UNIVERSITY OF THE WESTERN CAPE

FACULTY OF LAW

ALTERNATIVE DISPUTE RESOLUTION IN MEDICAL MALPRACTICE IN SOUTH AFRICA

Mini-thesis submitted in partial fulfilment of the requirements for the LLM degree in the Department of Mercantile and Labour Law

by

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DECLARATION

I declare that '**Alternative Dispute Resolution in Medical Malpractice in South Africa'** is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

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ABSTRACT

South Africa has seen a spike in medical malpractice litigation, including the number and size of claims instituted against healthcare practitioners. This has led to a backlog in medical malpractice court cases throughout South Africa and a strain on both the public and private healthcare sectors, affecting an already burdened healthcare system. The surge in medical malpractice litigation is not a new phenomenon in developed countries. Most have curbed this through alternative dispute resolution (ADR). This has been facilitated by effectively introducing efficient legal frameworks that promote ADR. Unfortunately, this is not the case in a developing country such as South Africa.

To date, much research and literature has attributed blame for the large-scale increase in medical malpractice litigation to legal practitioners. This has been aided by comments made by the former Minister of Health, Dr Aaron Motsoaledi (Dr Motsoaledi). In as much as this may be the common perception, there appears, to the contrary, to be systematic problems in the South African healthcare system. The legal profession is only a minor contributing factor to the increase in medical malpractice litigation. The strained financial resources and shortage of healthcare staff in public hospitals contributes to the increased risk of medical malpractice cases. Furthermore, when considering the South African legal system, contingency fee arrangements have, in certain circumstances, increased vexatious litigation and, as such, it is on this basis that medical malpractice litigation has been on the increase in South African courts. This study seeks to analyse the current state of the South African healthcare system, and in light of the increasing number of medical practice claims and litigation, propose ADR mechanisms that offer efficient, cost effective, and expeditious channels to resolving these issues and to ensure that parties recognise the full benefits of ADR.

This study proposes legal reform in medical malpractice litigation in South Africa. This thesis compares the experiences, legislative and policy frameworks in Australia and the United States of America (USA), in order to learn lessons that could assist South Africa in framing legislation and best practices for ADR. It contends that, in order to effectively develop and implement ADR to address medical malpractice litigation, it requires the involvement of the government, legislature, judiciary, legal profession and the public. It has identified court-

annexed mediation as the appropriate ADR mechanism in addressing medical malpractice litigation.

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KEYWORDS

Alternative Dispute Resolution

Department of Health

Health Profession Council of South Africa

Mediation

Mediation in Motion

Medical Malpractice

Medical Practitioners

Medical Protection Society

Obstetrics and gynaecology

South African Society of Obstetricians and Gynaecologists

ABBREVIATIONS AND ACRONYMS

ADR	Alternative Dispute Resolution
ANC	African National Congress
CJCs	Community Justice Centres
CJRA	Civil Justice Reform Act of 1990
DA	Democratic Alliance
Dr Carter	Dr Terence Carter
Dr Motsoaledi	Dr Aaron Motsoaledi
GDP	Gross Domestic Product
HPCSA	Health Profession Council of South Africa
ICESCR	International Covenant on Economic Social and Cultural Rights of 1996
Ipp Panel	Review of the Law of Negligence Panel
Ipp Report	Review of the Law of Negligence Report
MPS	Medical Protection Society
NADRAC	National Alternative Dispute Resolution Advisory Council
SASOG	South African Society of Obstetricians and Gynaecologists
The Bill	State Liability Amendment Bill, 2018

UDHR	Universal Declaration of Human Rights
UMA	Uniform Mediation Act
USA	United States of America

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CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1. INTRODUCTION

The term medical malpractice refers to all forms of intentional or negligent professional misconduct committed by healthcare practitioners, which include breach of confidentiality and the break in trust in doctor-patient relationship.[1] The test for medical malpractice in relation to a healthcare practitioner is articulated in the case of *Mitchell v Dixon*[2] as an objective test, comparing the conduct of the healthcare practitioner to that of a reasonable healthcare practitioner in the same circumstances.[3] Medical malpractice occurs when a patient is harmed due to the healthcare practitioner's failure to exercise the degree of skill and care of a reasonable competent healthcare practitioner in his or her branch of the profession.[4]

Globally, medical malpractice litigation has increased significantly,[5] with several developed countries such as Australia, the USA and England having developed and adopted legislative measures to address this problem. The surge has been attributed by various factors, including complex treatments, the introduction of patient-centred legislations and a changing legal landscape.[6] The global trend is that the majority of medical malpractice claims are being instituted against obstetricians and gynaecologists.[7] What is common with the above-mentioned countries is that they have developed and adopted ADR mechanisms through legislative intervention in order to divert potential medical malpractice claims against

[1] Carstens P & Pearmain D *Foundational Principles of South African Medical Law* (2007) 599.
[2] *Mitchell v Dixon* 1914 AD 519 525.
[3] '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.' - *Mitchell v Dixon* 1914 AD 519 525.
[4] McQuoid-Mason D & Dada M *A-Z of Medical Law* (2011) 339.
[5] Oosthuizen WT and Carstens PA 'Medical malpractice: The extent, consequences and causes of the problem' (2015) 78 *THRHR* 269.
[6] Kass JS & Rose RV 'Medical Malpractice Reform—Historical Approaches, Alternative Models, and Communication and Resolution Programs' (2016) 18(3) *The Journal of the American Medical Association* 301; Pienaar L 'Investing the reasons behind the increase in medical negligence claims' (2016) 19 PER/PELJ 8.
[7] Pepper M & Slabbert M 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 *SAJBL* 30.

obstetricians and gynaecologists.[8] These countries are also among the few where sanctions are imposed if ADR does not precede litigation.[9] As a result, they have succeeded in reducing the number of medical malpractice claims instituted by plaintiffs and increased the number of settlements.[10]

The development of legalisation and policy frameworks to address medical malpractice litigation in the developed countries has not been without its own challenges. For example, ADR mechanisms, such as compulsory court-annexed mediation, and early disclosure and apology have been met with reluctance in certain states in Australia and the USA.[11] It is against this backdrop that this mini-thesis critically assesses the local and international regulatory frameworks governing the right to healthcare in South Africa, and attempts to introduce ADR mechanisms by learning what other countries have done in legislating ADR towards addressing medical malpractice litigation.

1.2. BACKGROUND TO THE STUDY

In 2015, at the Medico-Legal Summit held in Pretoria on 9 and 10 March 2015, the former Minister of Health, Dr Aaron Motsoaledi (Dr Motsoaledi), referred to South Africa as 'experiencing an explosion in medical malpractice litigation.'[12] He further noted that this was a crisis 'having a serious impact on the current and future availability of specialists in key disciplines in the health profession.'[13] As a result, Dr Motsoaledi expressed the need for urgent legal reform to deal with the medical malpractice litigation crisis. One of the attributing interventions which the summit resolved was the need for the immediate implementation of mediation in all disputes within the state healthcare facilities and between its personnel,

[8] These mechanisms include early disclosure and apology, court-annexed mediation, pre-mediation agreements and pre-trial screenings.
[9] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.
[10] Victorian Law Reform Commission *Civil Justice Review Report 14* (2008) 213; Hyman CS & Schechter CB 'Mediating Medical Malpractice Lawsuits Against Hospitals: New York City's Pilot Project (2006) 25(5) *Health Affairs* 1394.
[11] Victoria State Government *Access to Justice Review Report and Recommendations* (2016) 197; Spigelman JJ 'Mediation and the Court' (2001) 39(2) *Law Society Journal* 63.
[12] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018).
[13] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018).

patients and members of the public.[14] So much so, the summit resolved the need for pre-compulsory mediation and the possibility of future compulsory meditation in South African courts.[15]

Positives could be elicited from the summit as its advancement for mediation was seen through the implementation of mediation to address the 2017 Life Esidimeni tragedy. The Life Esidimeni tragedy involved the deaths of over 94 of patients with mental health disorders, that were relocated from the Life Esidimeni Hospital to unlicensed facilities.[16] In an attempt to avoid protracted litigation, the Gauteng Health Department appointed retired Chief Justice Dikgang Moseneke to mediate between the government and the families of those who had died.[17] The Health Ombudsman, Professor Malegapuru Makhob suggested that mediation would be a better solution to deal with potential litigation. His argument was that a legal challenge would be protracted and damage existing relationships.[18] Whilst it is accepted that the matter was eventually resolved through arbitration, the process was nonetheless encouraged by the urge for resolution through ADR.

Another key issue raised in the summit was that medical malpractice litigation would have an adverse effect on the availability of specialists in key disciplines in the healthcare profession.[19] It was opined that there was a link between medical malpractice litigation and the continuity of certain healthcare specialisations. This was as in 2017, it was reported that five obstetricians practising privately in the northern areas of Durban had given up the speciality

[14] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018).

[15] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018).

[16] L Prince 'Esidimeni patients were treated 'like animals' at an auction – Motsoaledi' available at *https://city-press.news24.com/News/esidimeni-patients-were-treated-like-animals-at-an-auction-motsoaledi-20170215* (accessed 21 March 2018).

[17] Nicolson G 'Life Esidimeni: Justice at last? Dikgang Moseneke enters the tragedy' available at *http://www.dailymaverick.co.za/article/2017-07-20-life-esidimeni-justice-at-last-dikgang-moseneke-enters-the-tragedy/#.WtrKOohuZPY* (accessed 21 April 2018).

[18] Nicolson G 'Life Esidimeni: Justice at last? Dikgang Moseneke enters the tragedy' available at *http://www.dailymaverick.co.za/article/2017-07-20-life-esidimeni-justice-at-last-dikgang-moseneke-enters-the-tragedy/#.WtrKOohuZPY* (accessed 21 April 2018).

[19] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018).

in medicine in a period of six months as a result of medical malpractice claims.[20] This is further compounded by the high cost of indemnity from legal claims which can be attributed to the staggering subscriptions that healthcare practitioners need to pay the Medical Protection Society (MPS) to protect and support their professional interests.[21]

The MPS has confirmed an increase, between 2009 and 2015, in the value of claims being brought against healthcare professionals, with claim sizes increasing by over 14 per cent on average, each year.[22] This is troubling as it further confirmed the fact that, the estimated long-term average claim frequency for healthcare professionals rose by 27 per cent between 2009 and 2015.[23] With those statistics in mind, the subscription rate that MPS has to charge private obstetricians is becoming even more expensive due to the increasing uncertainty of the future cost of providing protection for obstetric risk on an occurrence basis.[24] It is clear that medical malpractice claims are having an increasing ripple effect, affecting subscriptions paid by healthcare practitioners, making their practice exorbitantly expensive, and resulting in some leaving the medical profession.

The above notwithstanding, efforts for engagement on the matter have been attempted by organisations such as the South African Society of Obstetricians and Gynaecologists (SASOG). In their discussions with the Minister of Health on the crisis, they have called for the enactment of new legislation, which amongst other issues, suggests mediation as an

[20] M Naidoo 'Obstetrics is in a state of crisis' available at *https://www.iol.co.za/news/south-africa/kwazulu-natal/obstetrics-is-in-a-state-of-crisis-2064315* (accessed 1 April 2018).

[21] M Naidoo 'Obstetrics is in a state of crisis' available at *https://www.iol.co.za/news/south-africa/kwazulu-natal/obstetrics-is-in-a-state-of-crisis-2064315* (accessed 1 April 2018) ; Vinassa A 'Why Delivering a Baby is both a Professional and Public Crisis' in Choma D (ed) *The Health Professions Council of South Africa Bulletin 2017* (2017) 12. The term insurance has been omitted in this paper on the basis that the MPS has stated that it is not an 'insurance company' and that benefits available to its subscribers are discretionary – MPS 'MPS Memorandum and Articles of Association' available at *https://www.medicalprotection.org/docs/default-source/pdfs/financial-information/mps_memoarts.pdf?sfvrsn=208170ac_24* (accessed 8 February 2020).

