MEDICAL MALPRACTICE

A Roundup of Developments

- by Greg Whitaker

During 2021, a significant number of reports were released around the vexing problem of medical negligence in South Africa's public sector. It is the purpose of this article to summarise and comment on the key aspects of each report.

MEDICAL MALPRACTICE IN THE SOUTH AFRICAN PUBLIC SECTOR – ACTUARIAL SOCIETY OF SOUTH AFRICA

30 April 2021

The Extent of Medical Malpractice in the South African Public Sector

Figures provided by National Treasury show that the contingent liability for medico-legal claims increased from approximately R 28.6 billion for the financial year ending 31 March 2015 to approximately R 120.3 billion for the financial year ending 31 March 2021. Total claims payments from 1 April 2012 until 21 March 2021 were approximately R 10.5 billion.

For every R 1 billion in claims payments, the government could employ an additional 5,750 staff nurses at a basic salary of approximately R 14,500 per month in 2021 money terms.

The accuracy of contingent liability figures is questionable with data-related problems and liability calculation methodologies being major issues. An interrogation of the contingent liability figure in the Northern Cape revealed that it could be reduced by at least 40%. Nevertheless, even if the true total contingent liability figure is substantially lower, the current state of affairs is not sustainable.

Contributing Factors and Cerebral Palsy

There are various medical and legal reasons that give rise to medical negligence claims. Contingency fee agreements, capping contingency fees, the emergence of the litigation funding industry, the impact of patient-centric legislation, issues of collusion between various role players, allegations of unethical conduct, the use of manual filing systems and the disappearance of patient files are matters that require further investigation. Little attention has been paid to the flexibility and manipulability of the law of delict.

Much of the discussion in this report relates to claims related to cerebral palsy as these represent the vast majority of claims, by both number and amount. The medical literature highlights the complexity and difficulty in establishing causation, which is one of the five elements of delict that must be satisfied for a successful claim. The long delay between the date of the birth incident and when a claim is made (often five to 15 years) does not help either. In addition, "causation" is understood differently in statistical and legal contexts. This makes the establishment of factual causation particularly challenging as demonstrated in the case studies presented in the report. Whilst much focus is placed on using expert medical evidence to show a breach in the standard of care, it is equally if not more important to make use of experts well versed in causation.

In cerebral palsy cases, lack of foetal monitoring was proven in approximately 75% of cases, with the conclusion generally being drawn that this caused the cerebral palsy. Although birth weight is a significant risk factor for cerebral palsy, it was not considered in the majority of cases. The pool of experts providing evidence is limited resulting in courts being exposed to a limited set of ideas. Furthermore, in very few cases is contributory negligence argued, with the result that apportionment of damages in such cases is extremely rare. Little focus is placed on how many of the eight free ante-natal visits are attended by claimant mothers and the use of the Department of Health's Road to Health chart.

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When it comes to the treatment of children with cerebral palsy there is conflicting evidence, not only of the effectiveness of therapy, but also of the optimal dosage of therapy. There is also a wide disparity in costs between various experts and between various provinces.

Recommendations related to cerebral palsy cases include:

- Improved record-keeping
- Capping the time between incident date and the date of claim
- Judicial review of the "but for" test in birth injury claims
- Better foetal monitoring
- The apportionment of damages in matters where all free ante-natal services have not been utilized
- The introduction of medical malpractice speciality courts and assessors
- The introduction of an early notification scheme for obstetric brain injury
- Greater use of placental pathology in establishing causation
- Rigorous, well-designed and objective research to establish the optimal dosage of therapy for children with cerebral palsy

Quantum

Settlement values in one anonymized province for cerebral palsy cases average around R13 million, but there have been settlements in excess of R20 million. The largest driver of cost in birth injury claims is that of future care giving. There is invariably a substantial differential between the cost of care proposed by plaintiff experts and the costs of care giving proposed by defendant experts. Capping the monthly payment for care giving by way of a published tariff is a possible way of controlling these costs.

