospital for negligently causing permanent brain damage to a newborn" *Times LIVE* 13 December 2016 www.timeslive.co.za accessed 12 January 2017; Zelda Venter "Soldier claims R2m in damages for botched op" *Pretoria News* 15 March 2017 www.iol.com accessed 16 March 2017 www.news24.com accessed 13 March 2017; Ingrid Oellermann "Health must pay R23,5 mln" *The Witness* 10 March 2017 www.news24.com accessed 13 March 2017; Estelle Ellis "Health in R14bn lawsuits crisis" *Herald Live* 29 March 2017 www.heraldlive.co.za 2017 accessed 29 March 2017.

¹⁰ Statistics South Africa home page available at <http://www.statssa.gov.za> accessed 16 March 2017.

¹¹ Brand South Africa "Health care in South Africa" *South African info* available at <http://www.southafrica.info> accessed 16 March 2017.

indication of the proportion of the community that could potentially be affected by new medico-legal legislation. Although many users of public health care are indigent, even the more affluent are turning to public health care as they can no longer afford private health care due to the rising cost thereof. Medical schemes, which foot the lion's share of the private health care bill, are feeling the crunch. According to the White Paper on National Medical Insurance published by DOH, medical schemes membership contributions over the past ten years have on average been increased at a rate of nearly double the Consumer Price Index (CPI).¹²

B Literature on Medical Negligence Litigation in South Africa

2.4 In 1991, Strauss discussed the incidence of medical malpractice litigation in South Africa, comparing it to the trend in the United States of America.¹³ Although he recognised that the incidence of malpractice litigation in South Africa appeared to be on the rise, he was positive that "... there are special reasons why malpractice litigation in South Africa will probably never reach the pandemic proportions of the USA." His opinion was grounded in the iconic 1924 case of *Van Wyk v Lewis*,¹⁴ where the Appeal Court held that the *res ipsa loquitur* rule does not apply in medical negligence cases.

2.5 A year later Claassen & Verschoor averred that there had been a definite growth in the number of claims brought by patients against doctors and hospitals in South Africa.¹⁵ They expressed the opinion that the increase in medical malpractice claims has led to doctors turning to "defensive medicine". Doctors perform additional diagnostic examinations, refer patients to specialists and do follow-up procedures, though not for the sake of providing better patient care, but rather to avoid the possibility of being sued, thereby increasing medical costs.¹⁶

¹² Department of Health *National Health Insurance White Paper* "National Health Insurance for South Africa: Towards Universal Health Coverage" December 2015 at 13: "(increase of) 9.2 % when CPI is approximately 4.6%."

¹³ SA Strauss *Doctor, Patient and the Law* 3rd ed (1991) 243.

¹⁴ 1924 AD 438

¹⁵ NJB Claassen & T Verschoor *Medical Negligence in South Africa* (1991) 1.

¹⁶ Claassen & Verschoor 3.

2.6 In 2011 Coetze & Carstens did an overview of the state of medical malpractice and compensation in South Africa at the time.¹⁷ They expound on existing statutory licensing authorities for medical practitioners and hospitals,¹⁸ medico-ethical codes of conduct¹⁹ and reporting of medical errors and adverse events to the Health Profession Council of South Africa (HPCSA).²⁰ They also discuss civil²¹ and criminal liability²² and social and private insurance,²³ the applicable compensation systems and the relationships among the various systems.²⁴ They investigate issues pertaining to causation,²⁵ the doctrine of "loss of chance",²⁶ informed consent,²⁷ matters of proof²⁸ and gathering of evidence.²⁹

2.7 Due to a lack of cooperation from the national and provincial Departments of Health, statutory health bodies and the Medical Protection Society (MPS), the authors had to rely on media reports in an attempt to construct a synopsis of the number and value of claims against the state and private practitioners.³⁰ They express concern about the shortages of medical health practitioners in especially the public health sector³¹ and refer to opinions that attribute "the high number of negligence cases in the private and state sectors to a lack of

¹⁷ LC Coetze & PA Carstens "Medical Malpractice and Compensation in South Africa" *Chicago-Kent Law Review* 2011 Volume 86:3 1263.

¹⁸ Coetze & Carstens 1263 and further.

¹⁹ Coetze & Carstens 1267.

²⁰ Coetze & Carstens 1268.

²¹ Coetze & Carstens 1269 and further.

²² Coetze & Carstens 1272 to 1273.

²³ Coetze & Carstens 1274 and further.

²⁴ Coetze & Carstens 1280.

²⁵ Coetze & Carstens 1287 to 1288.

²⁶ Coetze & Carstens 1289.

²⁷ Coetze & Carstens 1290 to 1291.

²⁸ Coetze & Carstens 1291 to 1294.

²⁹ Coetze & Carstens 1294 to 1295.

³⁰ Coetze & Carstens 1295 to 1298.

³¹ Coetze & Carstens 1299.

accountability and poor management".³² Coetzee & Carstens ascribe the increase in medical litigation to a number of contributing factors: increased realisation of constitutional rights; better access to information; greater transparency and improved accountability in terms of current legislation; greater awareness of their rights on the side of patients; more medical specialisation; and the more impersonal nature of modern doctor patient relationships.³³

2.8 Oosthuizen & Carstens did an analysis of the situation pertaining to the extent and consequences of medical malpractice in the public and private sectors up to 2013. The authors consider various possible causes for the "sharp increase in medical malpractice litigation".³⁴ They lament the lack of information on the extent of medical malpractice, as "the causes and prevalence of medical errors would be much easier to assess and address if the data was readily available."³⁵ They examine the increased incidence of unprofessional conduct cases that the HPCSA has had to deal with, but register alarm over the quality of service rendered by the HPCSA to both the medical profession as well as patients.³⁶ The authors illustrate the extent of litigation against the state by providing information on the figures concerned per province,³⁷ also referring to a number of serious problems in the public health care sector that are exacerbating the extent of the litigation crisis.³⁸

2.9 As shown by Oosthuizen and Carstens, the problem is not limited to the public sector. They quote figures pertaining to assistance rendered by the MPS to their members to demonstrate the increase in claims, the amount of compensation awarded and the concomitant rise in the cost of indemnity insurance in the private sector.³⁹ As rightly pointed out by the authors, it is the patients that suffer the most due to rising costs and a decline in health service delivery.⁴⁰ They touch on associated consequences, such as a trend towards

³² Coetzee & Carstens 1300.

³³ Coetzee & Carstens 1301.

³⁴ WT Oosthuizen & PA Carstens "Medical malpractice: The extent, consequences and causes of the problem" *THRHR* 2015 (78) 269.

³⁵ Oosthuizen & Carstens "Medical malpractice" 270.

³⁶ Oosthuizen & Carstens "Medical malpractice" 270 to 272.

³⁷ Oosthuizen & Carstens "Medical malpractice" 273 to 275.

³⁸ Oosthuizen & Carstens "Medical malpractice" 275.

³⁹ Oosthuizen & Carstens "Medical malpractice" 275 to 277.

⁴⁰ Oosthuizen & Carstens "Medical malpractice" 277 to 278.

practising defensive medicine⁴¹ and the professional and emotional impact of litigation on medical practitioners,⁴² and consider the possibility that information may be suppressed due to a reluctance to report errors.⁴³

2.10 Oosthuizen & Carstens followed up the contribution discussed above (see para. 2.8 and 2.9) a few months later, but this time they brought a different angle to the debate.⁴⁴ They point out that the discussions about medical negligence often focus on the financial aspects, for example the cost of insurance and the possibility of capping certain types of damages. Other issues that are raised include changes that have occurred to medical practices, such as running more tests or avoiding certain high-risk procedures or specialities. There is general disquiet about the effectiveness of the current system.⁴⁵ The authors, while acknowledging the complexities surrounding medical malpractice reforms, however submit that “discussions surrounding the matter should have a strong patient-oriented focus.”⁴⁶ Since patients are most affected by medical malpractice, the authors are of the view that patients’ interests should carry the most weight in this debate.

2.11 There is no empirical data in South Africa on topics such as the consequences of medical malpractice for patients, the incidence of adverse events and the relationship between adverse events and malpractice claims. Oosthuizen and Carstens however consider the results of research conducted in the USA, in particular a Harvard study,⁴⁷ to indicate that the vast majority (98%) of “all adverse events due to negligence in the study did not result in malpractice claims.”⁴⁸ There has been only one research project, initiated by the WHO World Alliance for Patient Safety, which was conducted retrospectively in a number of

⁴¹ Oosthuizen & Carstens “Medical malpractice” 278 to 279.

⁴² Oosthuizen & Carstens “Medical malpractice” 279.

⁴³ Oosthuizen & Carstens “Medical malpractice” 279 and 280.

⁴⁴ WT Oosthuizen & PA Carstens PA “Re-evaluating medical malpractice: A patient safety approach” 2015 (78) *THRHR* 380.

⁴⁵ Oosthuizen & Carstens “Patient safety” 381.

⁴⁶ Oosthuizen & Carstens “Patient safety” 381.

⁴⁷ Leape *et al* “The nature of adverse events in hospitalized patients: Results of the Harvard Medical Practice Study II” 1991 *New England Journal of Medicine* 380.

⁴⁸ Leape *et al* 383 to 384.

developing countries, including South Africa.⁴⁹ The authors strongly contend that "Research into the prevalence of adverse events, negligence and malpractice in South Africa is required".⁵⁰

2.12 They refer to a number of hindrances faced by patients when instituting claims for compensation, such as the costs, the period of time it takes to finalise claims,⁵¹ the burden of proof that a claimant bears,⁵² the need for expert medical advice⁵³ and problems with obtaining compensation from state institutions.⁵⁴ The authors ardently argue 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 reconsidered as it relates to patient safety. It must be determined whether it contributes to, and ensures, a safer health care environment."⁵⁵

2.13 Oosthuizen and Carstens question the current adversarial liability and compensation system and the focus on individual responsibility, while systemic issues and problems are often overlooked.⁵⁶ They refer to the patient safety approach, which recognises that "... faulty systems, rather than careless individuals, are usually responsible for medical errors."⁵⁷ To learn from mistakes, it is necessary to be transparent about errors that were committed so that it can be addressed. This position however is not in line with the confrontational approach followed in malpractice litigation in South Africa. The main thrust of the authors' argument is that the current system of litigation is not conducive to patient safety, as it does not encourage openness and transparency. Openness and transparency is vital to improve patient safety, as adverse events must be honestly revealed and discussed with a view to

⁴⁹ Leape *et al* 384.

⁵⁰ Leape *et al* 385.

⁵¹ Leape *et al* 386.

⁵² Leape *et al* 386.

⁵³ Leape *et al* 387.

⁵⁴ Leape *et al* 388.

⁵⁵ Leape *et al* 389.

⁵⁶ Leape *et al* 390.

⁵⁷ Leape *et al* 391.

avoiding similar events and adjusting protocols to ensure that patient care improves over time.⁵⁸

2.14 Pienaar investigates the possible reasons for the increase in medical negligence claims.⁵⁹ She considers medical and technological progress as factors adding to the escalation in the value of claims: on the medical side by increasing life expectancy; and on the side of technological progress by the availability of assistive devices.⁶⁰ Regarding the increase in the number of claims, Pienaar contends that allegations of possible lower standards of health care, advertising by lawyers and the practice of pursuing patients with possible claims, even if true, are at most contributing factors. Patients are more aware of their rights and more disposed towards pursuing possible claims.⁶¹

2.15 Although she does not single out one specific element, Pienaar regards progressive patient-centred legislation, such as the Constitution of the Republic of South Africa, 1996 (the Constitution), National Health Act 61 of 2003, Consumer Protection Act 68 of 2008 and Children's Act 38 of 2005 as significant factors, raising awareness and thereby encouraging patients to institute action. She contends that patient-centred jurisprudence is equally important through the courts' recognition of patient autonomy, informed consent,⁶² privacy of health information⁶³ and the best interest of a child in a medical context⁶⁴. She concludes by suggesting that, because "legislation is at the very least a contributing factor to the increase in medical negligence claims, it seems appropriate to suggest that solutions to curbing the increase in these claims, too, should perhaps be introduced through legislation."⁶⁵

⁵⁸ Leape *et al* 391.