[22] MPS 'Challenging the Cost of Clinical Negligence the Case for Reform' available at *https://www.medicalprotection.org/docs/default-source/pdfs/Booklet-PDFs/sa-booklets/challenging-the-cost-of-clinical-negligence---the-case-for-reform.pdf* (accessed 23 February 2018) (accessed 21 March 2018).

[23] MPS 'Challenging the Cost of Clinical Negligence the Case for Reform' available at *https://www.medicalprotection.org/docs/default-source/pdfs/Booklet-PDFs/sa-booklets/challenging-the-cost-of-clinical-negligence---the-case-for-reform.pdf* (accessed 23 February 2018) (accessed 21 March 2018).

[24] MPS 'The challenges of obstetric claims' available at *https://www.medicalprotection.org/southafrica/for-members/news-centre/news/2014/11/17/the-challenges-of-obstetric-claims* (accessed 23 February 2018).

alternative process to litigation so as to stem the outflow of specialists from the system.[25] The former Minister of Health has since highlighted the need for pre-compulsory mediation and the possibility of future compulsory meditation in South African courts.[26] It will therefore be necessary to investigate whether compulsory court-annexed mediation can, in fact, be implemented in South Africa to address the increase in medical malpractice litigation and whether appropriate legislation should be promulgated in this regard.

1.3. RESEARCH QUESTION / PROBLEM STATEMENT

Internationally, ADR mechanisms have become part of the chosen conscious process for resolving environmental, commercial, divorce, employment or political disputes.[27] It is not surprising that this conscious process has shifted towards resolving medical malpractice disputes. The study is based on the question:

> 'With the explosion in medical malpractice litigation both in number and value in South Africa, is ADR the potential solution to significantly reform our current civil adversarial system and resolve, if not, avoid a healthcare crisis altogether'?

The explosion in medical malpractice litigation mentioned in this study derives itself from the recent body of literature, debates and statistics surrounding medical malpractice. Considering the impact of medical malpractice litigation in South Africa, there is a crucial need to propose remedies to eradicate the issues emanating from this issue.

1.4. METHODOLOGY

This is a desktop study that reviews various primary sources such as case law, policies and legislation. In addition, a number of secondary sources such as journals articles, academic books, newspapers and web publications are consulted. The study employs an analytical approach particularly when dealing with jurisdiction specific issues in South Africa.

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[25] Vinassa A 'Why Delivering a Baby is both a Professional and Public Crisis' in Choma D (ed) *The Health Professions Council of South Africa Bulletin 2017* (2017) 12.

[26] Medico Legal Task Team 'Medico declaration - National Department of Health' available at http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion (accessed 21 March 2018).

[27] Rycroft A 'Why is Mediation not taking root in South Africa' (2009) *Africa Centre for dispute settlement Quarterly Newsletter October* 2.

Thereafter, the study employs a comparative approach. Two countries are chosen as comparators for this purpose. The USA[28] was chosen because it offers established ADR mechanisms that have been applied successfully to address medical malpractice litigation. Australia was also chosen as a comparator because, following its crisis in medical malpractice litigation, legal reforms similar to those found in the USA have been implemented with a beneficial impact on medical malpractice claims.

1.5. AIMS OF RESEARCH

The aim of this study is to critically evaluate medical malpractice litigation in South Africa by analysing various data, to consider factors contributing to the increase in medical malpractice litigation and to propose the use of ADR in addressing the challenges arising from the increase in medical malpractice litigation. This paper argues that ADR ought to be the normative approach or preferred approach to litigation.

Currently, the Department of Health and State Attorney's office is faced with an overbearing burden by employing significant resources to defend actions instituted against public hospitals.[29] The submission in this paper is that, such burdens can be reduced, if not avoided in an ADR system which allows for settlement negotiation between parties, whilst ameliorating huge legal costs.

Finally, the most recent implementation of ADR mechanisms, such as in the Life Esidimeni crisis, will be relevant in assessing the direction South Africa is taking in medical malpractice cases and in strengthening this paper's argument.

1.6. SIGNIFICANCE OF RESEARCH

The South African healthcare system is burdened by an increase in medical malpractice litigation. The strained financial resources and shortage of staff in public hospitals contributes

[28] This study shall limit its analysis only to a few states, providing examples of the successful application of ADR processes in an adversarial civil justice system.

[29] Bloom J 'Another huge (R5m) medical negligence award in Gauteng' available at *http://www.politicsweb.co.za/opinion/another-huge-r5m-medical-negligence-award-in-gaute* (accessed 6 April 2018).

to the increased risk of medical malpractice litigation.[30] The significance of this paper is that the government is now searching for solutions to address the healthcare crisis. This paper is set to aid the government in understanding what the main contributing factors are for medical malpractice litigation and how these factors can be remedied, if not, avoided by using ADR mechanisms. Furthermore, it seeks to propose pre-compulsory mediation and possible compulsory meditation in the South African courts.

The further significance of this research is that, it will attempt to make tailor-made ADR mechanisms by exploring further ADR mechanisms such as early disclosure and apology systems, pre-trial screenings[31] and other legislated ADR mechanisms within medical malpractice cases that are not as yet contained within the South African jurisdiction. The further premises on the significance of this paper, is that South Africa's civil justice system will be on the brink of significant change with the proposed implementation of the State Liability Amendment Bill, 2018 (the Bill)[32] once it passed into law.

1.7. LIMITATIONS OF THE STUDY

The scope of the research area will be limited to mediation in the healthcare system. Specifically, the focus of this mini-thesis will be on issues pertaining to the increase in medical malpractice litigation.

1.8. PROPOSED CHAPTER STRUCTURE

This mini-thesis comprises of seven chapters including this one:

Chapter 2 focuses on litigation in medical malpractice claims in South Africa and provides a statistical overview of medical malpractice claims in provinces in South Africa. The chapter also discusses the increase in subscriptions paid by healthcare practitioners and the impact therefrom. Finally, it considers the domestic regulatory framework applicable in addressing

[30] von Holdt K & Murphy M 'Public hospitals in South Africa: stressed institutions, disempowered management' in Buhlungu S, Daniel J, Southall R & Lutchman J (eds) *State of the nation: South Africa* 4ed (2007) ch 13.
[31] Fraser JJ Jr. 'Technical Report: alternative dispute resolution in medical malpractice' (2001) 107(3) *Pediatrics* 604 – 605.
[32] State Liability Amendment Bill, 2018 in Government Gazette No. 41658 of 25 May 2018.

medical malpractice cases and that influence the obligation to address medical malpractice dispute cases.

Chapter 3 considers the relevant international regulatory frameworks by analysing its interplay with the domestic regulatory frameworks applicable to medical malpractice litigation, its nuances and impact on the right to health and right of access to healthcare services.

Chapter 4 focuses on ADR mechanisms and mandatory mediation rules and the requirements or strategies for effective mediation in medical malpractice disputes in South Africa. A practical application or study will be applied by using cases that warranted mediation but were resolved through litigation.

Chapter 5 will follow the history of ADR in Australia, its processes and legislations addressing medical malpractice disputes through ADR mechanisms. In addition, the chapter considers which form of ADR is most suitable to addressing medical malpractice disputes. More importantly, it also considers the success of the ADR mechanisms and the enforcement thereof.

Chapter 6 similar to chapter 5, this chapter will analyse ADR mechanisms developed and adopted in the USA and will offer a comparative analysis of the USA and Australia with a strong emphasis on court-annexed ADR processes, the mediation systems, models, processes and demonstrate the importance of mediation in curbing the increase in medical malpractice.

Chapter 7 will draw conclusions and furnish the findings of the study. Recommendations on this basis will also be furnished.

CHAPTER 2

PROBLEMATISING MEDICAL MALPRACTICE CLAIMS

2.1 INTRODUCTION

Currently, there is no legislation that exists which regulates and addresses medical malpractice claims in South Africa.[33] Reliance is placed on common law, and as a result, there has been no measure of control on the increase in medical malpractice litigation and the size of the claims sought and awarded to plaintiffs.[34]

Given the undesirable statistics that have been reported by the Gauteng Department of Health[35] in respect of medical malpractice claims and the overall impression created by these statistics,[36] it is not surprising that Dr Motsoaledi called for legal reform at the Medico-Legal Summit in 2015.[37] Although most of the reported statistics are reflective of the public healthcare sector (given the readily available statistics), the private healthcare sector must also be considered. Like the public healthcare sector, the private healthcare sector is also taking strain, and this is reflective through the sharp increase in subscriptions paid by private healthcare practitioners over the years.[38]

This chapter, therefore, provides a statistical overview of the medical malpractice claims instituted against the public healthcare sector for the period between 2011 to 2015.[39] It further discusses the impact that medical malpractice litigation has on the availability private

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[33] Dhai A 'Medico-Legal Litigation: Balancing Spiralling Costs with Fair Compensation' (2015) 8 *SAJBL* 2 – 3.

[34] Dhai A 'Medico-Legal Litigation: Balancing Spiralling Costs with Fair Compensation' (2015) 8 *SAJBL* 2 – 3.

[35] Gauteng Department of Health *Annual Report 2012/2013* (2012) Gauteng Department of Health: Pretoria; Gauteng Department of Health *Annual Report 2016/2017* (2016) Gauteng Department of Health: Pretoria; Gauteng Provincial Department *Estimates of Provincial Revenue and Expenditure* (2017) Gauteng Provincial Department, Gauteng Department of Finance: Pretoria.

[36] The aggregate in medical malpractice claims in Gauteng for the 2012/2013 to 2014/2015 financial year amounted to R8 628 314 000.00. Furthermore, during this period, Gauteng had lost all its medical malpractice cases. See Oosthuizen WT and Carstens PA 'Medical malpractice: The extent, consequences and causes of the problem' (2015) 78 *THRHR* 273.

[37] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018).

[38] MPS 'The challenges of obstetric claims' available at *https://www.medicalprotection.org/southafrica/for-members/news-centre/news/2014/11/17/the-challenges-of-obstetric-claims* (accessed 23 February 2018).

[39] It should be noted that the years 2011 to 2015 were considered based on limited information available at the time of writing this study.

healthcare practitioners and the subscriptions paid by them. The chapter illustrates that the increase in medical malpractice litigation and the size of claims is as a direct result of the socio-economic divide in South Africa, which has had an impact on the realisation of the right of access to healthcare as enshrined in the Constitution.[40]

2.2 STATISTICAL OVERVIEW OF PROVINCIAL MEDICAL MALPRACTICE CLAIMS

Following the Medico-Legal Summit, the National Department of Health held a discussion in 2016, hosted by Dr Terence Carter (Dr Carter), the then Deputy Director-General of Hospitals, Tertiary Health Services and Workforce Development in the National Department of Health.[41] Stemming from the Medico-Legal Summit, Dr Carter highlighted the measures that had been implemented by the state in tackling medical malpractice litigation since the Medico-Legal Summit held in 2015, as well as the various alternatives of reducing the cost of medical malpractice claims.[42] Before turning to the alternatives and measures highlighted by Dr Carter, it is important to first set out a statistical overview in respect of the medical malpractice claims that have been instituted against the public healthcare sector in South Africa, to better understand the premise to implement alternative measures.

Medical Malpractice Claims Against Provinces[43]

Provincial Claims for the Period from 2011 – 2015		
PROVINCE	**AMOUNT CLAIMED**	**AMOUNT PAID OUT**
Western Cape	R277 923 389.00	R61 996 027.00
Eastern Cape	R8 051 060 166.00	R341 182 935.00

[40] The Constitution of the Republic of South Africa, 1996 s 27.

[41] Carter T, 'Medico-Legal Declaration – National Department of Health – 23 October 2016' available at http://www.samedical.org/files/conference_presentations/2016/20_Presentation.pdf (accessed 21 March 2018).

[42] Carter T, 'Medico-Legal Declaration – National Department of Health – 23 October 2016' available at http://www.samedical.org/files/conference_presentations/2016/20_Presentation.pdf (accessed 21 March 2018).

[43] Carter T, 'Medico-Legal Declaration – National Department of Health – 23 October 2016' available at http://www.samedical.org/files/conference_presentations/2016/20_Presentation.pdf (accessed 21 March 2018).