The typical heads of damages claimed in a cerebral palsy claim are for future loss of earnings, past medical expenses, future medical expenses and general damages. Actuarial calculations are normally relied upon in calculating future loss of earnings and the capitalized value of future medical expenses. Unfortunately, information on the damages awarded is not readily available and it is recommended that it be routinely collected and captured by the Department of Health and made available for analysis.

The net discount rate is the most critical assumption an actuary makes when calculating the present value of a damages claim. In South Africa the net discount rate is not mandated by legislation or prescribed by the Actuarial Society of South Africa. Net discount rates of between 0% and 3% per annum have typically been used for the capitalization of future medical expenses. The debate around standardising the net discount rate needs to be reopened.

Alternative Methods of 'Payment'

The "once-and-for-all rule" is a common law convention which requires that all damages flowing from a cause of action must be claimed in one court action, that is, in monetary terms as a once-off lump sum. The main advantages of this approach are that it concludes the matter and the claimant has some flexibility as to how the lump sum is spent. However, the lump sum will either be far too much (if the claimant dies early) or too little (if the claimant lives longer than expected and/or investment returns are lower than assumed).

Alternative methods of settlement have been argued for in certain cases. These include:

- The provision of care directly through the public healthcare system,
- The payment of damages claims via periodic payments to the claimant, and
- The payment directly to service providers as and when medical expenses arise.

The courts have indicated that the alternatives have merit, but as yet they have not been implemented.

One alternative that has been implemented is that of a reversionary trust whereby the lump sum awarded is paid into a trust administered for the claimant's benefit. The defendant is obliged to "top up" the fund in certain circumstances but is also entitled to a "clawback" of the residual funds in the trust on the death of the claimant. Variations of this model, such as fixing the life expectancy at 10 years, should be explored.

International Compensation Schemes

The issues facing South Africa are not unique and the systems introduced in other countries should inform the way forward for South Africa. Some countries, for example France, Japan, New Zealand and the Scandinavian countries, have introduced "no-fault" compensation schemes and their suitability for the South African context should be explored. A feature of some of the international liability systems is the capping of the period of time in which a claim must be filed and the stringent

requirements in order to successfully file a birth injury related claim in some of the "no-fault" schemes such as the Florida Birth-Related Neurological Injury Compensation Association.

THE PUBLIC HEALTH MEDICAL NEGLIGENCE CONUNDRUM – LEXIS NEXIS

18 October 2021

Causes

Various reasons are cited for medical negligence claims. These include:

- Shortages in medical personnel, hospital beds, medical equipment, and inadequate funding.
- Poor management, lack of accountability, and bad record keeping.
- Healthcare Associated Infections caused by overcrowding in hospitals, high patient-to-staff ratios, lack of isolation facilities, ageing infrastructure, inadequate environmental cleaning, inter-hospital transfer of patients with drug-resistant infections and inadequate disinfecting of medical equipment.
- Greater actualisation of constitutional rights resulting in increased access to information, transparency, and accountability through newly enacted legislation and legal and other developments.

Types of adverse events

Some of the adverse events relating to birth injuries are cited as:

- Cerebral palsy secondary to birth asphyxia, due to mismanagement of the labour process.
- Sphincters being destroyed after misdiagnosis of 3rd or 4th degree perineal tear as a second-degree tear after a normal vaginal delivery with an episiotomy.
- Foetus born with cerebral palsy following transfer from clinic and failed attempt of MacRobert's manoeuvre and increased waiting time in labour ward.
- Foetus not surviving the hypoxia after abdominal pains were medically mismanaged and resulting in foetal distress at 32 weeks gestation.
- Pulse oximeter was placed on a neonate's foot and not adequately monitored for pressure care resulting in necrosis and amputation of the right small toe.
- Severely (due to diarrhoea) dehydrated minor prematurely discharged resulting in permanent brain damage and left sided spastic hemiplegia.
- Bilirubin-induced neurological dysfunction in readmitted baby after dehydration and pyrexia following birth.