⁵⁹ L Pienaar "Investigating the Reasons behind the Increase in Medical Negligence Claims" *PELJ / PER* 2016 (19).

⁶⁰ Pienaar 5 and 6.

⁶¹ Pienaar 6 to 7.

⁶² Pienaar 12 to 14.

⁶³ Pienaar 15.

⁶⁴ Pienaar 16 to 17.

⁶⁵ Pienaar 18.

2.16 Van den Heever reflects on issues which, in his view, may be the reasons behind the increase in medical negligence litigation.⁶⁶ He mentions amendments to Road Accident Fund legislation that may have incited attorneys to explore alternative and more lucrative types of personal injury litigation, such as medical malpractice. He refers to the Contingency Fees Act 66 of 1997, which allows litigation to be conducted on a “no win no fee” basis, giving patients who would not have been able to afford professional legal services previously greater access to justice. He alludes to the suggestion by some commentators that a decline in medical professionalism and the standard of care has brought on the increase in claims. Van den Heever regards patient dissatisfaction to possibly be a major contributing factor. He alludes to a breakdown in communication between the health practitioner and patient and patients’ perception of a lack of care that often precedes the decision to litigate. A further possible cause for the increase in medical malpractice litigation, in his opinion, is the fact that patients are more aware of their rights.⁶⁷

2.17 In an attempt to propose solutions, Van den Heever compares conventional reforms to fundamental reform. He considers three categories of conventional reforms. In the first place, he mentions reforms that limit access to courts, which may include screening panels and shorter statutes of limitation. Secondly, he discusses reforms that alter certain liability rules, such as the elimination of joint and several liability, standards for expert witnesses and criteria for proving the absence of informed consent. Lastly, he deliberates on reforms that affect the size of the damages awarded (capping). He states that: “Capping may be applied to the total amount of damages or the non-economic portion of the claim. It could also include periodic payments so that future medical costs are paid as they arise instead of lump sum payments.” He expresses the opinion that: “This would render malpractice claims less lucrative.”

2.18 It appears from the discussion above that Prof Strauss’ faith that malpractice litigation in South Africa will never reach USA proportions may now seem overly optimistic. Although claims against private medical practitioners may never reach the heights of litigation levels in the USA, malpractice claims against the state is certainly aspiring to that dubious honour.

⁶⁶ P van den Heever “Medical malpractice: The other side” *De Rebus* October 2016 49.

⁶⁷ Van den Heever 49.

C Health spending and expenditure on litigation

2.19 The national budget for 2016/2017 indicates that an amount of R527.9 billion has been allocated to health. This represents 14,1% of the non-interest expenditure allocated to a vote.⁶⁸ According to statistics released by the World Bank (the latest available), the average spending on health care in the world as a percentage of a country's gross domestic product is 10%. South Africa's total health care expenditure (including public as well as private health expenditure)⁶⁹ for 2014 was 8,8% of the country's gross domestic product (GDP),⁷⁰ which is lower than the world average of 10%.⁷¹

2.20 For a developing country such as South Africa, where the right of access to health care services is constitutionally guaranteed and must be progressively realised, higher spending on health care is a positive sign. However, the same budget which provides for actual health care services is also used to pay out medico-legal claims. The increase in payments for medico-legal claims means that money has to be diverted away from the delivery of health care services, which further reduces the funding of an already severely

⁶⁸ National Treasury 2016 Budget: *Estimates of National Expenditure: Overview* at page x available at <http://www.treasury.gov.za/documents> accessed 24 January 2017.

⁶⁹ The World Health Organization Global Health Expenditure database defines the term "Health expenditure, total (% of GDP)" as follows: "Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation." Available at <http://data.worldbank.org/indicator> accessed 24 January 2017.

⁷⁰ The World Bank "Health expenditure, total (% of GDP)" *The World Bank* available at <http://data.worldbank.org/indicator> accessed 24 January 2017.

⁷¹ According to information published on the World Bank website, it appears that South Africa's health care expenditure as a proportion of GDP in 2014 was substantially lower than that of many other countries, including the United States of America and the Marshall Islands (which at 17,1% spent the highest proportion of GDP on health care), followed by countries spending above the world average such as the Maldives (13,7%), Haiti (13,2%), Sweden (11,9%), Switzerland (11,7%), France (11,5%), Germany (11,3%), Austria (11,3%), Cuba and Sierra Leone (11,1%), New Zealand (11%), the Netherlands (10,9%), Denmark (10,8%), Belgium and Lesotho (10,6%), Canada (10,4%), Japan (10,2%) and Liberia (10%). Paraguay (9,8%), Malawi (9,6%), Portugal (9,5%), Australia (9,4%), Swaziland (9,3%), Italy and Slovenia (9,2%), the United Kingdom (9,1%) and Spain (9%) are slightly below the world average. South Africa (8,8%) compares well to Namibia (8,9%) Brazil (8,3%) Afghanistan (8,2%) and Greece (8,1%) and leads Rwanda (7,5%), Algeria, Colombia and Uganda (7,2%), the Russian Federation (7,1%), Mozambique (7%), Zimbabwe (6,4%), Mexico (6,3%) and Zambia (5%). Countries spending well below the world average of 10% are Kenya (5,7%), Egypt (5,6%), China (5,5%), Botswana (5,4%), Ethiopia (4,9%), Argentina (4,8%), India (4,7%), the Central African Republic (4,2%), Nigeria (3,7%), Angola (3,3%) and Kuwait (3%). Indonesia (2,8%), Pakistan (2,6%) Qatar (2,2%), and Turkmenistan (2,1%) are at the lower end of the scale, with the Lao People's Democratic Republic (1,9%) and Timor-Leste (1,5%) at the bottom of the list.

burdened system. From case law and the example of Road Accident Fund (RAF) legislation, it is clear that an urgent need exists to deal with this problem.

2.21 The impact of these claims is reaching dire proportions in especially the public health sector. Claims are instituted against the Member of the Executive Council (MEC) for Health in the province, but the money to pay the claim, which could run into several million rand in each case, is in most instances derived from the budget of the hospital concerned. The more damages to be paid, the less money is available for service delivery, the poorer the quality of the service rendered by the hospital, the more room for negligence and error, the more the claims. It is a vicious circle and if it not addressed, the entire public health system could implode.

2.22 The acting Chief Litigation Officer of the Department of Justice and Constitutional Development (DOJCD) made a presentation on the problems and costs related to the high incidence of medico-legal claims against the state at the March 2015 Medico-legal Summit.⁷² She indicated that the principal amounts paid out for litigation on behalf of the Department of Health by the offices of the State Attorney amounted to the following during the years 2010/2011 to 2013/2014:

| 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 |

2.23 What is especially alarming is the huge increase over time in the amounts being paid out, especially in KwaZulu-Natal. It was reported there are over R5 billion in pending claims

⁷² MO Phahlane "Office of the Chief Litigation Officer: Department of Health Medical Negligence Summit" Paper presented at the March 2015 Medico-Legal Summit, Pretoria.

against the KwaZulu-Natal Province, up from R3million in claims in 2008. The number of cases has purportedly risen from 50 in that year to more than 50 in 2015.⁷³

2.24 More updated information was presented at the Medical Malpractice Workshop of 3 March 2017.⁷⁴ The contingent liabilities for medical malpractice are indicated as follows:

Table: Contingent liabilities for medical malpractice⁷⁵

| Department of Health | Annual report for year ending | Contingent liability at year end |
|----------------------|-------------------------------|----------------------------------|
| Eastern Cape | 31/03/2016 | 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 |

2.25 The increased quantity of medico-legal claims and pay-outs for such claims are not limited to the public sector. The private health care sector is also under pressure and insurance for private medical practitioners has risen sharply over the past few years. The MPS, the largest indemnity backer of health care professionals in South Africa, estimated that “the long-term average claim frequency for doctors in 2015 is around 27% higher than that in 2009”,⁷⁶ while the amounts claimed have escalated by an average of 14% per year from 2009 to 2015.⁷⁷

⁷³ Chelsea Pieterse and Jonathan Erasmus “High cost of medical negligence” *The Witness* 17 October 2015 available at <http://www.news24.com/Witness/> accessed 17 February 2017.

⁷⁴ Algorithm Consultants and Actuaries *The capping of medical negligence claims* February 2017 at 4.

⁷⁵ Algorithm Consultants 4

⁷⁶ Medical Protection Society (MPS) *Challenging the Cost of Clinical Negligence: The Case for Reform* November 2015 at 10 [MPS].

⁷⁷ MPS 15.

2.26 Bateman indicates that medical negligence pay-outs in the private sector soared by 132% in 2009 and 2010.⁷⁸ He reports that members of the MPS experienced a 30% rise in the actual average number of claims over the four years preceding 2011. Bateman points out that in turn this has led to an increase in subscriptions payable, especially by doctors in riskier disciplines – such as obstetrics, spinal surgery and paediatrics.⁷⁹

2.27 Malherbe refers to information made available by the MPS, indicating that the number of claims reported to the MPS has more than doubled in the two years preceding 2013, that claims exceeding R1 million have increased by nearly 550% compared to claims in 2003, while claims exceeding R5 million have increased 900% during the 5 years since 2008.⁸⁰

2.28 Howarth *et al* discusses the dire situation in a number of high-risk specialities, particularly orthopaedics, neurosurgery, neonatology and obstetrics. The authors make an ominous prediction of a dystopian future that entails:⁸¹

Fewer specialists in highrisk specialties, with those remaining practising defensive medicine. An absence, or severe curtailing, of private specialist obstetric care. Paediatricians and ophthalmologists reluctant to manage neonates. Fewer neurosurgeons in private practice, fewer still with a primary interest in anything other than spinal surgery, and all restricted to the larger urban areas. Likewise few, if any, spinal surgery services outside major urban areas. The problem is not restricted to the private arena, as those patients would now have to be treated in state facilities. Not only are these facilities already busy, but private patients would have to compete for resources and their medicolegal liabilities would move across to the state.

2.29 The rising cost of medical insurance for private practitioners is passed on to the consumer, which in turn leads to an increase in the cost of private health care. This leads to a growing number of people who are unable to afford private health care. The outcome is that the burden on the already over-burdened and barely coping public health care system becomes even heavier.

⁷⁸ C Bateman "Medical negligence pay-outs soar by 132%" *South African Medical Journal* 101 4 (2011) 216.

⁷⁹ Bateman 216.

⁸⁰ J Malherbe "Counting the cost: The consequences of increased medical malpractice litigation in South Africa" *South African Medical Journal* 103 2 (2013) 83.

⁸¹ G R Howarth *et al* "Public somnambulism: A general lack of awareness of the consequences of increasing medical negligence litigation" *SAMJ* 104 11 November 2014 752.

