EXECUTIVE SUMMARY

Introduction

1 South Africa has changed dramatically over the past 30 years with its transition to a constitutional democracy, the introduction of a strong culture of human rights, protection of the freedoms of the individual by means of a progressive Bill of Rights and the establishment of the Constitutional Court as the apex court to protect and enforce these rights. Among the people of South Africa there is also an increased awareness of their rights. In a constitutional democracy such as ours this is a positive development. However, one of the consequences of this increased awareness seems to be an upsurge in litigation to protect a perceived breach of individual rights.

2 This trend is also apparent in the huge escalation in delictual claims based on medical negligence over the past 12 years or so, in both the public as well as the private health sectors. Apart from the increase in the numbers of claims instituted, the exponential rise in the compensation claimed and awarded is a major cause for concern. 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.

3 The national Department of Health (NDOH) and the Minister of Justice and Correctional Services requested the SALRC to include an investigation into medico-legal claims in the SALRC research programme. This request flowed from the challenges faced by the public health sector due to the escalation in claims for damages based on medical negligence, the increasing financial implications for the fiscus, and medical negligence case law.

4 The NDOH held a medico-legal summit on 9 and 10 March 2015 in Centurion to deliberate the growing crisis with regard to medico-legal claims in South Africa. A Medical Malpractice Workshop in the form of interactive panel discussions was held in Johannesburg on 3 March 2017 to discuss matters pertaining medico-legal litigation. Both events were attended by representatives from the medical and legal fraternities,

officials from national and provincial state departments, actuarial scientists, academics, mediators, and the insurance industry.

5 The last significant event was the Presidential Health Summit held in Boksburg on 19 and 20 October 2018. Nine commissions were set up to enable participants to deliberate on the massive challenges the health system is facing and to suggest interventions to improve the quality of health care. Each commission made recommendations on short-term, medium-term and long-term solutions to address the challenges facing the health care system. The proposed solutions were not considered as binding resolutions, but served as inputs to the Presidential Health Summit Compact and action plan that was developed after the summit.

6 A number of documents and reports pertaining to the public health sector – developed by or at the behest of the President, Auditor-General, Minister of Health, Office of Health Standards Compliance, Department of Health, National Treasury, or funded by the government – were reviewed for this paper, including:

- Reports on the provision and administration of public health services in some of the provinces published by the Public Protector;
- Hearing and investigation reports on public health services or aspects of public health services published by the South African Human Rights Commission;
- Consolidated General PFMA Reports on National and Provincial audit outcomes for the years 2017-18, 2018-19 and 2019-20 published by the Auditor-General;
- Annual inspection reports for the years 2015/16, 2016/17, 2017/18 and 2018/19 published by the Office of Health Standards Compliance;
- Clinton Health Access Initiative *Medico-legal Claims Analysis for National Treasury* (December 2019);
- *Presidential Health Summit 2018 Compact* (July 2019);
- *Presidential Health Summit 2018 Report* (February 2019);
- South African Lancet National Commission *Confronting the Right to Ethical and Accountable Quality Health Care in South Africa* (December 2018);
- Health Ministerial Task Team *Hospital Mismanagement and Poor Service Delivery Closure Report* (May 2017);
- Declaration following Medico-legal Summit of March 2015 (March 2016);
- Steve Biko Centre for Bioethics *Discussion Document prepared in Preparation for a Medico-legal Summit* (September 2013);
- National Litigation Strategy Report (2012);

- Chapter 10 (“Promoting health”) of the National Development Plan (August 2012)
- Reports of the Integrated Support Teams (April and May 2009).

7 In addition to the matters referred to above, Chapter 1 provides a snapshot of the scope of the problem and explains briefly what the investigation is aiming to achieve. Chapter 2 reviews the aspects of the South African legal landscape that pertain to medico-legal claims by reference to current government policies; the elements of delict; the test for medical negligence; the common law, including the “once and for all” rule; vicarious liability; and compensation for damages.