Common omissions leading to adverse events include:

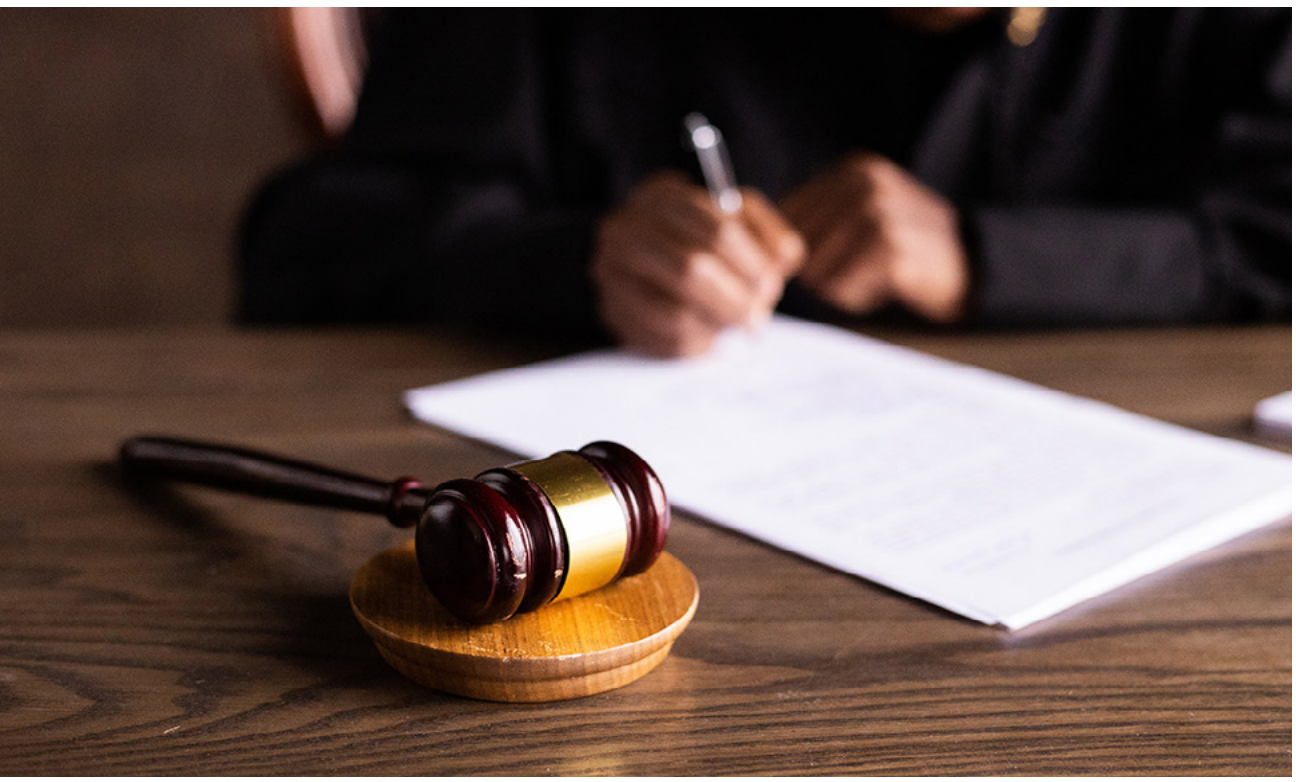
- Clinical manifestations not responded to.
- Poor monitoring.
- Failing to apply guidelines/protocols.
- Failing to give treatment as prescribed.
- Incorrect treatment.
- System failures.
- Lack of supervision.
- Lack of training.
- Lack of knowledge.

Public Health medical negligence litigation

In some public medical negligence cases, comments made by judges seem to indicate that Health MECs of Provinces are abusing litigation and the litigation process to delay the inevitable. The author notes that a disturbing phenomenon was an indication that litigation was being abused to manage the cash flow crisis created by medical negligence claims where the public health sector spent approximately R148 million in the 2018/19 financial year on litigation.