KwaZulu-Natal	R7 417 797 805.00	R496 347 078.00
Mpumalanga	R1 012 855 397.00	R62 343 129.00
Free State	R1 204 009 676.00	R36 897 433.00
Limpopo	R1 247 505 948.00	R68 906 854.00
North West	R995 268 683.00	R48 373 947.00

Fig 1: Medical Malpractice Claims against Provinces

As indicated in Fig 1, the statistics report the monetary value in medical malpractice claims brought against each province and paid out. Interestingly, it appears that Gauteng was excluded from Dr Carter's discussion, despite it being the province with the highest amount in medical malpractice claims. For example, a closer look at Gauteng will reveal that, it alone faced medical malpractice claims amounting to R8 628 314 000.00 for the 2012/2013 to 2014/2015 financial year.[44] This is significantly more than any other province, albeit the 2011/2012 financial year having been excluded. Apart from Gauteng, during the period between 2011 to 2015, the Eastern Cape and KwaZulu-Natal had the highest claims, which were R8 051 060 166.00 and R7 417 797 805.00 respectively, and the lowest being the Western Cape, at a monetary value in medical malpractice claims of R277 923 389.00. The aggregate in medical malpractice claims was R20 206 421 064.00, whilst the total amount paid out by the state was only R1 116 047 403.00.

The common thread with the statistics is that, the amount paid out by the provinces is far less than the amount claimed. This suggests that the state has insufficient funds readily available to pay out claims. This is supported by the proposed Bill,[45] as well as recent judgments handed

[44] Gauteng Department of Health *Annual Report* 2012/2013 (2012) 322; Gauteng Department of Health *Annual Report* 2013/2014 (2013) 234; Gauteng Department of Health *Annual Report* 2014/2015 (2014) 325.
[45] The State Liability Amendment Bill, 2018 in Government Gazette No. 41658 of 25 May 2018. Also see Chapter 2.5.2.

down by the courts such as in the case of *MEC, Health and Social Development, Gauteng v DZ*[46] wherein the Gauteng Department of Health appealed to the Constitutional Court. Here, the Gauteng Department of Health had conceded on the issue of negligence and quantum[47] but sought to amend its plea in terms of which it alleged that it was not required to pay for future medical expenses in lump sum.[48] In short, it sought for the development of the common law "once-and-for-all" rule[49] to allow for periodic or instalment payments to be made for medical malpractice claims awarded in favour of a plaintiff.[50] It was further argued that medical malpractice claims against the state should be assessed against the impact it has on the healthcare budgets and the impact it has on the right of access to healthcare services.[51] It is contended that the relief sought by the Gauteng Department of Health is akin to the provisions contemplated in the Bill. The Bill and the recent cases heard by the courts are indicative of reactions to the increasingly successful medical malpractice claims against the state and the surmounting pressure of insufficient funding available to the state.[52]

An argument that can be made is that it can be averred that it is common cause that the provinces with the highest medical malpractice claims are the ones that are historically previously disadvantaged. It is also common cause that there is widespread diverse access to quality basic services in South Africa and that this is a major contributing factor to the increase in medical malpractice claims. The Eastern Cape and KwaZulu-Natal which have the highest claims in comparison to the other provinces listed, are previously disadvantaged provinces.[53] There lies an inconsistency and inequality in access to basic services which is borne out of the apartheid legacy.[54] The interplay of access to basic services, socio-economic rights, racial

[46] *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37.
[47] *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37 paras 2 - 3.
[48] *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37 para 2.
[49] The court stated that: 'the "once and for all" rule is to the effect that a plaintiff must generally claim in one action all past and prospective damages flowing from one cause of action. The corollary is that the court is obliged to award these damages in a lump sum'. *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37 para 16.
[50] *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37.
[51] *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37 paras 13, 93.
[52] Further cases include *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37 and *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* [2020] 2 All SA 177 (GJ).
[53] Nnadozie RC 'Access to Adequate Water in Post-Apartheid South African Provinces: An Overview of Numerical Trends' (2011) 37(3) *Water SA* 339 – 348.
[54] Nnadozie RC 'Access to Adequate Water in Post-Apartheid South African Provinces: An Overview of Numerical Trends' (2011) 37(3) *Water SA* 339 – 348.

demographics and the delivery capacity of government has always been a declining trend in previously disadvantaged provinces in South Africa, even in the post-apartheid era.[55] This is unfortunate, given that the local government is tasked to ensure that the basic services are provided to communities in a sustainable manner, promoting social and economic development, and promoting a safe and healthy environment.[56] It is argued that local governance control in each province has attributed to poor basic service delivery. The Western Cape, for example, is governed by the Democratic Alliance (DA), whilst the Eastern Cape by the African National Congress (ANC).[57] To better illustrate this, this study has considered findings related to access to water in South Africa, in the post-apartheid era.[58] Therefore, an analogy is drawn between the decline in access to water services and the increase in medical malpractice claims and the trend decline in access to healthcare services in certain provinces in South Africa. The findings follow below:

Water Access at Provincial Level[59]

Water Access at Provincial Level for the period 1995 to 2005						
Province	**1995 Piped**	**1995 Backlog**	**1995 Piped Water %**	**2005 Piped**	**2005 Backlog**	**2005 Piped Water %**
Western Cape	915 842	44608	**95**	1 261 052	22 723	**98**
Eastern Cape	701 598	543 401	**56**	1 132 238	599 660	**65**
Northern Cape	178 050	10 732	**94**	232 031	11 416	**95**
Free State	571 331	91 323	**86**	817 068	40 707	**95**

[55] Nnadozie RC 'Access to Adequate Water in Post-Apartheid South African Provinces: An Overview of Numerical Trends' (2011) 37(3) *Water SA* 340.
[56] Constitution of the Republic of South Africa, 1996 s 152.
[57] Electoral Commission of South Africa '2019 National and Provincial Elections' available at https://www.elections.org.za/NPEDashboard/app/dashboard.html (accessed 19 August 2019).
[58] Nnadozie RC 'Access to Adequate Water in Post-Apartheid South African Provinces: An Overview of Numerical Trends' (2011) 37(3) *Water SA* 339 – 348.
[59] Nnadozie RC 'Access to Adequate Water in Post-Apartheid South African Provinces: An Overview of Numerical Trends' (2011) 37(3) *Water SA* 339 – 348.

KwaZulu-Natal	1 031 198	544 528	**65**	1 950 712	506 250	**79**
North West	594 651	135 995	**81**	879 847	153 122	**85**
Gauteng	2 014 663	64 900	**97**	2 891 100	92 360	**97**
Mpumalanga	407 884	127 239	**76**	664 975	127 549	**84**
Limpopo	596 018	229 927	**72**	973 077	371 497	**72**

Fig 2: Water Access at Provincial Level

The findings in Fig 2 are similar to that at Fig 1 above. It is reported that since 1995, the Eastern Cape and KwaZulu-Natal have had the largest backlog in receiving piped water. This is closely followed by Limpopo. By 2005, the Western Cape's backlog had declined significantly. However, in KwaZulu-Natal there was almost no decline and worse, the Eastern Cape's backlog had increased. What this suggests, is that, both the Eastern Cape and KwaZulu-Natal appear to be at the receiving end to accessing basic services and the Western Cape appears to be leaps ahead of these provinces. As previously discussed, this could simply be attributed to the local governance control in the provinces.

A study conducted by Nkomo demonstrated that individuals in the Western Cape responded positively to the basic service delivery provided by the DA, which was recorded at 55 per cent whilst, individuals in the Eastern Cape did not respond the same and ranked the service delivery of the ANC at 23 per cent.[60] These findings confirm that there is an inconsistency in respect of access to basic services and service delivery and that this can be ascribed to local governance control. As a result, the previously disadvantaged and poor rural provinces remain at the receiving end. Westaway assigns the inconsistency in respect of access to basic

[60] Nkomo S 'Public service delivery in South Africa Councillors and citizens critical links in overcoming persistent inequities' (2017) 42 *Afrobarometer Policy Paper* 4.

services and poor service delivery to the apartheid legacy, particularly in the Eastern Cape.[61] Whilst he recognises that South Africans no longer live in an apartheid era, he states that the inequalities have worsened, and this is because democracy did not discontinue the apartheid era.[62]

The aforementioned findings contribute to the poor state of the quality of healthcare in South Africa, especially in rural provinces. Pearmain and Carstens argue that, in most cases, it is in rural hospitals that the side effects of a compromised quality of healthcare is most felt.[63] The effects have led to the overburdening of workload and understaffing, the lack of equipment and insufficient and thinly spread medical expertise in rural areas.[64] These factors are argued to be one of the drivers behind the increasing number and size of medical malpractice claims.[65] Therefore, it is submitted that a number of the medical malpractice claims can be associated to certain demographic areas, namely, poor rural areas.

It is further submitted that the state's failure to meet its obligations in relation to basic service delivery appears to be one of the major contributors to the increase in the socio-economic divides and inequalities in South Africa.[66] Similarly, it is also a constant contributor to the increase in the number and size of medical malpractice claims.[67] The state urgently needs to address these issues and ensure that there is a key focus on the skewed delivery in healthcare services to formerly disadvantaged rural and poor provinces. Whilst the above-mentioned statistics reflect the strain the public healthcare sector is enduring, consideration must be had

[61] Westaway A 'Rural poverty in the Eastern Cape Province: Legacy of apartheid or consequence of contemporary segregationism?' (2012) 29 *Development Southern Africa* 115-125.
[62] Westaway A 'Rural poverty in the Eastern Cape Province: Legacy of apartheid or consequence of contemporary segregationism?' (2012) 29 *Development Southern Africa* 118, 124.
[63] Carstens P & Pearmain D *Foundational Principles of South African Medical Law* (2007) 623.
[64] von Holdt K & Murphy M 'Public hospitals in South Africa: stressed institutions, disempowered management' in Buhlungu S, Daniel J, Southall R & Lutchman J (eds) *State of the nation: South Africa* 4ed (2007) ch 13; Pepper M & Slabbert M 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 *SAJBL* 29 – 35.
[65] Bateman C 'SAMA pitches in to help victims of adverse medical events' (2015) 105(5) *SAMJ* 337.
[66] Nnadozie RC 'Access to Adequate Water in Post-Apartheid South African Provinces: An Overview of Numerical Trends' (2011) 37(3) *Water SA* 339 – 348; Nkomo S 'Public service delivery in South Africa Councillors and citizens critical links in overcoming persistent inequities' (2017) 42 *Afrobarometer Policy Paper* 1 – 16.
[67] von Holdt K & Murphy M 'Public hospitals in South Africa: stressed institutions, disempowered management' in Buhlungu S, Daniel J, Southall R & Lutchman J (eds) *State of the nation: South Africa* 4ed (2007) ch 13.

of the private healthcare sector which faces similar problems. A consideration of the factors affecting the private healthcare sector are discussed below.

2.3 THE PRIVATE HEALTHCARE SECTOR

As briefly mentioned above, the private healthcare sector is facing similar challenges to those faced by the public healthcare sector. This has resulted in a substantial increase in the subscriptions paid by private healthcare practitioners.[68] Presently, the highest subscription paying private healthcare practitioners are obstetricians, neurosurgeons and spinal surgeons.[69] Below is a consideration of the increase in subscriptions against the impact it has had on the availability of healthcare practitioners.