8 Chapter 3 gives an overview of the constitutional provisions pertinent to the field of medico-legal claims and the various statutes applicable to this field of the law. Subordinate legislation, government-issued guidelines and measures and proposed legislation are also touched upon. This is followed by an overview of important case law involving medical negligence claims against the state and the development of the common law in Chapter 4.

9 Chapter 5 provides a synopsis of the submissions received in response to Issue Paper 33 and the views of authors and commentators. The problems identified and concerns raised about the public health sector is of special importance. Relevant highlights of the reports pertaining to the public health system published by the Public Protector and the SA Human Rights Commission, the Auditor-General’s consolidated general PFMA reports on national and provincial audit outcomes for the years 2017-18, 2018-19 and 2019-20, and the annual inspection reports for the years 2015/16, 2016/17, 2017/18 and 2018/19 published by the Office of Health Standards Compliance are also presented in Chapter 5. Chapter 6 offers an overview of the findings made and recommendations put forward in previous government-initiated reports with regard to the public health sector.

10 Chapter 7 considers the legal position in other countries, in particular in relation to compensation systems. Chapter 8 sets out the steps for a strategy to deal with legal action when instituted.

11 Chapter 9 puts proposals forward for dealing with medico-legal claims against the state, while Chapter 10 contains a list of respondents to Issue Paper 33.

12 The proposals put forward by the SALRC in Chapter 9 focus mainly on measures to alleviate the financial burden of medico-legal claims against the state on the fiscus, and to provide for alternative procedures for the speedy resolution of medical negligence claims.

Summary of recommendations

13 The constitutional right of access to courts can never be denied, but taking a matter to court should be avoided as far as possible. A uniquely South African system is proposed, which – having regard to our particular circumstances and history – is a hybrid of specific international examples and an expansion of the development of the common law that has already been initiated by the Constitutional Court.

14 It is proposed 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 and eventually crippling the public health system.

Proposed components

15 The proposal is divided into different components, which are:

1) Prerequisites
2) Improving quality of public health care
3) Record keeping
4) Patient safety and patient safety incident reporting
5) Mediation
6) Certificate of merit
7) Redress
8) Pre-action protocol
9) Litigation
10) Compensation
11) Birth defects and serious permanent injuries
12) Other proposals

Prerequisites

16 There are a number of prerequisites that are critical to the proposals put forward in this paper for dealing with the medico-legal crisis in South Africa. These prerequisites are the following:

1) National strategy for dealing with medico-legal claims that must be adhered to in each province.
2) Strategy for handling medico-legal claims in the Office of the State Attorney that dovetails with the national medico-legal strategy followed in the provinces.
3) Dedicated medico-legal unit in each province made up of suitably experienced medical and legal professionals, with their own administrative support, which should preferably be situated in the office of the provincial head of health.
4) Proper system of record keeping supported by a state-owned information technology system. The same system and technology should be used in all provinces and the national department.
5) Reporting system supported by the same system and technology to enable data sharing and a centralised data base. The information to be reported and the manner of reporting should be determined at national level and the guidelines should be followed by all provinces.
6) Compulsory budgeting for medico-legal litigation (projected legal costs) and compensation payments by provinces in accordance with normal budgeting practices. The assistance of National Treasury should be sought where necessary.
7) Dedicated alternative dispute resolution team in each province. For the sake of impartiality, the members of the team cannot be employed by the state, but should be from outside government.
8) Introduction of patient safety measures in all provinces. The implementation of these measures could be staggered over a determined period of time, prioritising measures based on the magnitude of the underlying risk and the frequency of particular types of incident.
9) Establishment of a dedicated national monitoring body to ensure that applicable legislation, national guidelines and the corrective measures proposed in audit reports, OHSC reports, government-initiated reports and other documents are implemented and applied. This body should not duplicate the current functions of the Office of Health Standards Compliance, but should either be a separate body or a separate unit within the OHSC that monitors compliance on a broader strategic level.