Legal obligation to render and standard of public health services

An approach that proceeds from the basis that if the cause of damages in the public health system is eliminated, the currently prejudiced patient's interests will be served and the financial consequences of negligent adverse events will disappear or at least be contained, is faced with the difficulty of paucity of patient safety incident information.



In addition to the commonly cited professional lapses, there is the phenomenon of poor record keeping and retention of patient records which impacts on the ability of a claimant to frame his case and the public health system to mount an effective defence against claims for negligent adverse events.

Proposed solutions

Some of the proposed solutions mentioned are:

- Delaying of payments to claimants with high value claims by forcing the payment in damages in instalments or by forcing claimants with a need for future medical care to make use of public healthcare facilities – referred to as the public healthcare defence.
- Amendment of the State Liability Act 1957 (the State Liability Amendment Bill was referred back to inter alia the Departments of Health and Justice as well as National Treasury in January 2021).
- Solutions involving legal reforms (the essence of the South African Law Reform Commission report).
- Revisiting the causes of cerebral palsy (one of the main recommendations of the Actuarial Society of South Africa's report).

The author criticises the "public healthcare defence" in that it is based on purely financial and not any policy or legal considerations. He states that it ignores legal principles used to assess future damages and constitutes an attempted coercive and legally unfounded measure to sidestep the common law to lessen the payment of proven damages without legislation. Further, it essentially constructively condones serial negligently caused adverse events within the public health sector which constitute a breach of the government's constitutional duty to provide adequate and professional healthcare. It also condones the use of the consequences of such breach to justify the curtailment of a judgment creditor's common law right to a final settlement of the judgment debt owed by the judgment debtor. Finally, it deprives the claimant of choice of where and how he/she is to be treated and does not fully take the claimant's particular needs and situation into account.

Focus should be on the victims

The author emphasizes that the focus on and apparent obsession with the financial consequences of negligent adverse events in the public health sector completely ignores the often devastating and far-reaching personal consequences of an ailing public health system for patients unable to pay for health care. In all deliberations over and measures proposed and implemented to remedy the medical negligence problem, the interests of the public health care patient should be paramount – it is a constitutional imperative.

The first step

The public health system is plagued with a variety of operational problems such as ageing infrastructure, inadequate funding, over-utilisation, poor working conditions, understaffing, ineffective management, and lack of accountability. The author states that without minimising or excusing lapses of medical professionalism in the public health sector, any proposals for and remedial action undertaken should be viewed against this backdrop.

One of the most important steps to be implemented, is the introduction of a standardised Electronic Health Record system (EHR) which integrates both patient safety incident reporting and clinical protocol management:

> *A framework for patient incident reporting does exist. Implementing an Electronic Health Record system will to a large extent remove the contributory factors of medical negligence claims and manage causative risks such as non-adherence to protocols. Not only will it assist in managing risk, but it has substantial benefits for patients and the quality of health care. To ensure compliance, accountability must be ensured in a way which recognises the challenges faced by medical professionals in the public health system but nonetheless ensures that negligent adverse events have behaviour-changing consequences.*

DISCUSSION PAPER 154 PROJECT 141 MEDICO-LEGAL CLAIMS – SOUTH AFRICAN LAW REFORM COMMISSION

11 November 2021

Status of the Discussion Paper

Following a request from the Department of Health and the Minister of Justice and Correctional Services to investigate medico-legal claims against the government, the South African Law Reform Commission (SALRC) published a first document for public comment on 17 July 2017. The second discussion paper released on 11 November 2021 was prepared to elicit responses on the preliminary findings and proposals of the SALRC. The SALRC notes that:

It will serve as a basis for the SALRC's further deliberations in the development of a report with proposed draft legislation; therefore, the opinions, conclusions and proposals in this paper should not be regarded as the SALRC's final views. Respondents are not restricted to the issues covered in this paper and are welcome to draw other relevant matters to the SALRC's attention.