2.3.1 MPS' Subscriptions

There has been a steady increase in the subscriptions that private healthcare practitioners have had to pay over the recent years. In 2011, the annual MPS subscription for obstetricians was R187 830 and for neurosurgeons and spinal surgeons, R174 700.[70] By 2012, it cost obstetricians R220 700 and neurosurgeons and spinal surgeons R209 470.[71] In 2014, there was a further increase, and obstetricians paid an annual subscription of R330 000 and neurosurgeons and spinal surgeons, R318 190.[72] Unfortunately, these increases cannot be avoided. The increase in medical malpractice litigation, and the number and the size of the claims over the most recent years have contributed to the increase in subscriptions. The MPS estimated that the long-term average claim frequency for private healthcare practitioners in 2015 was around 27 per cent higher than in 2009[73] whilst the value in the claims sought

[68] MPS 'The challenges of obstetric claims' available at *https://www.medicalprotection.org/southafrica/for-members/news-centre/news/2014/11/17/the-challenges-of-obstetric-claims* (accessed 23 February 2018).
[69] Pepper M & Slabbert M 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 *SAJBL* 30; Roytowski D, Smith TR & Fieggen AG et al 'Impressions of Defensive Medical Practice and Medical Litigation among South African Neurosurgeons' (2014) 104(11) *SAMJ* 736.
[70] Pepper M & Slabbert M 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 *SAJBL* 30.
[71] Unknown author 'Doctors lose patience as suits spike' available at https://www.news24.com/Archives/City-Press/Doctors-lose-patience-as-suits-spike-20150429 (accessed 11 April 2018).
[72] Oosthuizen WT and Carstens PA 'Medical malpractice: The extent, consequences and causes of the problem' (2015) 78 *THRHR* 276.
[73] Medical Protection Society 'Challenging the Cost of Clinical Negligence: The Case for Reform' (November 2015) *MPS* 10.

against private healthcare practitioners had escalated by an average of 14 per cent per year between 2009 to 2015.[74]

Therefore, it is not surprising that South Africa's healthcare system is on the verge of a medical malpractice litigation storm.[75] It is reported that there has been an increase of 925 per cent in respect of MPS' subscriptions for obstetricians and gynaecologists between 2009 and 2017, with obstetricians and gynaecologists paying approximately R800 000.00 in 2017.[76] With this in mind, it appears that the increasing trend in subscriptions is likely to result in healthcare practitioners ceasing their practices, simply because it is too expensive to practise.[77]

2.3.2 Scarcity of Healthcare Practitioners

Therefore, it is contemplated that the steady increase in subscriptions could potentially affect the future availability of specialist healthcare practitioners in South Africa. The increases have become exorbitantly expensive to the extent that not all private healthcare practitioners can afford to pay the said subscriptions.[78] According to Dr Graham Howarth, MPS' Head of Medical Services (Africa), the cost of an average claim has doubled every five years in South Africa.[79] There is a looming crisis wherein the scarcity of specialists could potentially result in an overburden of workload on healthcare practitioners that remain in practice. This is likely to increase the possibility for more medical errors and possibly, contribute to more medical malpractice claims and litigation.

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[74] Medical Protection Society 'Challenging the Cost of Clinical Negligence: The Case for Reform' (November 2015) *MPS* 15.

[75] Pepper M & Slabbert M 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 *SAJBL* 29 – 35.

[76] The Bhekisisa Health Journalism Centre 'Why you might battle to find a doctor to deliver your baby in SA' available at http://www.bhekisisa.org/article/2017-06-02-the-real-reason-sas-doctors-wont-deliver-your-baby (accessed 12 September 2018).

[77] Naidoo M 'Obstetrics is in a state of crisis' available at *https://www.iol.co.za/news/south-africa/kwazulu-natal/obstetrics-is-in-a-state-of-crisis-2064315* (accessed 1 April 2018).

[78] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018) ; Naidoo M 'Obstetrics is in a state of crisis' available at *https://www.iol.co.za/news/south-africa/kwazulu-natal/obstetrics-is-in-a-state-of-crisis-2064315* (accessed 1 April 2018).

[79] Whitehouse S 'Counting the costs of GP claims' (2013) *Practice Matters* 8.

This potential threat of limited specialist healthcare practitioners has already been felt in certain provinces in South Africa. Most recently, in 2017, it was reported that five obstetricians practising privately in the northern areas of Durban had ceased to practise in their speciality, all within a period of six months.[80] In Worcester, four obstetricians had left practise, offering no obstetric services in the area.[81] These reports are troubling and should subscriptions for obstetricians and gynaecologists keep increasing and there is no intervention by the state soon, South Africa will find its crisis deepen further to the extent that there will be no obstetricians in the private healthcare sector and patients will have no option but to attend at the already over-burdened public hospitals.

Fortunately, the situation in South Africa reflects the experience of healthcare systems and healthcare practitioners in many parts of the world. However, the situation in South Africa is probably far worse given the existing lack of basic service delivery and the socio-economic inequalities that exist amongst the previously disadvantaged categories of people, especially in the poor rural areas. The extent of the inconsistencies in South Africa is undesirable. It is appreciated that South Africa is a developing country and that its socio-economic situation cannot be compared to developed countries, however, a comparison is necessary to properly criticise South Africa's healthcare system.

2.4 SOUTH AFRICA'S GROSS DOMESTIC PRODUCT

Almost 25 years post-apartheid, and with a population estimated at 57,73 million as at 1 July 2018,[82] South Africa spent a large proportion of its Gross Domestic Product (GDP) on healthcare. In 2015, South Africa spent approximately 8.2 per cent of its GDP on healthcare expenditure, whilst the average spending on healthcare in the world was at 9.9 per cent.[83] Although South Africa's spending was substantially lower than that of many countries,[84] and

[80] Naidoo M 'Obstetrics is in a state of crisis' available at *https://www.iol.co.za/news/south-africa/kwazulu-natal/obstetrics-is-in-a-state-of-crisis-2064315* (accessed 1 April 2018).

[81] Vinassa A 'Why Delivering a Baby is both a Professional and Public Crisis' in Choma D (ed) *The Health Professions Council of South Africa Bulletin 2017* (2017) 12.

[82] Statistics South Africa *Mid-year population estimates 2018* (2018) 1.

[83] The World Bank 'Current health expenditure (% of GDP)' available at https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ZA&view=chart (accessed 1 April 2018).

[84] For example, the Marshall Islands, which at 22.1% spent the highest proportion of GDP on health care followed by countries spending above the world average such as Sierra Leone (18.3%), the United States of America (16.8%), Liberia (15.1%), Tuvalu (14.9%), Micronesia (13%), Switzerland (12%), Andorra (11.9%), Maldives

compared favourably in percentage of health expenditure when compared to other countries in Africa, Lesotho and Malawi appear to have spent more on health than South Africa.[85] Despite this, South Africa's efforts in its investment to health should still be commended because Malawi and Lesotho's health expenditures are largely donor-funded.[86]

Whilst South Africa may have a favourable expenditure on health when compared to other countries, the Constitution still requires that the right of access to healthcare services be progressively realised by the state within its available resources.[87] A narrow interpretation of the percentages provided by the World Bank in relation to the GDP spending on healthcare in South Africa, when compared to the rest of the world, suggests that the progressive realisation of the right of access to healthcare services is promising.

Although this may be the case, a broader interpretation would suggest that a large portion of this spending is perhaps being used to pay-out medical malpractice claims instituted against the state. This is supported by the fact that there is no separate budget for medical malpractice claims or the settlement thereof in South Africa.[88] It is argued that this limits the state's ability of achieving its duty to progressively realise the right to access to health care services.[89] Therefore, the reality in South Africa is that the money allocated to health services is, in fact, diverted away from the delivery of healthcare services as enshrined in the Constitution and used to pay out medical malpractice claims, reducing the funding of an

(11,5%), Germany (11,1%), France and Sweden (11%), Japan (10,9%), Netherlands and Palau (10.6%), Belgium and Canada (10.4%), Denmark (10,3%), Austria (10.3%), Moldova and Armenia (10.1%), Norway (9.9%). The United Kingdom (9.8%), Malta (9.6%), Finland, Australia and Serbia (9.4%), New Zealand (9.3%) and Malawi (9.3%), Uruguay (9.2%), Spain (9.1%), Italy (9%), Portugal, Namibia and Brazil (8.9%), are slightly below the world average. South Africa (8.2%) compares well to Iceland (8.6%), Ecuador (8.5%), Greece (8.3%), Lesotho (8.3%), Burundi (8.2%) and leads Rwanda (7,9%), Ireland (7.7%), Israel (7.4%), Republic of Korea (7.3%), Algeria (7%), Argentina (6.8%), Poland (6.3%). Countries spending well below the world average of 9.9% are Botswana (5.9%), Mexico (5,8%), the Russian Federation (5.5%), Mozambique, Zambia and China (5.3%), Kenya (5.2%), the Central African Republic (4,4%), Democratic Republic of Congo (4.2%) Egypt (4.1%), Ethiopia (4%), India (3.8%) Nigeria (3.5%), Qatar (3%,) Angola (2.9%), with Brunei Darussalam and Bangladesh (2.6%) and Monaco (2%) at the bottom of the list.

[85] The World Bank 'Current health expenditure (% of GDP)' available at https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ZA&view=chart (accessed 1 April 2018).

[86] United Nations Children's Fund South Africa *Health Budget South Africa 2017/2018* (2017) 7.

[87] Constitution of the Republic of South Africa, 1996 s 27(1)(a) and s 27(2).

[88] Claassen N 'Mediation as an alternative solution to medical malpractice court claims' (2016) 9 *SAJBL* 7.

[89] *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37 para 13.

already severely burdened healthcare system.[90] In order for the state to progressively realise the right of access to healthcare services, it requires the money to do so. At the moment, the money which is meant to be used to progressively realise the right of access to healthcare services is being used to pay for medical malpractice claims, leaving little to nothing for the progressive realisation of the right of access of health care services.

In light of the above, the argument is that, there is a regressive realisation of the right to health and access to healthcare services, and there is a need to consider existing domestic and international regulatory frameworks that regulate the right to health and access to healthcare services.[91] This would assist in balancing these rights with a view to achieving the rights through progressive realisation and in turn, addressing the increase in medical malpractice litigation.

2.5 DOMESTIC REGULATORY FRAMEWORKS

As mentioned above, there are international regulatory frameworks that exist and regulate the right to access to health care and which influence the state's duty to act positively towards progressively realising the right. Similarly, there are also domestic regulatory frameworks that specifically create a positive duty on the state and that specifically regulate the healthcare profession in South Africa.[92] Furthermore, over and above the international regulatory frameworks, the domestic regulatory frameworks also influence the rise to patients instituting claims against healthcare practitioners as a means to protect and exercise their rights. The most important framework governing the healthcare profession is the Health Professions Act 56 of 1974 (Health Professions Act). This chapter is not intended to discuss all the relevant domestic regulatory frameworks that reinforce patients' rights to institute claims but will focus on selected regulatory frameworks that have a significant impact on medical malpractice litigation in South Africa, namely the Constitution, the Bill, Health Professions Act and the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974 (Ethical Rules of Conduct).

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[90] South African Law Reform Commission Issue Paper 33 (Project 141) *Medico-legal claims* (2017) 15.

[91] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC).

[92] Examples of a few are the Constitution of the Republic of South Africa, 1996, the National Health Act 61 of 2003 and the Consumer Protection Act 68 of 2008, all of which are aimed at protecting patient rights, including healthcare services.

2.5.1 The Constitution

Section 27 of the Constitution provides for the 'right to have access to health care, including reproductive health care.'[93] This right is said to be a second generation right or socio-economic right which places a positive duty on the state to fulfil the enjoyment of this right.[94] As mentioned previously, the formulation of the duty is that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.[95] An infringement of this right or the non-fulfilment thereof often impacts other rights such as the right to life[96] or impairs human dignity.[97] In this context, the non-fulfilment of s 27 will often overlap or impair other rights.[98] This was qualified in *Le Roux and Others v Dey*[99] wherein the Constitutional Court stated that there is academic consensus that although interests may differ, interests often overlap.[100] By way of example, the court stated that, although 'assault is classified as an infringement of physical integrity it will also often infringe the victim's sense of dignity'.[101] Therefore, in the medical context, certain rights in the Constitution often form the basis and/or grounds of instituting medical malpractice claims.[102]

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[93] The Constitution of the Republic of South Africa, 1996 s 27(1)(*a*).

[94] First generation rights are so called "negative" rights as they impose a duty on the state not to act in a particular way, such as the state may not unfairly discriminate against anyone in terms of s 9(3) of the Constitution of the Republic of South Africa. Second generation rights on the other hand are so called "positive" rights, placing a positive duty on the state to act to progressively realise rights. Currie I & De Waal J *The Bill of Rights Handbook* 6ed (2015) 564; Gambru N 'Some Comments on Water Rights in South Africa' (2005) 8 *PER/PELJ* 4 – 5.