10) A possible alternative is the establishment of a national statutory body comparable to the NHS Resolution Authority in the UK. However, it may be argued that such a body would not be in line with the Constitution and the National Health Act.

17 Apart from the National Health Act 61 of 2003 (NHA), there are regulations on norms and standards and several national guidelines about various matters such as record keeping, a complaints system and patient safety incident reporting. A huge amount of work has been done and several shortcomings and challenges identified by means of various government and government-initiated reports. These include the consolidated general PFMA reports on national and provincial audit outcomes published by the Auditor-General, annual inspection reports published by the Office of Health Standards Compliance, Presidential Health Summit 2018 Compact, Presidential Health Summit 2018 Report, Clinton Health Access Initiative's *Medico-legal Claims Analysis for National Treasury,* Lancet National Commission's *Confronting the Right to Ethical and Accountable Quality Health Care in South Africa* and the Health Ministerial Task Team *Hospital Mismanagement and Poor Service Delivery Closure Report*.

18 The Commission, as a law reform body, cannot make recommendations on the delivery of quality health care; which includes the operation and management of health care facilities, service delivery, human resources, health service capacity and related matters. The shortage of medical personnel, constrained budgets, inadequate health infrastructure, shortage of medical equipment, medicines and other supplies and inadequate supervision of junior staff also merit mentioning.

19 As mentioned before, there is a profusion of legislative provisions, regulations and guidelines under the National Health Act, 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.

20 The Commission therefore propose that –

20.1 national expert teams be established to oversee and assist the provinces to address identified problems and implement the proposed solutions;

20.2 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 legal processes;

20.3 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: from origin to final disposal, addressing any deficiencies or pitfalls at any point along the way;

20.4 specific provision be made for access to health records, over and above the PAIA and POPIA processes;

20.5 reporting and learning guidelines be properly applied and implemented, followed by monitoring and evaluation;

20.6 current reporting guidelines be reviewed in light of the latest developments in patient safety reporting systems and the WHO *PSI* (2020) to ensure that the reporting system is 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, or from being used in disciplinary proceedings against the person who made the report;

20.7 as a compromise between introducing mediation as a completely voluntary option and introducing compulsory mediation, mediation should be voluntary, but it should be compulsory to attempt mediation before instituting court proceedings;

20.8 the parties to medico-legal court proceedings will have to justify failure to mediate the matter to the satisfaction of the court;

20.9 mediation could be attempted to agree on some of the issues, even if the entire claim cannot be resolved through mediation;

20.10 pre-mediation clauses be included in the admission forms of public hospitals, which will assist efforts to raise awareness about the advantages of mediation;

20.11 a list of accredited mediators be created in each province.

20.12 the state should fund medico-legal mediation when the state is a party , since early expenditure on proper ADR will save a huge amount of money later;

20.13 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;

20.14 to ensure compliance with the solution agreed upon during the mediation process, the final agreement 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;

20.15 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;

20.16 South Africa adopts an administrative compensation system, based on the Welsh redress system, for smaller medical negligence claims;

20.17 once a plaintiff formally accepts an offer for redress under a redress system, the plaintiff cannot pursue a medical negligence claim in court anymore;

20.19 a pre-action protocol be introduced that is similar to the *Pre-Action Protocol for the Resolution of Clinical Disputes* of the UK, which will require amendments to civil procedure and court rules and which applies to health care providers in both the public and private sectors;

20.20 attempting to resolve a dispute by means of the pre-action protocol would be a prerequisite for instituting formal court proceedings, introducing additional steps to the civil process;

20.21 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;

20.22 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.