Proposals

The SALRC proposes that a system be developed that starts at the hospital when a serious adverse event occurs, through prescribed compulsory procedures to attempt early resolution, ending in compensation that provides fair restitution to the aggrieved health care user without bankrupting the public health system.

Prerequisites

The SALRC states a number of prerequisites that are critical in facilitating their proposals, namely:

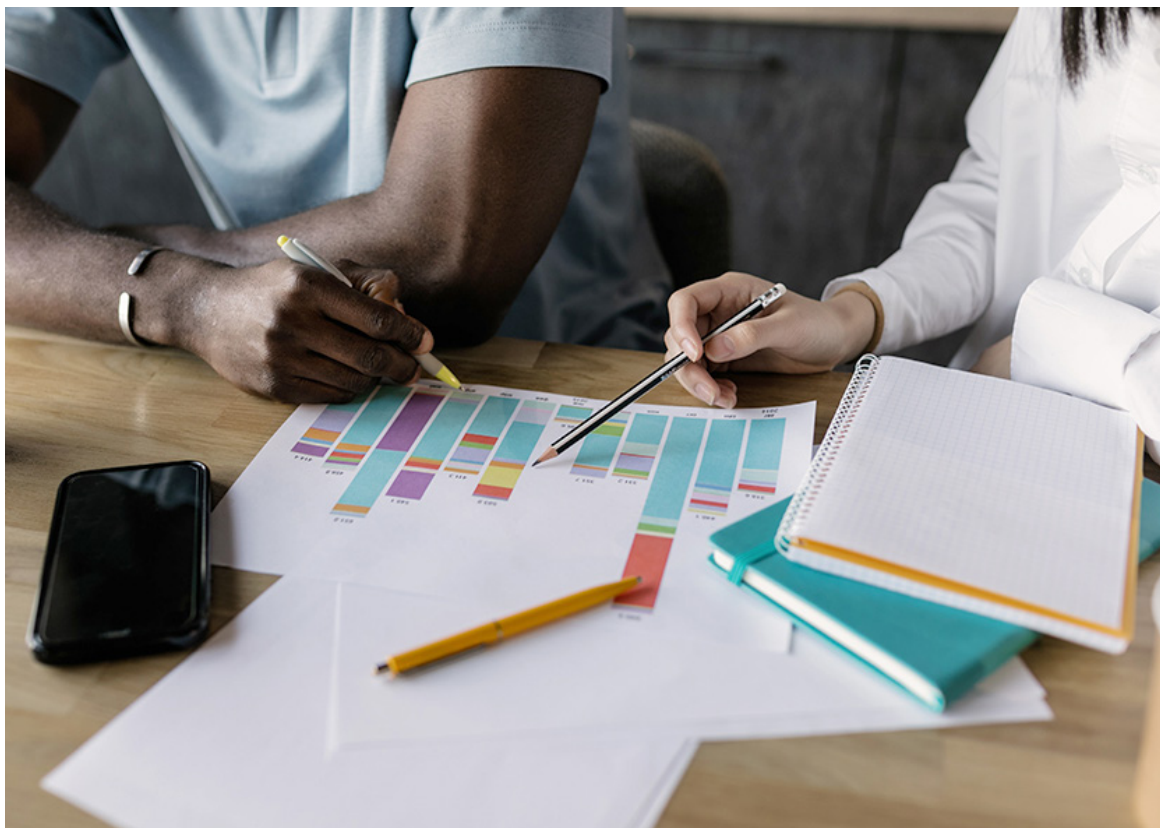
- National strategy for dealing with medico-legal claims must be followed in each province.
- The Office of the State Attorney must have a strategy that dovetails with the Department of Health's national strategy.
- Dedicated medico-legal units with suitably qualified personnel must be situated in the office of each of the provincial Heads of Health.
- A uniform electronic record keeping system must be used by all provinces supported by a state-owned information technology system.
- Standardized guidelines for reporting must be used and data centralized.
- Compulsory budgeting for medico-legal litigation.
- Dedicated alternative dispute resolution team in each province.
- Introduction of patient safety measures in all provinces.
- Establishment of a dedicated national monitoring body to ensure that applicable legislation, national guidelines and the corrective measures proposed in audit reports, Office of Health Standards Compliance (OHSC) reports, government-initiated reports and other documents are implemented and applied.