[95] The Constitution of the Republic of South Africa, 1996 s 27(2).

[96] The Constitution of the Republic of South Africa, 1996 s 11.

[97] The Constitution of the Republic of South Africa, 1996 s 10. In *S v Makwanyane and Another* 1995 (3) SA 391 para 326, the court stated that 'the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity'.

[98] General Comment 14 states that the right to health, for example, is 'closely related to and dependent upon the realisation of other human rights.' United Nations Committee on Economic, Social and Cultural Rights*: The Right to the Highest Attainable Standard of Health* (2000) E/C. 12/2000/4 Art. 12 para 3 of the Covenant;

[99] *Le Roux and Others v Dey* 2011 (3) SA 274 (CC).

[100] *Le Roux and Others v Dey* 2011 (3) SA 274 (CC) paras 141 – 142; Neethling J, Potgieter JM & Visser PJ *Neethling's Law of Personality* (1996) 85 – 86.

[101] *Le Roux and Others v Dey* 2011 (3) SA 274 (CC) para 142.

[102]In addition to the above, other constitutional rights such as bodily integrity, privacy and access to courts are relevant and significant to medical malpractice claims. South African Law Reform Commission Issue Paper 33 (Project 141) *Medico-legal claims* (2017) 36; Pienaar L 'Investing the reasons behind the increase in medical negligence claims' (2016) 19 *PER/PELJ* 8.

2.5.2 The Bill

The Bill, in its current format, has various limitations. It will have an impact on both the financial aspects and the choice in the treating healthcare practitioner of patients that have instituted medical malpractice claims against the state. The limitations in the Bill contemplate a restriction in the monies payable to a patient by providing for the structured payment of claims.[103] The further limitation is the choice of healthcare practitioner.[104] The limitation on the right to choose a healthcare provider is a problem on its own as it conflicts with the provisions set out in National Patients' Rights Charter[105] and s 27 of the Constitution. Whilst there appears to be various problems with the Bill, it has not yet been passed into law and it is most likely to be adapted to follow the recent judgments handed down by the courts.[106] For now, however, the Bill requires a lot of work and it will be necessary for relevant stakeholders to be consulted before it can be passed into law.

2.5.3 Health Professions Act

To draw the link between international instruments and to recognise the rights entrenched in the Constitution, and as a response to regulate the healthcare profession, the government introduced the Health Professions Act which provides for the establishment of the Health Professions Council of South Africa (HPCSA).[107] The HPCSA is a statutory regulatory body responsible for, *inter alia*, controlling and exercising 'authority in respect of all matters affecting the training of persons in, and the manner of the exercise of the practices pursued in connection with the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in human kind.'[108]

There are many professions within the healthcare profession and therefore, the Health Professions Act provides for the establishment of professional boards with regard to any

[103] The State Liability Amendment Bill, 2018 in Government Gazette No. 41658 of 25 May 2018 s 2A.
[104] The State Liability Amendment Bill, 2018 in Government Gazette No. 41658 of 25 May 2018 s 2A (2).
[105] The National Patients' Rights Charter under the Ethical Guidelines for Good Practice in the Health Care Professions Booklet 3 states under rule 2.5 that: 'Everyone has a right to choose a particular health care provider for services or a particular health facility for treatment, provided that such choice shall not be contrary to the ethical standards applicable to such health care provider or facility.'
[106] See chapter 2
[107] Health Professions Act 56 of 1974 s 2.
[108] Health Professions Act 56 of 1974 s 3(f).

healthcare profession. There are currently 12 boards established[109] and a register is kept in terms of the boards by the Minister of Health acting on the recommendation of the HPCSA.[110] According to Nortje and Hoffmann, their study revealed that the professional board with the highest number of ethical transgressions in the period between 2007 to 2013 was the Medical and Dental, followed by Psychology.[111] Notably, one of the dominant transgressions was malpractice or incompetence in treating and caring for patients, and improper professional role conduct.[112] In addressing the high number of ethical transgressions by healthcare professionals,[113] the recommendation by Nortje & Hoffmann is that healthcare practitioners should adhere to international healthcare standards and rehabilitative learning for sanctioned healthcare professionals through the attendance of ethics workshops.[114] These are good recommendations however, this paper argues that the attendance of ethics workshops should not be limited only to sanctioned healthcare practitioners, but should be compulsory. It is necessary to keep abreast with international healthcare standards and therefore, all healthcare practitioners, even those that have not been sanctioned should attend such ethics workshops.

2.5.4 Ethical Rules of Conduct

The ethical or unethical conduct of healthcare practitioners is determined against the Ethical Rules of Conduct. Healthcare practitioners are required to subscribe to these rules of conduct during the course of their professional work. Although the Ethical Rules of Conduct are not binding in courts,[115] they become important determining factors for medical malpractice

[109] The professional boards are: Dental Therapy and Oral Hygiene; Dietetics and Nutrition; Emergency Care; Environmental Health; Medical and Dental; Medical Technology; Occupational Therapy, Medical Orthotics, Prosthetics & Arts Therapy; Optometry and Dispensing Opticians; Physiotherapy, Podiatry and Biokinetics; Psychology; Radiography and Clinical Technology; and Speech, Language and Hearing Professions. Health Professions Council of South Africa 'Professional Boards' available at http://www.hpcsa.co.za/Professionals/ProBoards (accessed 12 November 2018).

[110] Health Professions Act 56 of 1974 s 15.

[111] Nortje N & Hoffmann W 'Seven year overview (2007 – 2013) of ethical transgressions by registered healthcare professionals in South Africa (2016) 21 *Health SA Gesondheid* 48.

[112] Nortje N & Hoffmann W 'Seven year overview (2007 – 2013) of ethical transgressions by registered healthcare professionals in South Africa (2016) 21 *Health SA Gesondheid* 48.

[113] Nortje N & Hoffmann W 'Seven year overview (2007 – 2013) of ethical transgressions by registered healthcare professionals in South Africa (2016) 21 *Health SA Gesondheid* 46 - 53.

[114] Nortje N & Hoffmann W 'Seven year overview (2007 - 2013) of ethical transgressions by registered healthcare professionals in South Africa (2016) 21 *Health SA Gesondheid* 52.

[115] McQuoid-Mason D J ''Over-servicing', 'underservicing' and 'abandonment': What is the law?' (2015) 105(3) *SAMJ* 181.

liability.[116] According to Carstens & Pearmain, ethical precepts and prevailing practices are important considerations in ascertaining what constitutes medical malpractice.[117] This is an interesting argument and within this argument, this thesis argues that, should a healthcare practitioner be found to be guilty of medical malpractice in court, surely what follows is that the healthcare practitioner should also be found guilty of unprofessional conduct in terms of the Ethical Rules of Conduct and either be suspended or declared an impaired healthcare practitioner.

Unfortunately, there does not appear to be a mechanism which presupposes automatic referral to a committee for inquiry for unprofessional conduct on a finding of medical malpractice liability by courts in South Africa.[118] The only instance where this is not the case is in criminal proceedings, particularly inquests.[119] The Health Professions Act states that where a registered healthcare practitioner has been convicted by a court of law for any offence, the professional board is empowered to institute an inquiry if it is of the opinion that such an offence constitutes unprofessional conduct.[120] Coetzee and Carstens are of the view that this provision does not only apply in criminal cases but extends to civil proceedings[121] on the basis that s 45(2) of the Health Professions Act states that:

> 'Whenever in the course of [*any proceedings*] before [*any court of law*] it appears to the court that there is *prima facie* proof of unprofessional conduct on the part of a registered person.'

Therefore, although the Health Professions Act makes use of the word convicted, which is ordinarily associated with criminal cases, the provision should be amended to remove the word convicted in order to avoid confusion. It is clear that healthcare practitioners have a

[116] Coetzee LC & Carstens PA 'Medical Malpractice and Compensation in South Africa' (2011) 86(3) *Chicago-Kent Law Review* 1267.
[117] Carstens PA & Pearmain D *Foundational Principles of South African Medical Law* (2007) 264.
[118] Coetzee LC & Carstens PA 'Medical Malpractice and Compensation in South Africa' (2011) 86(3) *Chicago-Kent Law Review* 1282 – 1283.
[119] Health Professions Act 56 of 1974 s 45(2).
[120] Health Professions Act 56 of 1974 s 45(1).
[121] Coetzee LC & Carstens PA 'Medical Malpractice and Compensation in South Africa' (2011) 86(3) *Chicago-Kent Law Review* 1282.

fiduciary duty and relationship with society. In light thereof, the Health Professions Act has been drafted in a manner in which it assumes that patient safety must be preserved, and where early detection and management of impaired healthcare practitioners is important. The definition of impairment should be extended to include healthcare practitioners that have been found guilty of medical malpractice in civil courts, alternatively, a finding of medical malpractice should automatically constitute unprofessional conduct on the part of the healthcare practitioner or result in the institution of an inquiry by the HPCSA.

2.6 CONCLUSION

This chapter examined the amounts claimed and amounts paid out for medical malpractice claims by the state in certain provinces in South Africa. It further examined the increase in the subscriptions paid by private healthcare practitioners as a consequence of the increase in medical malpractice litigation. It was argued that the exorbitant increase in subscriptions and amounts claimed for medical malpractice could potentially affect the availability of specialist healthcare practitioners.

It was revealed that one of the driving forces to the increase in medical malpractice claims and litigation is due to the socio-economic inequalities as a result of the apartheid legacy. The argument was that a link could be drawn between the high amounts in medical malpractice claims in certain provinces to poor basic service delivery. Although South Africa compares favourably to the rest of the world in its healthcare expenditure, there still appears to be a considerable gap in the state using its healthcare expenditure to narrow the socio-economic inequalities. Within this argument, it is contended that because there is no separate budget for medical malpractice claims, the healthcare expenditure is being used to pay out medical malpractice claims instead of progressively realising the right of access to healthcare as envisaged in the Constitution. The next chapter will discuss the international regulatory frameworks applicable to medical malpractice litigation and impact they have on the right to health and right of access to healthcare services.

CHAPTER 3

INTERNATIONAL REGULATORY FRAMEWORKS

3.1 INTRODUCTION

In order to fully appreciate and interpret the extent in which domestic regulatory frameworks govern the right of access to healthcare and the progressive realisation of this right, it is necessary to consider the interplay between the domestic and international regulatory frameworks. The Constitution plays a significant role when determining and/or interpreting international law domestically.[122] Section 39 of the Constitution states that the courts, tribunals or forums must consider international law and may consider foreign law when interpreting the Bill of Rights.[123] It is common cause that international law also recognises the concept of right to access to health care services[124] and the right to health.[125]

Section 233 of the Constitution goes on further, and deals with the application of international law. It provides that, when interpreting legislation, courts 'must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law.'[126] It appears that s 233 places great weight on international law and although s 233 imposes a positive duty on the court to interpret legislation within the confines of international law, the court is still duty bound to consider whether or not the relevant international law in question is binding in South Africa. For example, in *Government of the Republic of South Africa and Others v Grootboom and Others* (*Grootboom*),[127] the Constitutional Court said that:

> 'The relevant international law can be a guide to interpretation but the weight to be attached to any particular principle or rule of international law will vary. However,

[122] Constitution of the Republic of South Africa, 1996 s 39; *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC).
[123] Constitution of the Republic of South Africa, 1996 s 39(1)(b)-(c).
[124] Such as the Universal Declaration of Human Rights, the International Covenant on Economic Social and Cultural Rights and the African Charter on Human and Peoples' Rights.
[125] United Nations General Assembly *Universal Declaration of Human Rights* (1948) GA res. 217A (III), UN Doc A/810 Art. 25.
[126] Constitution of the Republic of South Africa, 1996 s 233.
[127] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC).

where the relevant principle of international law binds South Africa, it may be directly applicable.'[128]

In light of the abovementioned constitutional provisions, it is this mini-thesis' view that South Africa is ripe for legal reform and should embrace international law and foreign law, in attempting to address the issues surrounding its medical malpractice litigation system. This chapter will consider the international health regulatory framework, the principles that give rise to the right to healthcare and how international law may be used in South Africa. By virtue of South Africa being a member of the United Nations, it is required to commit and promote its universal human rights obligations.[129] Whilst regulatory frameworks may be imperfect and perhaps the process of enforcing international law domestically complex,[130] there are significant contributions that international law can have in the development and protection of the right to access to healthcare which will, in turn, minimise medical malpractice litigation.