D Case law

2.30 Not all claims go as far as the court; the majority of claims are settled before proceeding to court. Some claims that have proceeded to court are the following:

1. *MEC for Health, Eastern Cape v Mkhitha* (1221/15) [2016] ZASCA 176 (25 November 2016): Person unable to walk and confined to wheelchair after medical treatment for injuries sustained in motor collision – negligence of hospital staff a *novus actus interveniens* [Date of judgement: 25 November 2016];
2. *Mbhele v MEC for Health, Gauteng* (355/15) [2016] ZASCA 166 (18 November 2016): Failure to take reasonable care to prevent stillbirth [Date of judgement: 18 November 2016];
3. *AD and IB v MEC for Health, Western Cape* [2016] unreported case 27428/10: Child born with athetoid cerebral palsy due to failure to diagnose and treat jaundice timeously [Date of judgement: 7 September 2016];
4. *Smith v MEC for Health, KwaZulu-Natal* (3826/12) [2016] ZAKZPHC 68 (2 August 2016): Patient given formalin (a highly corrosive substance) instead of water to drink [Date of judgement: 2 August 2016];
5. *Daniels v Minister of Defence* [2016] JOL 36275 (WCC): Plaintiff misdiagnosed, failure to perform certain procedures [Date of judgement: 21 June 2016];
6. *Links v MEC for Health, Northern Cape* [2016] ZACC 10: Amputation of thumb and loss of use of left arm due to ischemia (loss of blood supply) [Date of judgement: 30 March 2016] – claim unsuccessful due to prescription;
7. *Madida v MEC for Health, KwaZulu-Natal* [2016] JOL 35522 (KZP) (14 March 2016): Child born with spastic quadriplegic cerebral palsy, epilepsy, scoliosis, chest deformity, poor cognitive ability, feeding difficulty and no hand function [Date of judgement: 14 March 2016];
8. *Fransman v MEC for Health, Western Cape* unreported case 2748/10: Child born with spastic cerebral palsy and microcephaly ascribed to hypoxic ischaemic encephalopathy [Ongoing]
9. *Nzimande v MEC for Health, Gauteng* unreported case 44761/2013: Injury caused to child during caesarean section and subsequent mismanagement of child and mother's injuries [Date of judgement: 8 September 2015];
10. *Molefe v MEC for Health, Gauteng* [2016] JOL 34014 (GP): Child suffering from cerebral palsy as a result of a Perinatal Arterial Ischaemic Stroke after falling to the floor during an unassisted birth [Date of judgement: 27 February 2015];

11. *Khoza v MEC for Health, Gauteng* unreported case 2012/20087 (February 2015): Child born with hypoxic eschemic encephalopathy [Date of judgement: 6 February 2015; date of revision: 9 February 2015];
12. *Goliath v MEC for Health, Eastern Cape* [2015] JOL 32577 (SCA): Gauze swab left behind in plaintiff's abdomen [Date of judgement: 25 November 2014];
13. *M v MEC for the Department of Health, Eastern Cape Province* (590/2008) [2014] ZAECBHC 15 (14 November 2014): Death of child due to sepsis and dehydration [Date of judgement: 14 November 2014];
14. *Lushaba v MEC for Health, Gauteng* (GSJ) unreported case 17077/2012 (16 October 2014): Child born with spastic quadriplegic cerebral palsy [Date of judgement: 16 October 2014];
15. *Mshibe obo Sindi v MEC for Health, Gauteng* (2012/32085) [2014] ZAGPJHC 167 (8 August 2014): Child born with cerebral palsy [Date of judgement: 8 August 2014];
16. *Mokhethi v MEC for Health, Gauteng* 2014 (1) SA 93 (GSJ): Child's arm amputated after negligent medical treatment [Date of judgement: 13 September 2014];
17. *Ntsele v MEC for Health, Gauteng* (2009/52394) [2012] ZAGPJHC 208; [2013] 2 All SA 356 (GSJ) (24 October 2012): Peri-natal asphyxia rendering child a dystonic spastic quadriplegic [Date of judgement: 24 October 2012];
18. *Molete v MEC for Health, Free State* (2155/09) [2012] ZAFSHC 125 (21 June 2012): Left arm left permanently disabled after negligent medical treatment [Date of judgement: 21 June 2012]];
19. *Rens v MEC for Health, Northern Cape* (799/06) [2009] ZANCHC 10 (17 April 2009): Amputation of left arm necessary after negligent medical treatment [Date of judgement: 17 April 2009];
20. *Hoffmann v MEC for Health, Eastern Cape* (1037/2007) [2011] ZAECPEHC 39: Child stillborn [Date of judgement: 9 September 2011].

2.31 Another concern that is apparent from the case law, is the length of time claims may take to be finalised. Examples of the duration of such cases are shown in the table below.

Table: Examples of duration of medico-legal claim cases

| | Case | Cause of action | Date of incident | Final judgement | Duration of case |
|----|---|---|------------------|------------------|------------------|
| 1. | <i>MEC Health, Eastern Cape v Mkhitha</i> | Person unable to walk and confined to wheelchair after medical treatment for injuries sustained in motor collision. | 23 January 2011 | 25 November 2016 | 5 y 10 m |
| 2. | <i>Mbhele v MEC for Health, Gauteng</i> | Failure to take reasonable care to prevent stillbirth. | 18 August 2006 | 18 November 2016 | 10 y 3 m |

| | Case | Cause of action | Date of incident | Final judgement | Duration of case |
|-----|--|---|-------------------------|----------------------------|-------------------------|
| 3. | <i>AD and IB v MEC for Health, Western Cape</i> | Child born with athetoid cerebral palsy due to failure to diagnose and treat jaundice timeously. | 12 January 2009 | 7 September 2016 | 7 y 8 m |
| 4. | <i>Smith v MEC for Health, KwaZulu-Natal</i> | Patient given formalin (a highly corrosive substance) instead of water to drink. | 5 May 2010 | 2 August 2016 | 6 y 3 m |
| 5. | <i>Daniels v Minister of Defence</i> | Patient misdiagnosed, failure to perform certain procedures. | 15 August 2011 | 21 June 2016 | 4 y 10 m |
| 6. | <i>Links v MEC for Health, Northern Cape</i> | Amputation of thumb and loss of use of left arm due to ischemia (loss of blood supply). | 5 July 2006 | 30 March 2016 (prescribed) | 9 y 8 m |
| 7. | <i>Madida v MEC for Health, KwaZulu-Natal</i> | Child born with spastic quadriplegic cerebral palsy, epilepsy, scoliosis, chest deformity, poor cognitive ability, feeding difficulty and no hand function. | 29 January 2009 | 14 March 2016 | 7 y 2 m |
| 8. | <i>Nzimande v MEC for Health, Gauteng</i> | Injury caused to child during caesarean section and subsequent mismanagement of child and mother's injuries. | 30 March 2013 | 8 September 2015 | 1 y 6 m |
| 9. | <i>Molefe v MEC for Health, Gauteng</i> | Child suffering from cerebral palsy as a result of a Perinatal Arterial Ischaemic Stroke after falling to the floor during an unassisted birth. | 22 April 2005 | 27 February 2015 | 9 y 9 m |
| 10. | <i>Khoza v MEC for Health, Gauteng</i> | Child born with hypoxic eschemic encephalopathy. | 26 May 2008 | 6 February 2015 | 6 y 9 m |
| 11. | <i>Goliath v MEC for Health</i> | Gauze swab left behind in plaintiff's abdomen. | April 2011 | 25 November 2014 | 3 y 7 m |
| 12. | <i>M v MEC for the Department of Health, Eastern Cape Province</i> | Death of child due to sepsis and dehydration. | 8 April 2007 | 14 November 2014 | 7 y 7 m |
| 13. | <i>Lushaba v MEC for Health, Gauteng</i> | Child born with spastic quadriplegic cerebral palsy. | 30 June 2000 | 16 October 2014 | 14 y 4 m |
| 14. | <i>Mshibe obo Sindi v MEC for Health, Gauteng</i> | Child born with cerebral palsy. | 19 August 2005 | 08 August 2014 | 9 y |
| 15. | <i>Mokheti v MEC for Health, Gauteng</i> | Amputation of child's arm necessitated after negligent medical treatment. | May 2007 | 13 September 2013 | 6 y 4 m |
| 16. | <i>Ntsele v MEC for Health, Gauteng</i> | Peri-natal asphyxia rendering child a dystonic spastic quadriplegic. | 07 September 1996 | 24 October 2012 | 16 y 1 m |
| 17. | <i>Molete v MEC for Health, Free State</i> | Left arm left permanently disabled after negligent medical treatment. | 25 December 2007 | 21 June 2012 | 4 y 6 m |

| | Case | Cause of action | Date of incident | Final judgement | Duration of case |
|-----|--|--|-------------------------|------------------------|-------------------------|
| 18. | <i>Hoffmann v MEC for Health, Eastern Cape</i> | Child still-born due to negligent treatment of mother by hospital staff. | 12 September 2004 | 09 September 2009 | 5 y |
| 19. | <i>Rens v MEC for Health, Northern Cape</i> | Amputation of left arm necessitated after negligent medical treatment. | February 1998 | 17 April 2009 | 11 y 2 m |

2.32 Although the cases indicated above are not a statistically representative sample, it does illustrate a reason for concern. As seen from the table, the shortest period that had elapsed between the cause of a claim and its finalisation was 1 year and 6 months, while the longest period was 16 years and 1 month. The claimant in one of these cases (*Links v MEC for Health, Northern Cape*) was unsuccessful as his claim had prescribed. It is worrying, however, that 15 out of 20 (i.e. 75%) of the cases referenced took longer than 5 years to be finalised. One of the main problems with pursuing claims through the courts in terms of the common law is the inevitable delays that occur: due to the often sluggish legal processes, full court rolls, delays caused by witnesses being unavailable, trouble in obtaining evidence, and so forth. As expressed by the maxim “justice delayed is justice denied”, the mere fact that these cases take so long to be finalised already indicates that the law is unsatisfactory in this regard.

CHAPTER 3: LEGAL PRINCIPLES UNDERLYING MEDICO-LEGAL CLAIMS

A Constitutional considerations

3.1 The obvious point of departure for constitutional considerations is the Constitution of the Republic of South Africa, 1996 (the Constitution). The constitutional rights that are relevant here are dignity; freedom and security of the person, specifically bodily integrity; privacy; health care; and access to courts. Human dignity is the first human right mentioned in the Constitution. Section 1 and section 1(a) of the Constitution state the following:

The Republic of South Africa is one, sovereign, democratic state founded on the following values:

- (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms.

3.2 The importance of human dignity is underscored by section 10 of the Constitution, which states that “Everyone has inherent dignity and the right to have their dignity respected and protected.” The human dignity provision is considered so important that it even appears chronologically before section 11, which deals with the right to life. Section 12(1) protects freedom and security of the person.⁸²

3.3 Section 12(2) expands the right to freedom and security of the person by protecting the right to bodily and psychological integrity.⁸³ Section 14 protects the right to privacy.⁸⁴

⁸² (1) Everyone has the right to freedom and security of the person, which includes the right –
 (a) not to be deprived of freedom arbitrarily or without just cause;
 (b) not to be detained without trial;
 (c) to be free from all forms of violence from either public or private sources;
 (d) not to be tortured in any way; and
 (e) not to be treated or punished in a cruel, inhuman or degrading way.

⁸³ (2) Everyone has the right to bodily and psychological integrity, which includes the right-
 (a) to make decisions concerning reproduction;
 (b) to security in and control over their body; and
 (c) not to be subjected to medical or scientific experiments without their informed consent.

⁸⁴ Everyone has the right to privacy, which includes the right not to have-
 (a) their person or home searched;
 (b) their property searched;
 (c) their possessions seized; or
 (d) the privacy of their communications infringed.

3.4 Section 27 deals with access to health care. Section 27(1)(a), (2) and (3) provides as follows:

- (1) Everyone has the right to have access to –
 - (a) health care services, including reproductive health care;
 - (b) ...
 - (c) ...
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- (3) No one may be refused emergency medical treatment.

3.5 Two additional constitutional rights are particularly relevant. These appear in section 34, which deals with the right of access to court;⁸⁵ and section 38, which deals with the enforcement of rights.⁸⁶ Section 34 guarantees the right of access to court or, where appropriate, another independent and impartial tribunal or forum. Section 38 protects a person's right to approach a court for the granting of appropriate relief if a right in the Bill of Rights has been infringed or threatened.

3.6 The national DOH, under the leadership of the Minister of Health as the responsible member of the executive, is the government department responsible for providing direction and policy guidance on the implementation of the constitutional right to health care services. To this end the National Health Act was adopted, which provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services.⁸⁷

3.7 The Negotiated Service Delivery Agreement (NSDA) developed for the health sector for the period 2010 to 2014 speaks to the health sector priority of improving the health status of the entire population and to contribute to Government's vision of "A Long and Healthy Life for All South Africans". Reference is also made to the Ten Point Plan for the overall improvement of the performance of the national health system. Some of the focus areas include: significantly improving the quality of health services provided to South African

⁸⁵ Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.