Improving quality of public health care

The SALRC, as a law reform body, cannot make recommendations on the delivery of quality health care. The shortage of medical personnel, constrained budgets, inadequate health infrastructure, shortage of medical equipment, medicines and other supplies and inadequate

supervision of junior staff are all aspects that require attention.

There is a plethora of legislative provisions, regulations and guidelines under the National Health Act (NHA), as well as several reports about deficiencies in the public health care system. However, there is a distinct lack of implementation of these instruments. It seems that a number of the provincial departments of health have neither the skills nor the capacity to address the issues highlighted in the audit reports, OHSC reports and government-initiated reports.



Record keeping

It is recommended that proper record keeping systems be introduced and maintained, as proper record keeping is critical both in terms of patient care as well as evidence in litigation. It is further recommended that record keeping guidelines be developed that address the NHA provisions and related regulations, and which provide for the entire "life-cycle" of a health record. In addition, specific provisions must be made for access to health records, over and above the Promotion of Access to Information Act and the Protection of Personal Information Act.

Patient safety and patient safety incident reporting

It is recommended that current reporting guidelines be reviewed in light of the latest developments in patient safety reporting systems and the World Health Organization Guidelines on Patient Safety Incident Reporting and Learning Systems. In this way, reporting systems can be optimally structured and utilised and allows for sharing of information, while ensuring that information provided by a health worker cannot be discovered for purposes of court proceedings, and cannot be used in disciplinary proceedings against the person who made the report.

Mediation

The SALRC proposes that it should be compulsory to attempt mediation before instituting court proceedings. Parties to medico-legal proceedings will need to demonstrate to the satisfaction of the court that the matter is not capable of being fully mediated. In the event that the entire matter cannot be resolved, mediation can be used to agree on some of the issues in dispute.

Practical measures noted include introducing pre-mediation clauses in admission forms of public hospitals, establishing a list of accredited mediators in each province and requiring the state to fund medico-legal mediation when the state is a party to the proceedings.

Finally, it is crucial that the person representing the state in mediation proceedings must be able to make proposals and take decisions with financial implications or have immediate and direct access to a person with the authority to approve a proposal or take a decision. The final mediated solution should be a formal, binding contract complying with the law of contracts; alternatively, the court should be approached to approve the mediation agreement formally as a settlement agreement by order of court.

Certificate of merit

It is proposed that in order to avoid frivolous, meritless, fraudulent or abandoned claims, a certificate of merit affidavit by an accredited and suitably qualified medical practitioner form part of the papers when action is instituted for damages based on medical negligence.

Redress

For smaller medical negligence claims, the SALRC proposes adopting an administration compensation system, based on the Welsh redress system, where redress comprises:

- Making an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability.
- Giving an explanation.
- Apologizing in writing.
- Reporting on the action taken to prevent similar cases.

Pre-action protocol

The SALRC recommends implementing a pre-action protocol similar to the Pre-Action Protocol for the Resolution of Clinical Disputes in the United Kingdom, which will require amendments to civil procedure and court rules. This will essentially introduce a further step in the civil process before instituting formal court proceedings.