3.2 APPLICABLE INTERNATIONAL FRAMEWORKS

This section has identified three international regulatory frameworks that will be discussed below that give effect to the right of access to healthcare and the progressive realisation of this right. The focus of the discussion will be on the Universal Declaration of Human Rights (UDHR),[131] the International Covenant on Economic Social and Cultural Rights of 1996 (ICESCR)[132] and the African Charter on Human and Peoples' Rights (African Charter).[133]

[128] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) para 26.
[129] United Nations *Charter of the United Nations* (1945) 1 UNTS XVI Art. 55 and Art.56.
[130] Section 231 of the Constitution states that a treaty is binding on South Africa after approval by the National Assembly and the National Council of Provinces, unless it is self-executing, or of a technical, administrative or executive nature. There appears to be many ropes to jump over before international law can be enforced and therefore, this makes the process complex and lengthy.
[131] United Nations General Assembly *Universal Declaration of Human Rights* (1948) GA res. 217A (III), UN Doc A/810.
[132] United Nations General Assembly *International Covenant on Economic, Social and Cultural Rights* (1967) 6 ILM 368.
[133] Organisation of African Unity *African Charter on Human and Peoples' Rights* (1981) 21 ILM 58.

3.2.1 Universal Declaration of Human Rights

The UDHR, adopted by the United Nations General Assembly in 1948, provides for a right to health.[134] Article 25[135] of the UDHR is broad and includes the right to food, clothing, housing, medical care and necessary social services. This provision creates a clear presentation of the interconnectedness of socio-economic rights. Unfortunately, the UDHR is not a treaty and is therefore, not legally binding on states.[136] Although South Africa has not ratified the UDHR, it is nonetheless generally regarded as customary international law that is universally binding.[137] What reinforces the significance of the UDHR is that the Constitution[138] recognises the importance of adhering to customary international law, stating that 'customary international law is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.'[139]

3.2.2 International Covenant on Economic Social and Cultural Rights of 1996

As mentioned above, socio-economic rights are interconnected. The ICESCR[140] is the most important international instrument that recognises socio-economic rights, particularly the right to health.[141] South Africa ratified the ICESCR in 2015.[142] According to Currie and de Waal, the right to health in the ICESCR is not confined to 'health care' as provided in the Constitution, but is of wider scope, and is of assistance when interpreting s 27 of the Constitution.[143] This view is accepted as it is confirms s 39 of the Constitution[144] in respect of

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[134] United Nations General Assembly *Universal Declaration of Human Rights* (1948) GA res. 217A (III), UN Doc A/810 Art. 25.

[135] 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.' Article 25 of the Universal Declaration of Human Rights also makes special mention to motherhood and childhood entitlement to special care and assistance.

[136] Dugard J *International Law – A South African Perspective* 3ed (2010) 314.

[137] *Filartiga v Pena-Irala* 630 F 2d 876 (1980) 882; Dugard J *International Law – A South African Perspective* 3ed (2010) 36, 314.

[138] Constitution of the Republic of South Africa, 1996.

[139] Constitution of the Republic of South Africa, 1996 s 39(1)(*b*) & s 232.

[140] United Nations General Assembly *International Covenant on Economic, Social and Cultural Rights* (1967) 6 ILM 368.

[141] Art. 12 of the ICESCR states that, 'the state parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'

[142] The Office of the High Commissioner for Human Rights 'Status of Ratification Interactive Dashboard' available at *http://indicators.ohchr.org/* (accessed 14 November 2018).

[143] Currie I & De Waal J *The Bill of Rights Handbook* 6ed (2015) 592.

[144] Constitution of the Republic of South Africa, 1996.

considering international law and foreign law when interpreting the Bill of Rights. Therefore, the implication is that the ICESCR creates an obligation on South Africa to refrain, in good faith, from acts that would defeat its object and purpose.[145]

Over and above South Africa's obligation in terms of the ICESCR, the ICESCR plays a crucial role in interpreting the concept of 'minimum core obligation' as cited in numerous judgments.[146] It is apparent that the Constitution has drawn on the interpretation of the socio-economic rights clauses found in the ICESCR and both instruments have set out the steps to be taken by the state to realise the socio-economic rights, particularly the right to access to healthcare. Therefore, s 27(2) of the Constitution and Art 2 of the ICESCR are, in fact, analogous. For example, Art 2 of the ICESCR states that:

> 'Each state party…undertakes to [*take steps*], individually and through international assistance and co-operation, especially economic and technical, to the maximum of its [*available resources*], with a view to achieving [*progressively*] the full [*realisation*] of the rights recognised in the present Covenant.'[147]

The equivalent of the above is found in s 27(2) of the Constitution which states that '[t]he state must [*take*] reasonable legislative and other measures, within its [*available resources*], to achieve the [*progressive realisation*] of each of these rights.'[148] In view of the above, it is not surprising that the courts have had regard to both Art 2(1) of the ICESCR and s 27(2) of the Constitution in order to draw links between domestic and international regulatory frameworks. An example, is the case of *Minister of Health and Others v Treatment Action Campaign and Others*[149] where the court adopted the same meaning found in the ICESCR for 'available resources' and 'progressive realisation' as found in s 27(2) of the Constitution.[150] Whilst the court drew similarities between the Constitution and the ICESCR, it refused to

[145] United Nations *Vienna Convention on the Law of Treaties 1969* (1969) 8 ILM 679 Art. 10 & 18.
[146] The concept of minimum core obligation is discussed in more detail below.
[147] United Nations Committee on Economic, Social and Cultural Rights *General Comment 3(10): The Nature of States Parties' Obligations* (1990) E/1991/23 Art. 2, para 1 of the Covenant.
[148] Constitution of the Republic of South Africa, 1996 s 27(2).
[149] *Minister of Health and Others v Treatment Action Campaign and Others* 2002 (5) SA 721.
[150] *Minister of Health and Others v Treatment Action Campaign and Others* 2002 (5) SA 721 paras 26 – 39.

adopt the minimum core obligation found in the ICESCR, as it recognised that the socio-economic rights of South Africa could not be applied to the degree found in the ICESCR and it had to be relevant to reasonableness.[151] In order to have a better understanding of Art 2(1), General Comment 3 elaborates on its interpretation.

3.2.2.1 General Comment 3: Taking Steps

General Comment 3[152] clarifies the definition to Art 2(1) and states that to 'take steps' means that the 'steps should be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognised in the Covenant.'[153] Therefore, the state is required to act expeditiously towards achieving rights, and where necessary, may use legislative, administrative, financial, educational and social measures to give effect to rights.[154] In *Grootboom*,[155] the court had a similar interpretation of s27(2) of the Constitution and stated that:

> '[T]he goal of the Constitution is that the basic needs of all in our society be effectively met and the requirement of progressive realisation means that the state must take steps to achieve this goal. It means that accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, lowered over time.'[156]

It is clear that the provisions of the Constitution mirror the standard envisaged by the ICESCR. The provisions create an environment in which the state should play a meaningful role as one of the key advocates for socio-economic rights. Whilst the provisions may mirror each other, there are differences, namely, the concept of 'minimum core obligation' which is discussed below.

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[151] *Minister of Health and Others v Treatment Action Campaign and Others* 2002 (5) SA 721 para 34.
[152] United Nations Committee on Economic, Social and Cultural Rights *General Comment 3(10): The Nature of States Parties' Obligations* (1990) E/1991/23 Art. 2, para 1 of the Covenant.
[153] United Nations Committee on Economic, Social and Cultural Rights *General Comment 3(10): The Nature of States Parties' Obligations* (1990) E/1991/23 Art. 2, para 1 of the Covenant.
[154] United Nations Committee on Economic, Social and Cultural Rights *General Comment 3(10): The Nature of States Parties' Obligations* (1990) E/1991/23 Art. 2, para 1 of the Covenant.
[155] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC).
[156] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) para 45.

3.2.2.2 General Comment 3: Minimum Core Obligation

The only distinction that can be drawn between the ICESCR and the Constitution is the concept of 'minimum core obligation.' General Comment 3 develops this concept[157] and recognises that whilst the state may not fulfil socio-economic rights immediately, it must, at the very least, ensure a satisfaction of minimum essential levels of each of the rights.[158] The Constitution remains silent in relation to the concept of minimum core obligation, albeit it has been qualified in *Grootboom*. Although the court in *Grootboom* did not find it necessary to decide whether it was appropriate for it to determine the minimum core obligation,[159] it did require the state to address the predicament of those individuals deprived and in desperate need, as a priority.[160] It is on the interpretation in *Grootboom* that it can be submitted that the court qualified that this would qualify the minimum core obligation.[161] Notwithstanding this, a large number of South Africa's population is deprived of adequate access to healthcare and therefore, in light of the *Grootboom* case, the argument is that the state is in breach of its minimum core obligation in respect of the right to access to healthcare. Clearly, the state has a duty to fulfil the right to access to healthcare and this duty is elaborated in General Comment 14.

3.2.2.3 General Comment 14: Obligation to Fulfil Right to Health

A significant development in the ICESCR is Art 12 which recognises the right of everyone to enjoy the highest attainable standard of physical and mental health.[162] General Comment 14 interprets Art 12 and highlights three types of obligations of the right to health, namely, respect, protect and fulfil.[163] For the purposes of this paper, Art 12 will be limited to the discussion of the obligation to fulfil. In relation to this, Art 12 states that the state must adopt

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[157] United Nations Committee on Economic, Social and Cultural Rights *General Comment 3(10): The Nature of States Parties' Obligations* (1990) E/1991/23 Art. 2, para 1 of the Covenant.

[158] United Nations Committee on Economic, Social and Cultural Rights *General Comment 3(10): The Nature of States Parties' Obligations* (1990) E/1991/23 Art. 2, para 1 of the Covenant.

[159] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) para 33.

[160] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) para 29.

[161] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) para 29.

[162] United Nations Committee on Economic, Social and Cultural Rights *General Comment 14(33): The Right to the Highest Attainable Standard of Health* (2000) E/C. 12/2000/4 Art. 12 of the Covenant.

[163] United Nations Committee on Economic, Social and Cultural Rights *General Comment 14(33): The Right to the Highest Attainable Standard of Health* (2000) E/C. 12/2000/4 Art. 12 of the Covenant.

appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health.[164] The submission is that this is an important development in the context of legal reform, as a strict application of Art 12 would require the state to ensure that the above-mentioned measures are adopted in order to address and minimise medical malpractice litigation, and better enforce the right to health as required by the ICESCR.

As mentioned above, the General Comments serve as a guide on how to interpret and implement basic human rights. It is argued that they serve the same purpose for the interpretation of the provisions in the Constitution. The court has stated that the General Comments should serve as a significant guide to the interpretation of the Constitution and the approaches to be taken when interpreting socio-economic rights, such as the minimum core obligation.[165] Unfortunately, the progressive realisation of rights cannot easily be attained due to levels of socio-economic inconsistencies in South Africa. Fortunately, the African Charter recognises this issue.