⁸⁶ Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights.

⁸⁷ Long title to the National Health Act 61 of 2003

citizens by establishing an independent National Quality Accreditation Body; overhauling key components of the management systems and structures in the public health sector; better planning and management of human resources for health; the strategic implementation of infrastructure development and maintenance initiatives; and mass mobilisation of communities and key stakeholders to promote better health outcomes.⁸⁸

3.8 In view of the six constitutional provisions, the National Health Act, 2003 and the *NSDA on Outcome 2: A Long and Healthy Life for All South Africans* referred to above, the drafting of legislation to address the problems being experienced with service delivery in the health sector and medico-legal claims would contribute to enhanced constitutionality.

3.9 The constitutional rights of individuals that are relevant in the medico-legal field are discussed in paragraphs 3.1 to 3.5 above. However, there are other matters covered by the Constitution that deserve to be mentioned here. Section 8 of the Constitution pertains to the application of the Bill of Rights set out in Chapter 2 of the Constitution. Section 8(3)(a) charges a court to apply, or if necessary develop, the common law to the extent that legislation does not give effect to a right enshrined in the Bill of Rights.⁸⁹

3.10 Although a court can therefore develop the common law where legislation does not give effect to the Bill of Rights, a court cannot legislate. Section 165 of the Constitution vests the judicial authority of the Republic in the courts,⁹⁰ while section 43 of the Constitution vests the legislative authority of the national sphere in the Republic in Parliament.⁹¹

⁸⁸ Department of Health *NSDA for Outcome 2: A Long and Healthy Life for All South Africans (2010-2014)* 3 available at www.poa.gov.za accessed 20 March 2017.

⁸⁹ (3) When applying a provision of the Bill of Rights to a natural or juristic person in terms of subsection (2), a court –
 (a) in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right; and
 (b) may develop rules of the common law to limit the right, provided that the limitation is in accordance with section 36 (1).

⁹⁰ (1) The judicial authority of the Republic is vested in the courts.
 (2) The courts are independent and subject only to the Constitution and the law, which they must apply impartially and without fear, favour or prejudice.
 (3) No person or organ of state may interfere with the functioning of the courts.
 (4) Organs of state, through legislative and other measures, must assist and protect the courts to ensure the independence, impartiality, dignity, accessibility and effectiveness of the courts.
 (5) An order or decision issued by a court binds all persons to whom and organs of state to which it applies.

⁹¹ In the Republic, the legislative authority –
 (a) of the national sphere of government is vested in Parliament, as set out in section 44;

3.11 The Constitution explicitly provides for the different functions of the legislature (sections 42 – 82), the executive (sections 83 – 102), and the judiciary (sections 165 – 180), giving recognition to the doctrine of the separation of powers. According to Mojapelo, “... the doctrine means that specific functions, duties and responsibilities are allocated to distinctive institutions with a defined means of competence and jurisdiction. It is a separation of three main spheres of government, namely, Legislative, Executive and Judiciary.”⁹²

3.12 Mojapelo explains the main objective of the separation of powers as follows:⁹³

The main objective of the doctrine is to prevent the abuse of power within different spheres of government. In our constitutional democracy public power is subject to constitutional control. Different spheres of government should act within their boundaries. ... Within the context of the doctrine of separation of powers the courts are duty bound to ensure that the exercise of power by other branches of government occurs within the constitutional context. The courts must also observe the limit of their own power.

3.13 The doctrine of the separation of powers is an important element of a constitutional democracy. It is an important aspect of the checks and balances that are part of such a system. Mojapelo states that “... the aim of separation of functions and personnel is to limit the power; the purpose of checks and balances is to make the branches of government accountable to each other.”⁹⁴

B Legal process

3.14 Any claim flowing from possible medical negligence has to be taken through the normal legal process. The implications are that the claimant must be aware of the possibility of legal recourse; obtain legal representation; institute proceedings in the appropriate court, prove that he or she has a cause for action, and must prove damages in a field that requires specific and specialised technical expertise.

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- (b) of the provincial sphere of government is vested in the provincial legislatures, as set out in section 104; and
 - (c) of the local sphere of government is vested in the Municipal Councils, as set out in section 156.

⁹² PM Mojapelo “The doctrine of separation of powers (a South African perspective)” *Advocate* (April 2013) at 37.

⁹³ Mojapelo 38.

⁹⁴ Mojapelo 40.

3.15 In South Africa, people who utilise public health care usually do so because they are unable to afford private health care. In fact, the majority of people using public health care services come from poor and previously disadvantaged communities, who have no choice but to use public health care as they cannot afford private health care. It follows therefore that they would also not be able to afford private legal representation if they were to suffer harm through medical negligence. One can only speculate how many incidents of medical negligence never proceed to litigation because of the impediments mentioned above. This situation renders this field of law unduly complex and difficult to access to the average user of public health care.

1 Law of obligations

3.16 Medico-legal claims in South Africa are dealt with in terms of the common law. As explained by Carstens and Pearmain, the legal basis for health service delivery in South Africa is the law of obligations.⁹⁵ They state that “health service delivery is essentially a theme to be broadly accommodated under the law of obligations, thus either the law of contracts or the law of delict.”⁹⁶

3.17 Although the relationship between doctor and patient or hospital and patient is traditionally a contractual relationship, the majority of health service cases that came before the courts in recent times have been decided on the basis of the law of delict.⁹⁷

2 Elements of delict

3.18 In South African private law the five elements of delict that must be proven by a plaintiff to claim successfully from a defendant are: conduct, wrongfulness, damage, causation and fault.⁹⁸ Conduct for purposes of delictual liability means a voluntary act or omission by a human being.⁹⁹ Wrongfulness is present if the act or omission infringes a right

⁹⁵ PA Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007).

⁹⁶ Carstens & Pearmain 283.

⁹⁷ Carstens & Pearmain 284.

⁹⁸ See in general Neethling & Potgieter *Neethling Potgieter Visser Law of Delict* 7th ed (2015).

⁹⁹ Neethling & Potgieter 25; Carstens & Pearmain 496; JR Midgley & JC van der Walt “Delict” in *The Law of South Africa* Vol 8 Part 1 2nd ed 2005 par 58 [LAWSA vol 8].

protected by law or breaches a legal duty owed by one person to another.¹⁰⁰ The next element of a delict to be referred to here is the element of damage. The plaintiff must be able to prove that loss has resulted from the wrongful conduct and that the plaintiff has suffered damages that can be compensated in monetary terms.¹⁰¹ If no harm has been suffered, there is no delict. When suffering loss due to negligence, an aggrieved party can claim damages; that is, compensation or satisfaction. The purpose of the compensation is to restore the plaintiff to the position he or she would have been in had the wrongful act not been committed.¹⁰²

3.19 Causation means that there must be a causal nexus between the defendant's conduct and the harm suffered by the plaintiff. The question to be asked is whether the defendant's act or omission is the cause of the loss that the plaintiff incurred. To determine whether there is a causal nexus between an act and a result, two factors must be present. First, factual causation, that is, the factual relation between the defendant's reprehensible conduct and the harm sustained by the plaintiff must be established.¹⁰³ Once the factual link had been established, it must be determined whether there is legal causation. In the authoritative case *Minister of Police v Skosana*¹⁰⁴ (*Skosana* case) the court explained that the second problem is "... whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether, as it is said, the harm is too remote."¹⁰⁵

3.20 Fault (blameworthiness) is constituted by either intentional or negligent conduct and is determined by examining the defendant's state of mind, mental disposition, or the degree of care the defendant exhibited in his or her conduct towards the plaintiff. In this sense fault is a subjective factor, however negligence is determined objectively by measuring the

¹⁰⁰ Neethling & Potgieter 33; LAWSA vol 8 par 60.

¹⁰¹ Neethling & Potgieter 222; LAWSA vol 8 par 142.

¹⁰² Carstens & Pearmain 523 to 524; LAWSA vol 8 par 143.

¹⁰³ Neethling & Potgieter 183; Carstens & Pearmain 509; LAWSA vol 8 par 128.

¹⁰⁴ 1977 1 SA 31 (A)

¹⁰⁵ *Skosana* case at 34-35.

conduct of the defendant against the yardstick of the conduct of a reasonable person in the same circumstances.¹⁰⁶ Claims for medical malpractice are mostly based on negligence.

3 Test for medical negligence

3.21 It is evident that the test for negligence applied in medical negligence cases cannot be the same as the customary reasonable man test used to determine negligence in other delictual claims. In the case of a medical practitioner, the test will be adapted to the standard of the reasonable medical practitioner, or the reasonable specialist medical practitioner in that field, with a similar degree of professional skill, in the same circumstances as the defendant.¹⁰⁷ The court articulated the test for negligence in relation to a medical practitioner in *Mitchell v. Dixon*¹⁰⁸ through Innes ACJ:

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

3.22 Carstens & Pearmain point out that the term “medical malpractice” incorporates all forms of intentional and negligent professional medical misconduct, such as a physician’s duty of confidentiality to a patient, the trust relationship between a doctor and patient as well as professional negligence of medical practitioners. In their discussion of the specific blameworthiness of medical practitioners based on negligence as an element of delict, they prefer to refer to “professional medical negligence”, rather than “medical malpractice”.¹⁰⁹ Carstens & Pearmain describe professionalism as it relates to medical practice:¹¹⁰

Professionalism is a normative yardstick and is indicative of a professional code of conduct setting the acceptable requirements and boundaries to which medical practice should conform.

¹⁰⁶ Neethling & Potgieter 129; Carstens & Pearmain 303; LAWSA vol 8 par 103.

¹⁰⁷ Carstens & Pearmain 619; DJ McQuoid-Mason “Medical Professions and Practice” in *Law of South Africa Vol 17 Part 2* 2nd ed 2008 par 44 [LAWSA vol 17 part 2]; Carstens 144.

¹⁰⁸ 1914 AD 519 at 525.

¹⁰⁹ Carstens & Pearmain 599.

¹¹⁰ Carstens & Pearmain 607.

3.23 McQuoid-Mason & Dada defines professional negligence as follows:¹¹¹

Professional negligence by doctors occurs where a patient is harmed because a doctor has failed to exercise the degree of skill and care of a reasonable competent doctor in his or her branch of the profession.

3.24 They also describe professional standards:¹¹²

Professional standards refer to the level of skill and care that a reasonably competent practitioner in that particular branch of health care would be expected to demonstrate.

3.25 As indicated above, the test for professional negligence as it pertains to medical practitioners is an objective test comparing the conduct of a particular practitioner to the conduct of the hypothetical reasonable practitioner in the same circumstances. It is therefore important to understand what professional negligence and the standard used to measure such negligence entail.

4 *Res ipsa loquitur* doctrine

3.26 Another matter that will warrant further investigation is the *res ipsa loquitur* doctrine and the application thereof in medical negligence cases. The term *res ipsa loquitur* translates as “the thing speaks for itself” or “the case speaks for itself”. The effect thereof is that an inference of negligence is made if an event occurs in a manner that would not usually occur unless there has been negligence, but there is not necessarily direct evidence of the negligence.¹¹³ Although the courts¹¹⁴ generally and some authors¹¹⁵ rely on the case of *Van Wyk v Lewis*¹¹⁶ as authority to conclude that the doctrine does not apply in medical

¹¹¹ D McQuoid-Mason & M Dada *A-Z of Medical Law* (2011) 339.

¹¹² McQuoid-Mason & Dada 343.

¹¹³ Carstens & Pearmain 567; McQuoid-Mason & Dada 359.

¹¹⁴ See for example *Mitchell v. Dixon* 1914 AD 519; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W); *Castell v De Greef* 1994 (4) SA 408 (C).

¹¹⁵ See for example Strauss 245.