20.23 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;

20.24 in view of the duties of an expert and the obligation to objectivity, the parties to a legal action use joint expert witnesses;

20.25 to address concerns about single expert witnesses for specialised technical medical evidence, a panel of three joint expert witnesses from the discipline

concerned be appointed from an official list compiled by the court in cooperation with the relevant medical professional body;

20.26 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;

20.27 a no-fault compensation system is not a viable solution to South Africa's medico-legal claims crisis;

20.28 the decisions of the Constitutional Court in the cases of *MEC, Health and Social Development, Gauteng v DZ obo WZ*[1] and *MEC for Health, Gauteng Provincial Government v PN*[2] be confirmed and expanded in legislation;

20.29 public health services funds be retained within the public health sector as far as possible;

20.30 structured settlements should be the norm for compensation awarded for damages suffered due to medical negligence by state employees, and that the components of a structured settlement should be the following:

1) Lump sum awards should only be paid for past expenditure and damages, and immediate and necessary expenses (eg rehabilitation costs, assistive devices, adjustments to living environment and so forth).
2) Future health care services must be provided in state hospitals as far as possible. Where state health services cannot provide the full range of services required, some of the state services are inadequate or services are not of an acceptable standard, monetary compensation should be paid for private health care only to the extent that the services offered by the state are insufficient. The monetary award for private health care should be included and paid as part of the periodic payment as calculated per annum.
3) Periodic payments in the nature of an annuity (not down payments on a lump sum amount) should be awarded for future maintenance, loss of earnings and the portion of future medical care, treatment, rehabilitation and therapy that the court is not satisfied the state would be able to deliver or where the health service delivered by the state is not of an acceptable

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1 *MEC, Health and Social Development, Gauteng v DZ obo WZ* [2017] ZACC 37.

2 *MEC for Health, Gauteng Provincial Government v PN* [2021] ZACC 6.

standard. Periodic payments calculated on an annual basis should be the default compensation option for all future compensation not delivered as services.

20.31 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;

20.32 the underlying principle for the calculation of future loss of income be changed, and that calculations of future loss of income be premised on a structured format or a guideline based on the average national income, or the average income of the area where the claimant lives;

20.33 it may be necessary to cap any damages other than special damages – such as constitutional damages and general damages (non-pecuniary damages) – to ensure that it does not become punitive damages in disguise;

20.34 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;

20.35 a deviation from the common law "once and for all" rule should be possible for adjusting periodic payments in exceptional circumstances.

21 The Commission does not support the creation of trusts for administering large lump sum compensation payments, unless there are exceptional circumstances to justify the creation of a trust.

Other proposals

22 South Africa's public health system is heavily reliant on nurses. However, many concerns were raised about nurses in comments received and literature reviewed. The following proposals are made with regard to nurses:

1) Review the training of nurses to reconsider the curriculum, practical training, quality of training and so forth.

2) Adequate nursing numbers should be determined and every effort made to fill posts, supported by campaigns to encourage more people to enter the profession.
3) Interventions are required to address issues with oversight of junior nurses, the administrative burden on nurses and attitudes of nursing staff towards patients.
4) Some of the administrative and managerial tasks performed by nurses should be assigned to other staff, freeing nurses to focus more on the care of patients.
5) Consider re-establishing state-run nursing colleges that were closed in the mid-1990s and re-introduce vocational training of nurses (additional to higher education training of nurses at universities).

23 In response to the some of the submissions received, the Commission proposes a number of additional measures:

- Amend 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.
- Introduce a "Good Samaritan" law exempting a medical practitioner acting in an emergency situation from negligence claims as long as certain conditions are complied with.
- Amend the Institution of Legal Proceedings Against Certain Organs of State Act 40 of 2002 where appropriate as indicated by the State Attorney, Pretoria.
- Ensure that the matters raised in the 2015 *Report of the Ministerial Task Team (MTT) to Investigate Allegations of Administrative Irregularities, Mismanagement and Poor Governance at the Health Professions Council of South Africa (HPCSA): A Case of Multi-System Failure* (the Mayosi Report) has been addressed.
- Address the concerns about the length of time it is taking the Nursing Council to review the training and qualifications of nurses.

24 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.