3.2.3 African Charter on Human and Peoples' Rights

The relevant regional instrument in South Africa that recognises economic, social and cultural rights, which in the view of this study is synonymous to the ICESCR, is the African Charter. South Africa ratified the African Charter in 1996. Similar to the ICESCR, Art 16 of the African Charter recognises the right to health. It provides for the 'right to enjoy the best attainable state of physical and mental health'[166] and states that, 'state parties to the Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.'[167]

Unfortunately, unlike the Constitution and the ICESCR, the African Charter is silent on the notions of 'progressive realisation' and 'available resources' and uses different words

[164] United Nations Committee on Economic, Social and Cultural Rights *General Comment 14(33): The Right to the Highest Attainable Standard of Health* (2000) E/C. 12/2000/4 Art. 12 of the Covenant.
[165] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) para 29.
[166] Organisation of African Unity *African Charter on Human and Peoples' Rights* (1981) 21 ILM 58 Art. 16.
[167] Organisation of African Unity *African Charter on Human and Peoples' Rights* (1981) 21 ILM 58 Art. 16.

throughout the African Charter. This issue was vaguely dealt with by the Commission in *Purohit and Moore v The Gambia.*[168] Although the Commission did not expressly rely on the ICESCR, it nonetheless noted the difference in wording of the right to health in the African Charter and the ICESCR, as it recognised the socio-economic inconsistencies that exist in African countries in relation to the availability and access to resources, infrastructures and the inability to fulfil rights immediately.[169] In the circumstances, the Commission interpreted the African Charter in line with the ICESCR and read Art 16 of the African Charter to qualify rights on the basis of available resources and progressive realisation of rights.[170] Therefore, parallels can be drawn from the African Charter despite its inconsistency with the ICESCR because the principles and rules entrenched in the African Charter still accord with the Constitution and the ICESCR. Furthermore, both the African Charter and Constitution recognise the socio-economic inequalities that exist in Africa today as a result of colonialism, apartheid and past injustices, remnants of which still exist and affect previously disadvantaged groups,[171] which have created barriers for achieving the progressive realisation of the right to access to healthcare.

3.3 CONCLUSION

International law has been integral to the development and recognition of the right to health and right of access to healthcare services. The Constitution imposes a duty on the courts to have regard to international law when interpreting and/or applying the Bill of Rights. Therefore, international law is of significant importance when interpreting domestic law.

International law becomes valuable where domestic law is silent on the interpretation of rights in the Bill of Rights or in the instance where immediate legal reform is required to give effect to the rights enshrined in the Bill of Rights. International law should only be considered when domestic laws have been engaged and exhausted. Therefore, it is important that

[168] *Purohit and Moore v The Gambia* [Communication 241/2001], Sixteenth Activity Report 2002-2003, Annex VII.
[169] *Purohit and Moore v The Gambia* [Communication 241/2001], Sixteenth Activity Report 2002-2003, Annex VII para 84.
[170] *Purohit and Moore v The Gambia* [Communication 241/2001], Sixteenth Activity Report 2002-2003, Annex VII para 84.
[171] Organisation of African Unity *African Charter on Human and Peoples' Rights* (1981) 21 ILM 58.

international law is accessible for the purposes of recognising and enforcing the rights which domestic law falls short.

Turning to medical malpractice litigation, the use of international law in litigation is crucially important. In addressing medical malpractice litigation, the Constitution requires the state, legislature and the courts to be pragmatic in their approach in dealing with medical malpractice litigation. Section 27 of the Constitution, which includes the right to healthcare, was informed by the interpretation of the ICESCR at international level. Furthermore, there are cases such as *Grootboom* which have expanded on this right by referring to the ICESCR. Of significance, the court referred to the concept of minimum core obligation expected of the state as reflected in the ICESCR albeit it being silent in the Constitution. It is clear that international law, in all its forms, is a useful instrument in asserting and insisting on legal reform. Therefore, legal reform must have a direct impact on dealing with medical malpractice litigation in South Africa. Norms and standards that are developed internationally must be used to support legal reform in order to give effect to the right to health and the right of access to healthcare. In order to achieve legal reform in the medical malpractice arena, various mechanisms and strategies need to be adopted. The next chapter will consider these mechanisms and strategies by discussing ADR as a means to achieving legal reform in medical malpractice disputes.

CHAPTER 4

ALTERNATIVE DISPUTE RESOLUTION

4.1 INTRODUCTION

The general proposition of this study is that ADR should be the standard option in addressing medical malpractice litigation in South Africa. Alternative Dispute Resolution has been defined as a broad spectrum of structured mechanisms,[172] set of practices, or techniques that are aimed at permitting the resolution of legal disputes and which empower parties to resolve disputes outside of the traditional litigation system.[173] Alternative Dispute Resolution often encompasses mechanisms such as mediation, arbitration and other mechanisms which are alternatives to traditional litigation.[174] These mechanisms often share common characteristics, in that they are; informal, voluntary, flexible, consensual and interest based.[175] The principle drive towards ADR is often its cost effectiveness and quicker resolution of disputes unlike traditional litigation proceedings.[176]

New avenues have been established to address the challenges arising out of medical malpractice litigation. For example, healthcare providers, insurers and indemnifiers are adopting various ADR mechanisms, particularly mediation and arbitration to address these challenges.[177] The most recent adoption is the inclusion of pre-mediation and pre-arbitration clauses in healthcare admission agreements and contracts.[178] This approach has been recommended by SASOG, wherein they recommend the inclusion of compulsory mediation clauses to contracts entered between healthcare practitioners and patients in order to address circumstances arising in the event of an adverse incident or threat of litigation.[179] Such ADR provisions are often referred to as 'mandatory ADR' because the contracting parties

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[172] Law Reform Commission *Report Alternative Dispute Resolution: Mediation and Conciliation* (2010) 13.
[173] Mnookin R 'Alternative Dispute Resolution' (1998) *Harvard Law School Paper Series* 1.
[174] Currie CM 'Mediation and Medical Malpractice Disputes' (1998) 15(3) *Mediation Quarterly* 215.
[175] Havenga P, Havenga M & Kelbrick R et al *General Principles of Commercial Law* 5ed (2006) 259.
[176] Vettori S 'Mandatory mediation: An obstacle to access to justice?' (2015) 15 *African Human Rights Law Journal* 356.
[177] Walters J 'Medical Malpractice Litigation: Is there an Alternative?' (2013) 12(3) *SA Orthopaedic Journal* 19.
[178] Van Waart J 'SASOG Better Obs Newsletter' (August 2017) *SASOG;* Van Waart J 'SASOG Better Obs Newsletter' (October 2017) *SASOG.*
[179] Van Waart J 'SASOG Better Obs Newsletter' (August 2017) *SASOG;* Van Waart J 'SASOG Better Obs Newsletter' (October 2017) *SASOG.*

bind themselves to participate in the particular ADR mechanism agreed upon should a dispute arise, despite objections to the process after the dispute has occurred.[180]

In countries such as England, Australia and the USA, ADR is readily adopted in medical malpractice disputes and there is growing interest in mechanisms which facilitate for ADR as the first resort.[181] Unfortunately in South Africa, ADR has not been fully embraced. Thus, the development, growth and adoption of ADR in medical malpractice cases has been very slow. Where ADR has been attempted, it follows only after the plaintiff patient has already instituted a claim at court.[182] Furthermore, the little appreciation of the principles, ethics and strategies of ADR have resulted in legal practitioners that are often less than effective in the process of last-minute settlement negotiations to ensure the best outcome for their client.[183] Therefore, it is evident that awareness should be created to ensure that ADR becomes an essential part of South Africa's legal system to avoid traditional litigation.

Naturally, both healthcare practitioners and patients unconsciously develop psychological mental barriers which inhibit them from considering ADR or engaging each other with a view to reaching a settlement. Their involvement in the dispute often leads to them being blinded by self-interest.[184] It is for this reason that this chapter argues that ADR should not be solely at the discretion of the healthcare practitioner and patient or the relevant body to the dispute. It is put forward that, to give choice making power to parties affected by the dispute will almost, unquestionably, result in unwillingness by the affected parties to take initiative. This was the case in *Lingwood and Another v The Unlawful Occupiers of R/E of Erf 9 Highlands,*[185] wherein occupants were in unlawful occupation of residential property and eviction proceedings were initiated against them in terms of the Prevention of Illegal Eviction

[180] Parrott M 'Is Compulsory Court-Annexed Medical Malpractice Arbitration Constitutional? How the Debate Reflects a Trend Towards Compulsion in Alternative Dispute Resolution' (2007) 75 *Fordham Law Review* 2700.
[181] Sohn DH & Bal SB 'Medical malpractice reform: the role of alternative dispute resolution' (2012) 470(5) *Clinical Orthopaedics and Related Research* 1370.
[182] Metzloff TB 'Alternative Dispute Resolution Strategies in Medical Malpractice' (1992) 9(2) *Alaska Law Review* 430.
[183] Rycroft A 'Why is mediation not taking root in South Africa?' (October 2009) *African Centre for Dispute Settlement* 5.
[184] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 29.
[185] *Lingwood and Another v The Unlawful Occupiers of R/E of Erf 9 Highlands* 2008 (3) BCLR 325 (W).

from and Unlawful Occupation of Land Act,[186] despite no reasonable steps taken by the parties to mediate the dispute. The court noted that the parties to the dispute had not engaged in any form of ADR in an effort to resolve the dispute and as a result, the court refused to pronounce on the eviction of the occupants.[187] The court highlighted the importance of parties involved in litigation to engage in ADR.[188] In this case, the court intervened and made an order directing that the parties first engage in mediation in an endeavour to explore all reasonable possibilities of securing suitable alternative accommodation or land and/or of achieving mutually acceptable solutions.[189]

This chapter shall focus to a large extent on court-annexed mediation, private arbitration and pre-trial proceedings as mechanisms to be used in conjunction with litigation in medical malpractice disputes. It shall further discuss strategies that should be adopted to these mechanisms to deal with medical malpractice disputes effectively. To a lesser extent, the chapter will briefly touch on negotiation. The argument to be made within this chapter is that, in order to achieve legal reform through effective ADR, such reform will require support from the state in terms of funding, approval of ADR institutions and most importantly, legislative support.[190] Therefore, the Department of Justice should make funding available to the Divisions of the High Court to enable proper engagement of the ADR mechanisms. What follows immediately below is a brief discussion on the traditional ADR mechanisms that exist, such as negotiation, mediation and arbitration.

4.2 TRADITIONAL ALTERNATIVE DISPUTE RESOLUTION MECHANISMS

4.2.1 Negotiation

Anstey defines negotiation as a process wherein parties to a conflict decide to use the process in conjunction with other ADR mechanisms in an attempt to resolve their differences.[191] The general consensus is that negotiation is geared towards the parties' efforts in ascertaining

[186] Prevention of Illegal Eviction from and Unlawful Occupation of Land Act 19 of 1998.
[187] *Lingwood and Another v The Unlawful Occupiers of R/E of Erf 9 Highlands* 2008 (3) BCLR 325 (W) para 34.
[188] *Lingwood and Another v The Unlawful Occupiers of R/E of Erf 9 Highlands* 2008 (3) BCLR 325 (W) para 33.
[189] *Lingwood and Another v The Unlawful Occupiers of R/E of Erf 9 Highlands* 2008 (3) BCLR 325 (W) para 38C.
[190] South African Law Reform Commission *Issue paper 8 Project 94 Alternative Dispute Resolution* (1997) 1 – 42.
[191] Anstey M *Managing Change, Negotiation Conflict* 3 ed (2006) 104.

each other's bottom line, while attempting to keep their own bottom line a secret.[192] It is established that negotiation can be useful to parties in a medical malpractice dispute. It is ideal, in that, the goal is to resolve disputes by reaching settlement agreements, compromises or deals which are rooted on being private, voluntary, consensual and confidential. Therefore, patients and healthcare practitioners can take comfort that they can attempt to resolve their medical malpractice dispute, wherein the outcome can remain private.

Often, parties to a dispute negotiate all the time and do so without formally informing the other party that they are negotiating.[193] It is submitted that negotiation remains an effective ADR mechanism that can successfully take the place of traditional litigation[194] in medical malpractice litigation.