¹¹⁶ 1924 AD 438.

negligence cases in South Africa, voices has been raised reasoning that the doctrine is an evidentiary aid that could be developed for application in such cases.¹¹⁷

3.27 Mokgoatlheng J did just that in the case of *Ntsele v MEC for Health, Gauteng Provincial Government (Ntsele case)*.¹¹⁸ The *Ntsele* case revolved around a child born on 7 September 1996, who, as a result of a "... delayed and prolonged delivery by vertex,"¹¹⁹ resulted in him suffering hypoxia (the lack of oxygen to his brain) which caused peri-natal asphyxia rendering him a dystonic spastic quadriplegic".¹²⁰ The judge, referring with approval to Van den Heever & Carstens¹²¹ considers this matter as exceptional, justifying the application of the *res ipsa loquitur* maxim. He states:¹²²

Consequently, because the knowledge of the treatment accorded to the plaintiff on the 7 September 1996 is peculiarly within the knowledge of the defendant's employees, and the defendant has not adduced any direct cogent evidence to discharge the evidential rebuttal burden of probable negligence, the invocation of the maxim *res ipsa loquitur* in this kind of exceptional case given the critical missing clinic and hospital records pertaining to the plaintiff's treatment on 7 September 1996, is legally justifiable ...

¹¹⁷ See in general P van den Heever & N Lawrenson "Inference of negligence – is it time to jettison the maxim *res ipsa loquitur*?" *De Rebus* July 2015 32; P van den Heever & P Carstens *Res Ipsa Loquitur and Medical Negligence: A Comparative Survey* (2011); B Patel "Medical negligence and *res ipsa loquitur* in South Africa" *SAJBL* Vol 1 No 2 December 2008 57 at 59; P van den Heever *The Application of the Doctrine of Res Ipsi Loquitur to Medical Negligence Actions: A Comparative Survey* Unpublished thesis, University of Pretoria (2002); P Carstens *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid* Unpublished thesis, University of Pretoria (1996).

¹¹⁸ Case no. 2009/52394 [2012], also available in ZAGPJHC 208 and [2013] 2 All SA 356 (GSJ) (24 October 2012).

¹¹⁹ The term "vertex" in this context relates to the position of the head of the baby at the time of birth. It means that the baby was delivered with the crown (top of the head) as the presenting part. This is the easiest presentation to deliver. Term "vertex presentation" as described in Farlex *The Free Dictionary* available at medical-dictionary.thefreedictionary.com accessed on 27 March 2017.

¹²⁰ *Ntsele* case at (18).

¹²¹ P van den Heever & PA Carstens *Res Ipsa Loquitur and Medical Negligence: A Comparative Survey* (2011).

¹²² *Ntsele v MEC Health, Gauteng* at (124).

C Claims for damages

1 Common Law “once and for all” rule

3.28 An aggrieved person, who suffered damages due to medical negligence of a medical practitioner, will have to take legal action to claim compensation or satisfaction for damages suffered as a result of the unlawful act or omission. However, in claims for damages, the common law “once and for all” rule applies. Visser and Potgieter explain the common law “once and for all” rule in the following manner: “In claims for compensation or satisfaction arising out of a delict, breach of contract or other cause, the plaintiff must claim damages once for all damages already sustained or expected in future in so far as it is based on a single cause of action.”¹²³

3.29 The origin of the “once and for all” rule dates back more than 300 years to the English case of *Fetter v Beale*.¹²⁴ In this case plaintiff was barred from claiming from the defendant a second time on the basis of an incident of battery (assault) for which plaintiff had previously instituted action and been awarded damages. The rule forms part of South African law, which was confirmed by the Appellate Division of the Supreme Court as far back as 1917 in the case of *Cape Town Council v Jacobs*.¹²⁵ Solomon JA observed that:

[O]nce the magistrate has finally decided the application the workman is debarred from making any further claim in respect of the same accident. That in an action at common law for damages for injuries sustained by an accident the plaintiff is only entitled to sue once and for all cannot I think be questioned. It may be that after he has recovered damages, it may transpire that the injuries are far more severe than appeared at the date of trial, but he is nevertheless precluded from claiming further damages in a subsequent action.

3.30 The application of the rule in South African law was affirmed in several subsequent cases, such as *Kantor v Welldone Upholsterers* 1944 CPD 388; *Green v Coetzer* 1958(2) SA 697 (W); *Mouton v Mynwerkersunie* 1977 (1) SA 119 (A); *Marine and Trade Insurance Company Ltd v Katz* NO 1979 (4) SA 961 (AD); *Evins v Shield Insurance Company Ltd* 1982 (SA) 814 (A); *Souls Cleopas v The Premier of Gauteng* unreported case 09/41967, Gauteng South High Court, April 2014, *The MEC for Health and Social Development of the Gauteng*

¹²³ Visser and Potgieter *Visser and Potgieter's Law of Damages* 3rd ed (2012) 153.

¹²⁴ (1699) ER 11, affirmed (1702) 91 ER 1122.

¹²⁵ 1917 AD 615.

Provincial Government v Zulu (1020/2015) [2016] ZASCA 185 (judgement delivered on 30 November 2016) and *The Premier of the Western Cape Provincial Government N.O. v Kiewitz* (158/2016) [2017] ZASCA 41 (judgement delivered on 30 March 2017).

3.31 In the case of *Mouton v Mynwerkersonie*, the court said the following:¹²⁶

In an action for damages it is normally expected that, at the end of the case, as a result of the evidence, a finding is made for once and for all about what amount of money must be paid by the defendant to the plaintiff as compensation for damages suffered. In other words, the extent of the defendant's duty for compensation must be determined, and that is the amount which must be stated in the order of the Court.” (own translation).¹²⁷

3.32 In modern delictual claims for damages on the basis of medical negligence, the “once and for all” rule is not always easy to apply. Factors such as life expectancy; future hospital, medical and therapeutic expenses; estimated amount for future care; and loss of future earnings are very difficult to determine, especially if the claim is lodged on behalf of a minor. In addition it is an unfortunate fact of life that the money awarded as damages is not always spent wisely or spent on the person that it is intended for. However, a plaintiff cannot be obliged, by law, to accept an offer to receive incremental payments for damages or to accept a certificate undertaking to make future payments in lieu of a cash payment.

3.33 This principle was emphatically confirmed by Tsoka J of the Gauteng South Division of the High Court in the *Souls Cleopas* case.¹²⁸ The learned judge said the following about the payment of damages:¹²⁹

It is not for the defendant, in the absence of any statutory injunction, to determine the form of compensation for the plaintiff's damages. ... Once the plaintiff has determined the extent of defendant's duty to compensate him, the defendant has no choice but to pay up so long as the damages have, to the best of the plaintiff, been proved.

3.34 Tsoka J concluded with the following remark:¹³⁰

¹²⁶ 1977 (1) SA 119 (A) at 147 B-C.

¹²⁷ “In 'n skadevergoedingsaksie word dit normaalweg verwag dat daar aan die einde van die saak, na aanleiding van die getuienis, 'n bevinding gedoen word, vir eens en altyd, watter bedrag geld deur die verweerde aan die eiser betaal moet word ter vergoeding van gelede skade. M.a.w., die omvang van die verweerde se vergoedingsplig moet bepaal word, en dit is die bedrag wat in die bevel van die Hof gestel moet word.”

¹²⁸ Unreported case 09/41967, Gauteng South High Court, April 2014.

¹²⁹ *Souls Cleopas* case at 7 [20]

The defendant's undertaking is an invitation for this court to venture into a territory exclusively reserved for the legislature. The invitation, though tempting, is to usurp the function of Parliament. It is not for the courts to legislate but to adjudicate. If the time has come, such as in motor vehicle accident fund cases, it is for the legislature to intervene and embark on such an exercise for the benefits of the defendant, not courts of law. Deference must be given to the principle of separation of powers.

3.35 The question of the development of the common law to modify the "once and for all" rule was considered by the Supreme Court of Appeal (SCA) in the matter of *The MEC for Health and Social Development of the Gauteng Provincial Government v Zulu (Zulu case)*.¹³¹ The case was brought to claim compensation for a child who had suffered brain damage during birth due to the negligence of the defendant's employees. One of the issues that the defendant (the appellant, being the Gauteng MEC for Health) had requested the SCA to make a determination on was that, instead of monetary compensation to be paid to the plaintiff (the respondent, Ms Zulu) for future medical expenses, defendant be directed to pay persons providing services to the plaintiff within 30 days of presentation of a written quotation to the defendant's accounting officer.¹³² The defendant averred that, in the event that it is found that South African law does not provide for such relief, the South African law must be developed to make such provision.¹³³

3.36 In a unanimous decision delivered by Swain JA, the SCA held that an amendment to the common law to the extent that the defendant requested, would be a substantive amendment that should be dealt with by the legislature. The SCA went on to say that:¹³⁴

In any event, in exercising their power to develop the common law, judges have to be 'mindful of the fact that the major engine for law reform should be the Legislature and not the Judiciary'. (*Carmichele v Minister of Safety and Security & another (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC) paragraph 36 cited by Swain AJ.) 'The judiciary should confine itself to those incremental changes which are necessary to keep the common law in step with the dynamic and evolving fabric of our society'. (*R v Salituro* (1992) 8 CRR (2d) 173; [1991] 3 SCR 654 cited by Kentridge AJ in *Du Plessis & others v De Klerk & another* 1996 (3) SA 850 (CC) para 61.6 cited

¹³⁰ *Souls Cleopas* case at 8 [22]

¹³¹ (1020/2015) [2016] ZASCA 185 (30 November 2016)

¹³² *Zulu* case at [3] paragraph 12.3.

¹³³ *Zulu* case at [3] paragraph 12.3.

¹³⁴ *Zulu* case at [12].

by Swain AJ.) The development of the common law sought by the appellant is not an incremental change, but one of substance and more appropriately dealt with by the legislature, being an issue of policy. Any legislated change in the common law rule could only be effected after the necessary process of public participation and debate.

3.37 From the discussion of the *Zulu* case above it is abundantly clear that the SCA is of the opinion that any changes to the common law once and for all rule cannot be entertained by the courts and should be addressed by the legislature.

2 Principle of *res iudicata*

3.38 Apart from the “once and for all rule”, which has its origins in English law, the Roman Dutch law also gives recognition to the same notion with the maxim *res iudicatas instaurari exemplo grave est*, also referred to as the *res iudicata* principle. The maxim translates as “to try afresh matters once adjudged creates a dangerous precedent”.¹³⁵ This is confirmed by Buchanan et al, who explains:¹³⁶

As a matter of general principle – sometimes referred to as the 'once and for all' rule – a person may only bring one action against the same defendant upon a single cause of action. Once he has brought that action his remedies at law are exhausted and he is precluded by the principle of *res iudicata* from bringing a further action. Thus, if a plaintiff claims damages for either delict or breach of contract, he must claim damages for all the damage flowing from that cause of action because, if he fails to do so, he will thereafter be precluded from claiming further damages in a subsequent action.

D Basis for state liability

1 Vicarious liability

3.39 Where claims based on medical negligence are instituted against the state, the MEC for Health in the province concerned is cited as defendant. The reason for this is to be found in the principle of vicarious liability, which refers to a situation where the law holds one

¹³⁵ Translation by Hiemstra VG and Gonin HL *Trilingual Legal Dictionary* 3rd ed (1986).

¹³⁶ JL Buchanan et al *The Quantum of Damages in Bodily and Fatal Injuries* Jutastat e-publications 2009 “General Principles” 7.

person responsible for the wrongful conduct of another, even though the person being held responsible is innocent of any wrongdoing.¹³⁷

3.40 One of the instances where vicarious liability is relevant is in an employer employee relationship. An employer would be held liable generally for a delict committed by an employee if the employee's wrongful act was committed in the course and scope of his or her employment. This also holds true for employees of the state.¹³⁸ Action for the commission of a delict in such a case would be instituted against the employer of the person who committed the delict.