Litigation

It is recommended that the following changes be made to the litigation process:

- Civil process changes be introduced to limit delays and expedite proceedings: ensuring that requirements such as filing a certificate of merit affidavit, seeking redress where appropriate or complying with the pre-action protocol must take place before a case can proceed to a court hearing.
- Civil procedure be amended to allow a summons to lapse if not timeously acted upon, improve pre-trial procedures and court case flow and management to expedite and simplify the finalisation of claims, for example earlier exchange of information, expert notices, summaries and witness statements; as well as early expert meetings and pre-trial conferences.
- Elements of the inquisitorial system (similar to existing provisions of the Criminal Procedure Act, 1977) be introduced into civil proceedings to allow parties to agree on certain facts or events before the formal court hearing commences.
- The use of joint expert witnesses.
- The Superior Courts Act 10 of 2013 and the Uniform Rules of Courts be amended to provide for the appointment of specialist assessors on application of either of the parties, or if the court is of the view that it would be in the interests of justice, or specifically when the case is of a complex nature involving highly technical expert evidence.

Compensation

The SALRC is of the view that a no-fault compensation system is not a viable solution to South Africa's medico-legal claims crisis.

The SALRC proposes that compensation should be awarded in the form of a structured settlement – with part of the compensation paid in a lump sum, part of the compensation paid as periodic payments, and part of the compensation provided as payments "in kind" by means of the delivery of services – allowing a combination of these methods and determining the ratio of one aspect in comparison to another aspect by considering the circumstances of each particular case.

Further aspects dealt with include changing the manner in which future loss of income is calculated – in particular it is proposed that calculations of future loss of income be premised on a structured format or guideline based on the average national income, or the average income of the area where the claimant lives.

In addition, it is mentioned that the capping of constitutional and general damages (non-pecuniary damages) may be necessary so as to avoid becoming a punitive system. Further, it is proposed that a schedule of benefits for specific injuries or conditions be compiled that can be adjusted annually or that could be linked to an index of average values for automatic adjustment every year.

Upskilling of nursing staff

South Africa's public health system is heavily reliant on nurses and the following proposals are made in this regard:

- Review the training of nurses to reconsider the curriculum, practical training, quality of training.
- Adequate nursing numbers should be determined and every effort made to fill vacant posts.
- Interventions are required to address issues with oversight of junior nurses, the administrative burden on nurses and attitudes of nursing staff towards patients.
- Consider re-establishing state-run nursing colleges that were closed in the mid-1990s and re-introduce vocational training of nurses.

Additional measures

Some additional measures proposed include:

- Amending the Contingency Fees Act, 1997 to provide for a sliding scale for the determination of contingency fees in relation to the size of a compensation award.
- The introduction of a "Good Samaritan" law exempting a medical practitioner acting in an emergency situation from negligence claims as long as certain conditions are complied with.
- Addressing concerns about the length of time it is taking the Nursing Council to review the training and qualifications of nurses.

Public and Private sector partnerships

The SALRC notes that:

Several private entities, hospital groups, medical professionals, insurance companies and so forth offered to assist the public health sector. Most of the offers for assistance made by persons and organisations in the private health sector appear to be well-intentioned, intended to aid the public health sector to benefit the health sector as a whole. However, the goodwill and offers of assistance and cooperation from the private health sector have not been taken up in full.

THE BEST LEGISLATION IN THE WORLD WILL NOT MAKE ANY DIFFERENCE **UNLESS IT IS APPLIED, IMPLEMENTED, COMPLIED WITH AND MONITORED.**

CONCLUSION

Medical malpractice in the South African public sector has far reaching financial and other impacts. A better system is required. Key issues have been identified and explored, and recommendations have been made. These now need to be debated amongst the relevant stakeholders and decisions taken on the way forward. As noted by the SALRC:

It must be stated emphatically that legislative intervention alone cannot address the myriad of challenges faced by the public health sector. As is often said, there is no claim without negligence. Legislation can address procedure, establish bodies to deal with some issues, create interventions that do not currently exist, alter the method and timing of compensation and so forth; but legislation cannot address systemic problems with leadership, governance, management, budgeting and procurement, quality of care, lack of skills, personnel shortages, training, attitudes of staff and maintenance of facilities and equipment. The best legislation in the world will not make any difference unless it is applied, implemented, complied with and monitored.