2 Constitutional and public obligations

3.41 Apart from liability of the state on the basis of vicarious liability resulting from the employer / employee relationship between the state and its workers, the state could be liable on an altogether different level due to the state's constitutional obligations towards its citizens. In addition to the rights espoused in section 27(1)(a)¹³⁹ and 27(2),¹⁴⁰ other relevant constitutional rights include the right to dignity; life; freedom and security of the person, specifically bodily integrity; privacy; access to courts; and the right to approach a court for the granting of appropriate relief if a right in the Bill of Rights has been infringed or threatened.¹⁴¹ Moodley refers to the foundational rights to dignity, equality and life, but also lists the social rights that affect health, such as adequate water, social security, housing and education.¹⁴²

3.42 The NDOH, under the leadership of the Minister of Health as the responsible member of the executive, is the government department responsible for providing direction and policy guidance on the implementation of the constitutional right to health care services. To this end the National Health Act 61 of 2003 was adopted, which provides a framework for

¹³⁷ Carstens & Pearmain 545; McQuoid-Mason & Dada 433; DJ McQuoid-Mason "Vicarious and Strict Liability" in *The Law of South Africa* Vol 30 2nd ed 2011 par 285 [LAWSA vol 30].

¹³⁸ Coetzee & Carstens 1271; LAWSA vol 30 par 289 and 294.

¹³⁹ (1) Everyone has the right to have access to –
(a) health care services, including reproductive health care;

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

¹⁴¹ Sections 1; 1(a); 10; 11; 12(1) and (2); 14, 34 and 38 respectively.

¹⁴² K Moodley *Medical Ethics, Law and Human Rights – A South African Perspective* (2011) 97.

a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services.¹⁴³

3.43 The constitutional protection of the right of access to health care services and related rights has impacted on the legal philosophical foundation for the exercise of individual rights. Traditionally, the basis of the relationship between a doctor and a patient, or a hospital and a patient, was contractual.¹⁴⁴ This mostly still holds true for private health care, but as pointed out by Carstens and Pearmain, “in the wake of the South African Constitution of 1996, national legislation and the reality that the majority of South African citizens are dependant upon health services as delivered by the public sector, there has been a shift to considerations of public law.”¹⁴⁵

¹⁴³ Long title to the National Health Act, Act 61 of 2003.

¹⁴⁴ Carstens & Pearmain 283 & 413.

¹⁴⁵ Carstens & Pearmain 283.

CHAPTER 4: PAYMENT OF COMPENSATION

A Lump sum payments

4.1 The usual practice by the courts when awarding damages as a result of a successful claim on the basis of a contractual or delictual obligation is to issue an order awarding payment of compensation in a lump sum. Lump sum payments refer to “an award granted by a court that covers past losses and losses likely to be suffered in the future”.¹⁴⁶

4.2 When calculating a lump sum award “future losses must be reduced to present value by taking a complex variety of factors into account”.¹⁴⁷ An assessment must be made of all past and future losses at a certain point in time and a lump sum is then awarded that should cover everything.¹⁴⁸ The losses considered include pecuniary loss (special damages) as well as non-pecuniary loss (general damages). Special damages include loss of earnings, cost of care, medical care, treatment and assistive devices. General damages must compensate for pain, suffering, distress and loss of amenity of life.¹⁴⁹

B Structured Settlements and Periodic Payments

4.3 Dehner *et al* define a structured settlement as “an agreement to settle a personal injury claim, where the claimant accepts a defined package of financial products, generally cash and periodic payments, on specified terms”. The authors define periodic payment to mean “a commitment to make future payments to a claimant according to an agreed schedule on specified terms”.¹⁵⁰

4.4 The first reported incidents of structured settlements in personal injury cases occurred in Canada in the 1960’s. Several claims were instituted against a drug company on

¹⁴⁶ US Legal Inc *Law and Legal Definition* available at <https://definitions.uslegal.com> accessed on 27 March 2017.

¹⁴⁷ The Law Reform Commission, Ireland *Report on Personal Injuries: Periodic Payments and Structured Settlements* (1996) 2 [LRC Ireland *Personal Injuries*]

¹⁴⁸ LRC Ireland *Personal Injuries* 5; *Report of the Working Group on Medical Negligence and Periodic Payments (Module 1)* October 2010 11 (Ireland) [Working Group Report (Ireland)].

¹⁴⁹ *Working Group Report* (Ireland) 11.

¹⁵⁰ JJ Dehner *et al* *Structured Settlements and Periodic Payment Judgements* (2005) 1-3.

behalf of children born with severe birth defects, especially foetal anomalies, as a result of the use of the drug Thalidomide by their mothers during pregnancy. The children faced life-long dependency at huge cost to their families. Since the drug company could not afford covering the costs of lump sum payments in full, the company resolved the claims through structured settlements, undertaking to make periodic payments to the victims over the course of their lifetimes.¹⁵¹

4.5 The practice of awarding damages by means of structured settlements or periodic payments has since increased. Apart from Canada, courts in countries such as the United States of America, United Kingdom, Australia, New Zealand, Finland, France, Germany, Luxembourg, Portugal, Spain and Sweden are empowered to order defendants to pay damages for certain future losses in periodic payments or in a lump sum.¹⁵²

C Existing South African legislation

4.6 There already are statutory measures in South Africa that deviate from the common law in respect of claims for damages for personal injury and that provide for structured settlements or periodic payments. Examples of such measures are discussed below.

1 Occupational Diseases in Mines and Works Act 78 of 1973

4.7 According to the long title of the Occupational Diseases in Mines and Works Act 78 of 1973 the purpose of the Act is to consolidate and amend the law relating to the payment of compensation in respect of certain diseases contracted by persons employed in mines and works and matters incidental thereto. Chapter VI of the Act pertains to compensation under the Act.

2 Compensation for Occupational Injuries and Diseases Act 130 of 1993

4.8 According to the long title of the Compensation for Occupational Injuries and Diseases Act 130 of 1993 the purpose of the Act is to provide for compensation or disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, or for death resulting from such injuries or

¹⁵¹ Dehner et al 1-36.

¹⁵² Dehner et al 1-37 to 1-40.

diseases, and to provide for matters connected therewith. Section 22 deals with the right of an employee to compensation, while sections 49 and 54 deals with the payment of compensation, including the payment of a monthly pension.

3 Road Accident Fund Act 56 of 1996

4.9 According to the long title of the Road Accident Fund Act, the purpose of the Act is to provide for the establishment of the Road Accident Fund; and to provide for matters connected therewith. Section 17 of the Act relates to the liability of the Road Accident Fund and agents. Section 17(4)(b) specifically makes provision for the possibility of payment of a claim for future loss of income or support in instalments as agreed upon.¹⁵³ Apart from provision for periodic payments of claims, section 17(4)(a) determines that the Fund may furnish a third party with an undertaking to compensate a third party for future accommodation in a hospital or nursing home, rendering a service or supplying goods.¹⁵⁴

D International legislation

4.10 South Africa is not unique in the world as far as the huge increase in claims on the basis of medical negligence is concerned. The phenomena is wide-spread and several countries have adopted statutory measures to deal with claims for damages in general or claims for damages based on medical negligence in particular. It will therefore be useful to take a closer look at the measures adopted by other countries.

1 Canada

4.11 As explained above (refer to paragraph 4.4) Canada was the first country reported to have utilised structured settlements and periodic payments for personal injury claims. Since the Thalidomide cases there has been legislative intervention in Canada. The state of Ontario in Canada introduced legislation to make it compulsory to order that damages for

¹⁵³ (4) Where a claim for compensation under subsection (1) –
 (b) includes a claim for future loss of income or support, the amount payable by the Fund or the agent shall be paid by way of a lump sum or in instalments as agreed upon;

¹⁵⁴ (4) Where a claim for compensation under subsection (1) –
 (a) includes a claim for the costs of the future accommodation of any person in a hospital or nursing home or treatment of or rendering of a service or supplying of goods to him or her, the Fund or an agent shall be entitled, after furnishing the third party concerned with an undertaking to that effect or a competent court has directed the Fund or the agent to furnish such undertaking, to compensate – [list of claims / expenses follows]

future care costs be satisfied by way of periodic payments in the event of a medical malpractice action where the award exceeds a certain amount.¹⁵⁵

4.12 The 1990 Ontario Courts of Justice Act for example requires courts in that province to order periodic payments for damages for personal injuries in certain instances, unless it would not be in the best interests of the plaintiff. Section 116 of the Ontario Courts of Justice Act, which deals with periodic payment and review of damages, gives courts the discretion to make an order for periodic payment. However, in the event of a medical malpractice action where the award exceeds a certain amount, section 116.1 makes it compulsory to order that the damages for future care costs be satisfied by way of periodic payments.¹⁵⁶

2 United Kingdom

4.13 The United Kingdom enacted the Damages Act of 1996 to “make new provision in relation to damages for personal injury, including injury resulting in death.” Section 2 of the Act empowers a court awarding damages in an action for personal injury to make an order in terms of which the damages are wholly or partly paid in the form of periodical payments.¹⁵⁷ The Act also provides for securing or guaranteeing payments and structured settlements.

3 Australia

4.14 Western Australia introduced the Civil Liability Act of 2002. According to the long title of the Act, the Act relates to various aspects of civil liability, restricts advertising legal

¹⁵⁵ The 1990 Ontario Courts of Justice Act requires courts in that province to order periodic payments for damages for personal injuries in certain instances, unless it would not be in the best interests of the plaintiff. Section 116 of the Ontario Courts of Justice Act (regarding periodic payment and review of damages), gives courts the discretion to make an order for periodic payment. However, in the event of a medical malpractice action where the award exceeds a certain amount, section 116.1 makes it compulsory to order that the damages for future care costs be satisfied by way of periodic payments.

¹⁵⁶ **Periodic payment, medical malpractice actions**

116.1 (1) Despite section 116, in a medical malpractice action where the court determines that the award for the future care costs of the plaintiff exceeds the prescribed amount, the court shall, on a motion by the plaintiff or a defendant that is liable to pay the plaintiff's future care costs, order that the damages for the future care costs of the plaintiff be satisfied by way of periodic payments.

¹⁵⁷ **2 Consent orders for periodical payments**

(1) A court awarding damages in an action for personal injury may, with the consent of the parties, make an order under which the damages are wholly or partly to take the form of periodical payments.

services relating to personal injury, restricts touting, and deals with related purposes. Part 2 of the Act pertains to “Awards of personal injury damages”, while Division 4 of Part 2 specifically deals with “Structured settlements”. The term “structured settlement” is defined as “an agreement that provides for all or part of the damages agreed or awarded to be paid in the form of periodic payments funded by an annuity or other agreed means.”¹⁵⁸

4.15 Section 15 of the Act provides for court orders approving of or in the terms of a structured settlement for personal injury damages.¹⁵⁹

4 Ireland

4.16 In Ireland the President of the High Court established a Working Group on Medical Negligence and Periodic Payments (Working Group) with the following terms of reference:

1. To examine the present system within the courts for the management of claims for damages arising out of alleged medical negligence and to identify any shortcomings within that system.
2. To make such recommendations to the President as may be necessary in order to improve the system and eliminate shortcomings.
3. To consider whether certain categories of damages for catastrophic injuries can or should be awarded by way of Periodic Payments Orders and to make such recommendations to the President as may be necessary.
4. To provide the President with such draft Legislation, Regulations, and Rules of Court as may be necessary to give effect to the Working Group’s recommendations.¹⁶⁰

¹⁵⁸ **Division 4 — Structured settlements**

14. Term used: structured settlement

In this Division —

structured settlement means an agreement that provides for all or part of the damages agreed or awarded to be paid in the form of periodic payments funded by an annuity or other agreed means.

¹⁵⁹ **15. Consent order for structured settlement**

(1) This section applies if the parties to a claim for personal injury damages make a structured settlement and apply to the court hearing, or with jurisdiction to hear, the claim for an order approving of, or in the terms of, the structured settlement.

(2) The court may make the order even though the payment of damages is not in the form of a lump sum.

¹⁶⁰ *Working Group Report (Ireland)* 3.

4.17 The Working Group made a number of recommendations, the most important of which was the following:¹⁶¹

Legislation should be enacted to empower the courts, as an alternative to lump sum awards of damages, to make consensual and non-consensual periodic payment orders to compensate injured victims in cases of catastrophic injury where long term permanent care will be required, for the costs of (a) future treatment (b) future care and (c) the future provision of medical and assistive aids and appliances.

E Lump Sum Payments vs Structured Settlements or Periodic Payments

1 Advantages and disadvantages of lump sum payments

4.18 The *Working Group Report* (Ireland) considered the advantages and disadvantages of lump sum payments.¹⁶² One of the flaws in the award of lump sum payments is the uncertainty inherent in the calculation of lump sum payments for especially future special damages. Factors that must be considered include the likely life expectancy of the plaintiff, cost of future medical care and treatment, loss of earning and inflation rates.¹⁶³ In this regard the *Report* states: “The one virtual certainty about a lump sum award to pay for future care is that the wrong amount will be awarded. That is inescapable.”¹⁶⁴

4.19 An argument put forward in favour of lump sum awards is that it brings conclusiveness and certainty in the resolution of a claim. However, in view of the risks visited upon both the plaintiff as well as the defendant by lump sum awards, this argument is outweighed by the disadvantages of this method of compensation. It is especially plaintiffs that require long-term care or permanent incapacity that suffer the risk of outliving their award. On the other hand, if the plaintiff dies before the money runs out, the plaintiff’s estate would be unjustly enriched.¹⁶⁵

¹⁶¹ *Working Group Report* (Ireland) 7.

¹⁶² *Working Group Report* (Ireland) 11 to 15.

¹⁶³ *Working Group Report* (Ireland) 11.

¹⁶⁴ *Working Group Report* (Ireland) 13.

¹⁶⁵ *Working Group Report* (Ireland) 14 & 15.

2 Advantages and disadvantages of periodic payments

4.20 The UK's *Royal Commission on Civil Liability and Compensation for Personal Injury* of 1978 (referred to as the Pearson Commission) considered the advantages and disadvantages of periodic payments.¹⁶⁶ According to the Pearson Commission periodic payments would be more effective than lump sum payments, especially if coupled with a review mechanism.¹⁶⁷

4.21 A strong argument in favour of structured settlements and periodic payments is the shortcomings of the lump sum award system, especially taking into consideration that a conventional lump sum award for future damages will inevitably either over-compensate or under-compensate the plaintiff. In addition, the defendant will not have to pay in full in year one for a claim that is calculated on the basis of future inflation up to for arguments sake year 30. The payment could rather escalate every year based on the CPI for example. Over time it will be cheaper. The problem of either over or under-compensation is highlighted in the *Working Group Report (Ireland)* by reference to several studies conducted by other commissions and working groups.¹⁶⁸

4.22 An argument often raised against periodic payments is the possibility that the payments would not be maintained over a long period of time. A defendant however will have to furnish security to the court's satisfaction to ensure that periodic payments are kept up in the long term.

F Additional considerations

4.23 From the discussion above it is clear that there are precedents, both internationally as well as locally, for deviating from the practice of awarding damages or compensation in the form of lump sum payments. Although neither the "once and for all" rule nor the *res iudicata* principle as such prohibits the payment of damages as structured settlements, in instalments or as periodic payments, the common practice by the courts in awarding

¹⁶⁶ *Royal Commission on Civil Liability and Compensation for Personal Injury* 1978 (HMSO, Cmnd 7054) (Pearson Commission).

¹⁶⁷ Pearson Commission par 566.

¹⁶⁸ *Working Group Report (Ireland)* 19.

damages had been to order lump sum payments. A court would not, in any event, impose a structured settlement or periodic payment upon an unwilling plaintiff.

4.24 In the majority of jurisdictions that expressly allow structured settlements or periodic payments, the awarding of damages in that manner is left to the discretion of the courts. An example of an obligation imposed to award periodic payments is to be found in the 1990 Courts of Justice Act of Ontario, Canada. Section 116.1 of that Act determines that in medical malpractice actions, for awards that exceed a certain amount, “the court **shall** ... order that the damages for the future care costs of the plaintiff be satisfied by way of periodic payments.” (emphasis added).

4.25 Though the “once and for all” rule and the *res iudicata* principle bar multiple claims based on the same cause of action; it does not bar damages awarded by means of structured settlements or periodic payments. The courts however have indicated that legislative intervention would be required before orders can be made that compel plaintiffs to accept awards in the form of undertakings or structured settlements, as provided, for example, by section 17 of the Road Accident Fund Act.¹⁶⁹

¹⁶⁹ *The MEC for Health and Social Development of the Gauteng Provincial Government v Zulu* (1020/2015) [2016] ZASCA 185 (30 November 2016); *Souls Cleopas and the Premier of Gauteng* Unreported case no. 09/41967 Gauteng South High Court (April 2014).

CHAPTER 5: POSSIBLE LEGISLATIVE INTERVENTION

A Calls for legislative intervention

5.1 Pepper and Nöthling Slabbert¹⁷⁰ make a number of suggestions, based in part on recommendations made by McLennan *et al*¹⁷¹ in relation to cerebral palsy litigation. Pepper and Nöthling Slabbert propose better self-policing by the medical profession, special health courts, policing by the medical profession of persons offering expert opinion, alternative dispute resolution, the creation of a no-fault system to resolve birth outcome disputes, and lastly, legislative intervention.¹⁷²

5.2 Pepper and Nöthling Slabbert are not alone in calling for legislative intervention. Dhai tenders the establishment of a statutory body to consider and settle claims through mediation.¹⁷³ Howarth & Carstens suggest the introduction of an approach based on medical as well as legal interventions. The medical approach proposed is the introduction of a system advocated by the Royal College of Obstetricians and Gynaecologists (RCOG) in the United Kingdom. The model advises utilising qualified midwives, medical practitioners, as well as consultants, for the delivery of babies. According to Howarth and Carstens it would, however, require legislative changes.¹⁷⁴ They also put forward the possibility of a no-fault system or the capping of non-economic damages, both interventions that would require amending the law.¹⁷⁵

¹⁷⁰ MS Pepper & M Nöthling Slabbert "Is South Africa on the verge of a medical malpractice litigation storm?" *SAJBL* Vol 4 No 1 20 June 2011 29.

¹⁷¹ A MacLennan *et al* "Who will deliver our grandchildren? Implications of cerebral palsy litigation" *JAMA* 2005 294: 1688-1690.

¹⁷² Pepper & Nöthling Slabbert 33.

¹⁷³ A Dhai "Medico-legal litigation: Balancing spiralling costs with fair compensation" *SAJBL* Vol 8 No 1 May 2015 2 at 3.

¹⁷⁴ G Howarth & P Carstens "Can private obstetric care be saved in South Africa?" *SAJBL* Vol 7 No 2 November 2014 69 at 70.

¹⁷⁵ Howarth & Carstens 72.

5.3 Howarth & Hallinan voice the need for critical legal reform, citing the need for “an efficient and cost-effective legal system that works for patients and their families, as well as for healthcare professionals ...”.¹⁷⁶ Roytowski *et al*, in discussing the results of a survey among neurosurgeons to determine whether high malpractice cover was influencing how they manage patients, remark that legal reform in some of the states of the USA has assisted in dealing with expenses relating to personal injury liability costs and submit that similar reforms could be implemented in South Africa.¹⁷⁷

5.4 The serious state of affairs with regard to the surge in medical negligence claims in South Africa, especially claims against the state, is indeed perturbing. A lot has been said and written on the topic, but concrete solutions are still lacking. Subsequent to the medico-legal summit hosted by the national DOH in Pretoria in March 2015, the Minister of Health released a declaration, developed by the Medico-Legal Task Team (now the Ministerial Advisory Committee) appointed by the Minister, containing statements and putting forward proposals on dealing with the matter. Apart from administrative, managerial and service delivery issues highlighted in the declaration, many of which require proper implementation of existing policies and guidelines, legal interventions are also accentuated.

5.5 Several proposals were made during panel discussions at the 3 March 2017 Medical Malpractice Workshop regarding actions that can be taken in the short term to alleviate the medical malpractice crisis. There was general consensus, however, that legislation to deal with several aspects of the crisis will ultimately be necessary.

5.6 Based on the arguments put forward by authors, the legal proposals made in the declaration issued by the Minister of Health resulting from the March 2015 Medico-legal Summit and issues raised by participants in the March 2017 Medical Malpractice workshop, in conjunction with pleas from both the medical as well as the legal fraternities, it is evident that legislative reform is urgently required. Although some of the participants in this debate have proposed broad topics for law reform and put forward suggestions regarding the extent and nature of possible legislative interventions, thoroughly researched, widely consulted, tangible recommendations are still lacking. A lot of work is still required in this respect.

¹⁷⁶ G Howarth & E Hallinan “Challenging the cost of clinical negligence” SAMJ Vol 106 No 2 February 2016 141

¹⁷⁷ D Roytowski *et al* “Impressions of defensive medical practice and medical litigation among South African neurosurgeons” SAMJ Vol 104 No. 11 November 2014 736 at 738

B Starting the investigation

5.7 There currently is no legislation in South Africa to address legal claims in the medical field; medico-legal claims are dealt with in terms of the common law. To investigate this state of affairs, the SALRC would need to do the following:

1. Review the law of South Africa relating to medico-legal claims;
2. Conduct comparative legal research to investigate the manner in which medico-legal claims are dealt with in other countries,
3. Consult government departments,
4. Consult experts and other stakeholders,
5. Consult members of the public, and
6. Investigate, consider and evaluate possible legislative options.

5.8 Although there has been a lot of discussion on the topic and various and divergent opinions have been expressed, the national DOH (as the main developer of health care policy) has given no specific indication on the direction any proposed legislation should take. The DOH requested an SALRC investigation since DOH is of the opinion that existing legal measures do not sufficiently address the problem.

5.9 All the items listed above need to be properly interrogated as part of a larger in-depth investigation. An investigation of this nature, where legislation will have to be developed from scratch, would definitely require substantial long-term commitment and fundamental review. An investigation of this magnitude and complexity cannot be rushed. Apart from key stakeholders such as the Department of Health, Justice and Constitutional Development, Defence, Correctional Services and the provinces, recommendations made as a result of this investigation will impact on a significant proportion of the population as users of public health services, the medical and legal professions and the courts. In-depth research will have to be conducted to come up with proposals to deal with this issue, the views of experts in the field must be solicited and proper public and stakeholder consultation must take place.

5.10 Various government departments, professional groups, voluntary organisations, non-profit organisations, insurers and academics all have a direct interest in this matter, and must be consulted. However, there is another substantial group of stakeholders whose views must also be solicited. Members of the public have a direct interest in the delivery of health care services and would make up the numerically largest stakeholder group in an investigation on medico-legal claims.

5.11 As indicated in paragraph 2.3, over 40 million people use the public health care system in South Africa. Based on sheer numbers, proper public consultation is imperative. However, not only members of the public who make use of public health care will be affected by possible legislation. Private health care services are also affected by medico-legal claims. Hence, the proposed investigation may need to cover both the private and public health care sectors.

5.12 It is obvious that there would indeed be some vested interests at stake in an investigation on medico-legal claims, as a large number of attorneys are practising in the area of personal injury claims. Due to changes in the legislation governing the RAF, personal injury claims against the RAF are no longer the lucrative business it used to be. A number of personal injury lawyers have therefore diverted their attention away from RAF claims and now focus on medico-legal claims.

5.13 No attorney can manufacture a medico-legal claim where none exists. However, concerns have been raised about certain attorneys' behaviour in pursuing potential clients, ranging from aggressive to unethical to blatantly illegal tactics. During the March 2015 DOH medico-legal summit, allegations were made of conduct such as aggressive advertising, which is legal; touting for clients at hospitals, which is unethical and contrary to the rules of the law societies; and bribing hospital staff to obtain information on patients or the files of patients, which is illegal. The debate that flowed from these allegations enjoyed widespread media coverage.

5.14 The groundwork for further policy development has already been laid through the work done at the medico-legal summit. As indicated by Howarth *et al* in their discussion on the lack of awareness of the consequences of spiralling medical negligence litigation, “[t]he medical profession cannot resolve the issues alone. There is not a medical answer – it has to enter the public debate.”¹⁷⁸

C Potential benefits of undertaking law reform

5.15 The potential benefits likely to accrue from undertaking reform or repeal of the law must also be considered. One of the issues that Tsoka J raised in the *Souls Cleopas* case is

¹⁷⁸ G R Howarth *et al* “Public somnambulism: A general lack of awareness of the consequences of increasing medical negligence litigation” *SA Medical Journal*, Vol. 104 No. 11 November 2014.

the possibility of deviating from the common law when dealing with medico-legal claims.¹⁷⁹ The judge explained the justification for deviating from the common law in RAF matters as follows:¹⁸⁰

In road accident fund matters, the reason for departure from the common law is not hard to fathom. The Road Accident Fund Act is a social legislation. The fund is created for the common good of all persons who are injured and sustained damages as a result of the driving of motor vehicles. It is understandable, therefore, that for the good of the public and in the public interest, the common law must be interfered with, so that only damages actually incurred due to the constraint on the public purse, must be paid for.

5.16 As explained above, the only way in which a deviation from the common law would be possible would be through legislative intervention. The present state of this area of the law is unsatisfactory. It is clear from issues such as the inaccessibility of the law for the very people who need it most, the delays in finalising cases, the limits imposed by the nature of legal processes conducted in terms of the common law, the enormous strain placed on the fiscus by the current litigious climate and the developing crisis in the private medical sector that these concerns should be addressed as soon as possible.

¹⁷⁹ Unreported case no. 09/41967 Gauteng South High Court April 2014.

¹⁸⁰ *Souls Cleopas* case at 6 [16].

CHAPTER 6: QUESTIONS FOR CONSIDERATION

A Call for comments

6.1 There are several issues that should be looked into to take this investigation forward. As indicated in the introduction to the issue paper, the purpose of this paper is to elicit comments on the matter under investigation (see page iii above). The comments are vitally important to give the SALRC an indication of the direction the investigation should take and the issues that the investigation should focus on. All comments will be taken into account, but respondents are requested to particularly consider the issues discussed below in preparing their comments in so far as they are able to do so.

6.2 The issues raised below serve as a framework for responses, but respondents are not limited to these issues. However, there are two questions that should provide interesting results and that all respondents are requested to express an opinion on:

- What in your opinion is the main reason for the enormous increase in medico-legal litigation against the state?
- What single intervention do you believe will have the biggest impact on improving the current situation?

B Concerns about current system

6.3 A number of concerns have been raised with regard to the current system. Respondents are requested to consider whether:

1. The traditional common law system is still the most appropriate response to dealing with medical negligence in the current environment.
2. If the response to item 1 above is NO, there is scope for the development of the common law.
3. The adversarial system is the best option for dealing with this particular area of the law, bearing in mind –
 - a. the personal nature of the claim for the persons affected by medical negligence;
 - b. the highly technical and specialised evidence required to prove both the cause of action as well as the quantum of damages.

4. Applying the inquisitorial system or aspects of the inquisitorial system to medical negligence claims would be beneficial.¹⁸¹
5. Alternative measures for dealing with medical negligence claims other than through the courts are available in current South African law.
6. The only way in which the current state of the law can be changed is by means of legislation.
7. If the problem can only be addressed through legislation, options that could be considered in view of the international experience as applied to challenges unique to South Africa.
8. The common law “once and for all” rule is problematic in the context of medical negligence claims.
9. The doctrine of avoidable consequences (the doctrine that places the responsibility of minimising damages upon the person who has been injured)¹⁸² has a place in South-African law.
10. Prescription periods as currently applied in South African law, especially with regard to minors, are satisfactory in the field of medical malpractice legislation.
11. The Contingency Fees Act 66 of 1997 and the principle of contingency fees should be reviewed.

C Existing measures or short-term solutions

6.4 Comments are requested on the issue of existing measures that apparently are not being applied or not fully implemented, or that should be introduced, but is still lacking. There are also short-term solutions that could be introduced without the need for legislation:

1. Keep and preserve proper records, including –
 - a. keeping electronic records;
 - b. making copies of records;
 - c. making back-ups of information in electronic format;
 - d. making copies to preserve records that can degrade.
2. Improve communication between medical practitioners and patients.

¹⁸¹ An example of a measure applying an aspect of the inquisitorial system in South African law is section 115 of the Criminal Procedure Act 51 of 1977.

¹⁸² Farlex *The Free Dictionary* available at the legal-dictionary.thefreedictionary.com accessed on 27 March 2017 (web).

3. Review consent forms and ensure that patients are adequately informed when consenting to treatment or procedures.
4. Implement a consistent, efficient and patient-centred complaints process that allows for local resolution.
5. Investigate adverse events without delay.
6. Introduce a system of peer review.
7. Compile and follow protocols, standard operating procedures and check lists.
8. Hold staff accountable if protocols, standard operating procedures and check lists are not complied with.
9. Determine the staff compliment that is required per health establishment and fill vacancies.
10. Ensure adequate supervision of junior staff.
11. Improve quality of service: if there is no negligence, there is no claim.
12. Take disciplinary action in terms of the Public Service Act, 1994 and relevant labour legislation for serious transgressions such as the theft of files or information or a breach of a patient's right to privacy.
13. Lay criminal charges for transgressions of section 17 (protection of health records) of the National Health Act 61 of 2003.
14. Budget separately for litigation – do not pay litigation costs and compensation from the operational budget of hospitals.
15. Improve cooperation between provinces and the relevant Office of the State Attorney with regard to –
 - a. gathering information
 - b. assembling case files;
 - c. tracing witnesses;
 - d. making witnesses available.
16. Appoint specialised and suitably qualified legal staff with experience of litigation (advocates admitted to the Bar or admitted attorneys) in the provincial departments of health to specifically deal with medico-legal litigation.
17. Develop a standardised *modus operandi* for dealing with medico-legal claims in the legal divisions of the provincial departments of health and the various offices of the state attorney that includes systems to ensure that matters are properly prepared and dealt with timeously.
18. Employ or utilise in-house medical experts in each province to assess claims to determine whether to defend or settle.
19. Appoint joint experts agreed on by both parties to testify in cases.
20. Consult with health professions associations to identify experts to testify in court.

21. Exercise proper case management once litigation is instituted.
22. Collect information and develop databases for information sharing, to determine trends, and to assist with the determination of compensation.
23. Provide training to health care professionals where shortcomings and inadequacies occur.
24. Provide training and assistance to state attorneys to deal with medico-legal claims.

D Amendment of State Liability Act 20 of 1957

6.5 Due to the detrimental impact of the substantial amounts awarded as compensation for medical negligence claims, it is recommended that consideration be given to amending the State Liability Act 20 of 1957 as an interim measure. The purpose of the amendment would be to make specific provision for structured settlement orders, which would include periodic payments, in cases of medical negligence claims against the state.

6.6 In addition, in so far as current financial provisions are inadequate for this purpose, it is suggested that provision should be made for a separate budget in each province for litigation and payment of compensation. Litigation and payment of compensation should not be paid from the operational budgets of health establishments. The current practice of paying for litigation from the budget of the hospital concerned impacts negatively on the delivery of health services. In the end this will lead to more litigation due to the resulting deterioration in the standard of service delivery.

6.7 The following should be taken into consideration with regard to the above proposal:

1. Lump sum awards should remain the norm for past expenses and damages, past and current special damages for the cost of care, medical treatment and assistive devices and other proven immediate and necessary expenses.
2. Lump sum payments, perhaps to a maximum amount, should still be awarded for general damages for pain and suffering and loss of amenities of life.
3. Periodic payments should be introduced as the default position for all future special damages for loss of earnings, medical care and treatment, therapy and so forth that are expected to be incurred.
4. Deviation from periodic payments for future damages should only be allowed if special circumstances are proven to exist to justify such a deviation.
5. Periodic payments should ideally be linked to an index of average values for earnings, cost of living, cost of care and treatment et cetera, to be revalued from time to time.

6. Variation of periodic payments should be possible in specific circumstances, such as a drastic change in the circumstances or health of the person who suffered harm.
7. The state should provide guarantees to the satisfaction of the court for any undertakings made or future payments to be made.
8. Any award, whether in the form of a lump sum or by means of periodic payments, must be underpinned by proper medical, statistical and actuarial evidence.

E Proposals for legislation

6.8 Comment is sought on a number of preliminary proposals for legislative intervention that had been put forward. Some proposals are mutually exclusive, but all proposals that had been made to date are included:

1. Establish a separate budget in each province for conducting litigation and payment of compensation in so far as current financial provisions are inadequate for this purpose.
2. Establish a separate fund or determine a source of funding to pay for litigation and compensation.
3. Introduce compulsory professional indemnity insurance of medical practitioners.
4. Provide for direct access by plaintiffs without a legal practitioner as intermediary.
5. Introduce alternative dispute resolution, such as mediation and pre-litigation resolution, as a first step before litigation is pursued.
6. Consider how mediation should be introduced:
 - a. compulsory mediation; or
 - b. voluntary mediation, making an attempt at mediation compulsory before bringing a court application; or
 - c. completely voluntary.
7. Establish a statutory body or tribunal to deal with medico-legal claims, either to –
 - a. screen and evaluate claims and the viability of such claims; or
 - b. adjudicate claims.
8. Implement a no-fault system for the payment of compensation,¹⁸³ which means that –
 - a. it would not be necessary to institute medical malpractice claims;

¹⁸³ A no-fault compensation system is applied in New Zealand. See The Commonwealth Fund “No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety” 2017 The Commonwealth Fund available at <http://www.commonwealthfund.org/publications> accessed 27 March 2017.

- b. the elements of delict, including causality, need not be proved;
 - c. payments are made in accordance with a fixed awards structure.
9. Introduce a certificate of merit requiring the plaintiff's lawyer to confirm, before the start of the case, that the case has merit.
 10. Provide for earlier exchange of information, expert notices, summaries and witness statements and hold early expert meetings.
 11. Introduce pre-trial conferences.
 12. Introduce capping of claims, especially claims for general damages (non-economic damages such as pain and suffering and emotional distress).
 13. Impose a limit on future care costs and loss of future earnings.
 14. Prescribe a net discount rate for future medical care.
 15. Prescribe guidelines for the calculation of compensation:
 - a. Determination of life expectancy;
 - b. Future medical expenses;
 - c. Cost of future care, treatment and therapy;
 - d. Cost of assistive devices.
 16. Provide for different methods of compensation, for example: monetary compensation, free treatment in state hospitals.
 17. Define benefits to be paid.
 18. Prescribe a tariff of general damages.
 19. Provide for structured settlements, including periodic payments for future care and maintenance costs.
 20. If periodic payments are introduced, provide for the frequency (monthly, quarterly, every six months, annually) and method for making payment (for example using the same or a similar system used for social grants).
 21. Provide for the payment of annuities or staggered payments.
 22. Provide for guarantees or undertakings towards paying future medical expenses.
 23. Provide for a contingency deduction or reducing contingency fees.
 24. Safeguard payments made for the benefit of children and disabled claimants, for example by paying awards into the Guardian's fund or requiring security.
 25. Provide for mandatory creation of trusts.

6.9 Any pointers to legislation or measures introduced in other countries, which proved successful in mitigating susceptibility to medico-legal claims or reducing the number of claims or compensation claimed, would be equally welcome.

F General concerns

6.9 There are a number of other factors of a more general nature that may have an impact on health service delivery and medico-legal litigation. Comments on or information pertaining to these issues will be equally welcome:

1. The reasons why people litigate.
2. Striking a balance between compensating deserving people and the availability of state resources.
3. Reports of unethical conduct by lawyers such as touting, illegal procurement of information, obtaining patient files illegally.
4. Aggressive advertising by personal injury lawyers.
5. Vexatious or frivolous litigation.
6. “Double dipping” – plaintiffs receiving social grants or using the public health system after receiving awards for maintenance, care and private health care.
7. The need for clear terms of reference for the health ombudsman.

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