4.2.2 Mediation

Boulle and Rycroft define mediation as 'a decision making process in which the parties are assisted by a third party, the mediator, the mediator attempts to improve the process of decision making and to assist the parties to reach an outcome to which each of them can assent.'[195] Therefore, it is common cause that there exists no winning or losing party in mediation as the parties will either agree on an outcome that is mutually beneficial, or there is no resolution.[196] The role of the mediator is primarily facilitative or evaluative as ascribed by legal practitioners.[197] Effectively, what this means is that, the mediator cannot make any decision of fact or law or determine the credibility of a party to a mediation.[198]

The benefit of mediation is that it is non-binding and therefore participants preserve their right to stop the mediation at any time and go to trial. Another benefit is that mediated settlements arise per agreement between the parties and can therefore be associated to a

[192] Gitchell RL & Plattner A 'Mediation: A Viable Alternative to Litigation for Medical Malpractice Cases' (1999) 2(3) *DePaul Journal of Health Care Law* 457.
[193] Ramsden P *The Law of Arbitration: South African and International Arbitration* (2009) 2.
[194] Havenga P, Havenga M & Kelbrick R et al *General Principles of Commercial Law* 5ed (2006) 259.
[195] Boulle L & Rycroft A *Mediation: Principles Process Practice* (1997) 3.
[196] Ramsden P *The Law of Arbitration: South African and International Arbitration* (2009) 3.
[197] Alexander NM 'Global Trends in Mediation' (2002) 13(10) *World Arbitration and Mediation Report* 274.
[198] Rule 80 (1)(b) of the Amendment of Rules Regulating the Conduct of the Proceedings of the Magistrates' Courts of South Africa in GN 183 GG 37448 of 18 March 2014.

win-win scenario, offering the best possible outcome and satisfaction to both participants.[199] Importantly in the medical context, mediation bridges the gap of poor communication and mistrust between parties.[200]

It is common cause that both the healthcare practitioner and patient will require each other in the future and in the medical context, mediation becomes advantageous due to the necessity of preserving the ongoing doctor-patient relationship. Lynch *et al* are of the view that relationships between disputing parties can be reconciled once the dispute has been resolved.[201] Whilst litigation often destroys relationships, mediation has the opposite effect by preserving parties' relationships.[202] Part of the argument here, is that, mediation is well suited and remains the ideal ADR mechanism for addressing medical practice disputes. According to Creo *et al*, mediation has a 75 per cent to 90 per cent successive rate in avoiding litigation[203] and a 90 per cent satisfaction rate among both plaintiffs and defendants.[204]

Unfortunately, compulsory mediation does not always offer the same successive rate. For example, the success rate of court-annexed mediation is at 23.7 per cent,[205] which is much lower than voluntary mediation which boasts a 75 per cent to 90 per cent success rate.[206] Notwithstanding the poor success rate of court-annexed mediation, it remains an ideal ADR mechanism for the purpose of addressing medical malpractice disputes. The finding is that

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[199] Metzloff TB 'Alternative Dispute Resolution Strategies in Medical Malpractice' (1992) 9 *Alaska Law Review* 429 – 457.

[200] Brand J, Steadman F & Todd C *Commercial Mediation: A User's Guide to Court-referred and Voluntary Mediation in South Africa* (2012) 29.

[201] Lynch C, Coker A & Dua JA 'A Clinical Analysis of 500 Medico-Legal Claims Evaluating the Causes and Assessing the Potential Benefit of Alternative Dispute Resolution' (1996) 103 *International Journal of Obstetrics and Gynaecology* 1236 – 1242.

[202] Van der Berg C 'Court-Annexed Mediation: Should it be Embraced by the Legal Profession?' (2015) 551 *De Rebus* 24 – 26.

[203] Creo RA, Shogan JO & Turner CT 'Malpractice Case Alternative Dispute Resolution' available at http://physiciansnews.com/2005/11/13/malpractice-case-alternative-dispute-resolution/ (accessed 15 April 2018).

[204] Szmania SJ, Johnson AM & Mulligan M 'Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices' (2008) 26 *Conflict Resolution Quarterly* 81.

[205] Peeples R, Harris C & Metzloff TB 'Following the Script: An Empirical Analysis of Court-Ordered Mediation of Medical Malpractice Cases' (2007) *Journal of Dispute Resolution* 106.

[206] Creo RA, Shogan JO &Turner CT 'Malpractice Case Alternative Dispute Resolution' available at http://physiciansnews.com/2005/11/13/malpractice-case-alternative-dispute-resolution/ (accessed 15 April 2018); Szmania SJ, Johnson AM & Mulligan M 'Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices' (2008) 26 *Conflict Resolution Quarterly* 81.

the reason for the shockingly low statistic is because legal practitioners are involved and take over the mediation process which disrupts the main purpose of mediation.

4.2.3 Arbitration

Another form of ADR is arbitration which, unfortunately, has been criticised as being more expensive than mediation because legal practitioners become heavily involved in the process.[207] Arbitration is a formal and binding process, defined as a process where 'a disinterested, impartial third-party will make binding decisions resolving the dispute and enter an award that can be enforced in court.'[208]

Unfortunately, arbitration is too rigid and adversarial. It is the position of this paper that, notwithstanding criticism, arbitration is still more time and cost efficient when compared to litigation.[209] A further strength to arbitration is that it has a unique advantage of having a skilled and knowledgeable arbitrator to decide on the facts of a case rather than having a Judge or Magistrate that is unable to comprehend or understand the science of a particular case – i.e. medicine.[210]

Whilst the above ADR mechanisms are not exhaustive of all the possible ADR mechanisms, it is also important to note that not all ADR mechanisms may be applicable to medical malpractice cases. Alternative Dispute Resolution mechanisms applicable to medical malpractice disputes have been identified and are discussed below.

4.3 ADR MECHANISM STRATEGIES FOR THE MEDICAL MALPRACTICE CONTEXT

As discussed above, the development, growth and adoption of ADR in South Africa has been slow for various reasons. In addition, legal practitioners have been reluctant to actively

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[207] Claassen N 'Mediation as an Alternative Solution to Medical Malpractice Court Claims' 2016 (9) *SAJBL* 8.

[208] Thorpe WR 'Effective Use of Mediation and Arbitration in Health Care Disputes' (2011) 4(7) *Bloomberg Law Reports – Health Law* 2.

[209] Creo RA, Shogan JO &Turner CT 'Malpractice Case Alternative Dispute Resolution' available at http://physiciansnews.com/2005/11/13/malpractice-case-alternative-dispute-resolution/ (accessed 15 April 2018); Szmania SJ, Johnson AM & Mulligan M 'Alternative dispute resolution in medical malpractice: a survey of emerging trends and practices' (2008) 26 *Conflict Resolution Quarterly* 71 – 96.

[210] Sohn DH & Bal SB 'Medical Malpractice Reform: The Role of Alternative Dispute Resolution' (2012) 470(5) *Clinical Orthopaedics and Related Research* 1374.

promote the principles and advantages of ADR[211] by focusing on serving their self-interest which guarantees their financial interests. Of course, these are legitimate considerations, however, the tide has changed and the case of *Brownlee v Brownlee*[212] places an onus on legal practitioners to consult their clients on ADR, warning that a failure or rejection to do so can attract adverse punitive costs orders against legal practitioners.[213]

Therefore, it is not surprising that there has been a shift towards introducing court-annexed ADR which endorses the view that ADR should not be the last resort.[214] It is advanced that, apart from the role of legal practitioners, courts also need to intervene and encourage litigants and legal practitioners to explore ADR when dealing with medical malpractice disputes, and that the court should punish parties that unreasonably fail or reject to resolve medical malpractice disputes through ADR mechanisms.

The seriousness of ADR becoming a reality and a new approach in legal practice is also noticeable through its international embracement. For example, in England, the existence of court-annexed ADR in civil disputes has also been introduced in various schemes such as the Chancery Guide,[215]the Queen's Bench Guide,[216] the Admiralty and Commercial Court Guide[217] and the Technology and Construction Court Guide.[218] These Guides encourage ADR, and also annex draft ADR orders which serve as templates in the Guides. These Guides and orders have been particularly valuable and widely used in medical malpractice cases.[219] These draft ADR

[211] Kotze H 'Rule 37 and Mediation' (October 2009) *African Centre for Dispute Settlement* 6 – 8.
[212] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ).
[213] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ) para 59.
[214] Amendment of Rules Regulating the Conduct of the Proceedings of the Magistrates' Courts of South Africa in GN 183 GG 37448 of 18 March 2014.
[215] HM Courts & Tribunals Service 'Chancery Guide 2016, as amended January 2019' Available at https://www.gov.uk/government/publications/chancery-guide (accessed 21 March 2019) para 18 .
[216] Fontaine B 'The Queen's Bench Guide 2018: A Guide to the Working Practices of the Queen's Bench Division within the Royal Courts of Justice' available at https://www.gov.uk/government/publications/queens-bench-guide (accessed 21 March 2019) para 8.4.
[217] Judges of the Commercial Court of England & Wales 'The Commercial Court Guide (Incorporating the Admiralty Court Guide) 2017' available at https://www.gov.uk/government/publications/admiralty-and-commercial-courts-guide (accessed 21 March 2019) para G.
[218] HM Courts & Tribunals Service 'The Technology and Construction Court Guide 2014, third revision with effect from 3 March 2014' available at https://www.gov.uk/government/publications/technology-and-construction-court-guide (accessed 21 March 2019) para 7.
[219] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920 para 32.

orders as stated by the Court in *Halsey v Milton Keynes NHS Trust*,[220] have two significant roles, (i) they recognise the importance of encouraging the parties to consider whether their case is suitable for ADR, and (ii)they are aimed at alerting the parties to the risk on costs even if they are ultimately held by the court to be the successful party, should they refuse to consider ADR.[221] The following section discusses how ADR mechanisms can be developed and improved to suit medical malpractice disputes.

4.4 THE DEVELOPMENT AND IMPROVEMENT OF ADR MECHANISMS TO BE USED IN THE MEDICAL MALPRACTICE DISPUTES

For ADR to become an effective process, a first resort, and not simply a legal ornament, it will become necessary to tailor-make ADR for medical malpractice disputes. The challenge in medical malpractice disputes is that it often creates emotional barriers.[222] On one end, there is the patient that often feels angry, humiliated and frustrated, and will have sustained some financial damage at the hands of the healthcare practitioner.[223] On the other hand, a healthcare practitioner fears that he or she may face a potential claim and may suffer reputational damage.[224] In both instances, the parties are often plagued with high emotions. It is for the above reasons and the views of this study, that ADR mechanisms need to be developed and adapted to suit medical malpractice disputes, in order to establish the desired criteria and outcome. This chapter has identified court-annexed mediation, pre-trial proceedings and private arbitration to be ideal processes in addressing medical malpractice disputes and discusses their strategies below.

[220] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.

[221] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920, para 33.

[222] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 29.

[223] It is important to understand that the emotional impact of medical malpractice disputes not only affects the patient but also the healthcare practitioner. Healthcare practitioners have reported depressive disorders and stress symptoms. Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 29; Charles SC, Wilbert JR & Franke KJ 'Sued and nonsued physicians' self-reported reactions to malpractice litigation' (1985) 142(4) *American Journal of Psychiatry* 438.

[224] Metzloff TB, 'Alternative Dispute Resolution Strategies in Medical Malpractice' (1992) 9(2) *Alaska Law Review* 433.

4.4.1 The Use of Court-Annexed Mediation

It is advanced that the use of court-annexed mediation would be the ideal ADR process in addressing medical malpractice disputes in South Africa. There are various advantages that support court-annexed mediation to be invaluable to resolving medical malpractice disputes.

As previously mentioned, medical malpractice disputes often lead to a breakdown in the doctor-patient relationship,[225] resulting in poor communication,[226] hostility in the relationship[227] and because the disputes are often plagued with medical jargon that patients may not understand, the patients are left confused.[228] These factors perpetuate the dispute and do not assist the parties in resolving the dispute at an early stage. Given the nature of medical malpractice disputes and considering the above-mentioned factors, it is expressed that the key focus of court-annexed mediation is to (i) encourage early dispute resolution, (ii) forgiveness and (iii) promoting harmonious relationships. These are all criterions which are necessary to give positive effect to the doctor-patient relationship.

In order to give effect to court-annexed mediation and to ensure its success, it would require support through the enactment of legislation. The introduction of the court-annexed mediation rules piloted in a few selected Magistrates' Courts in South Africa[229] have given mediation, as a court-annexed process, wide attention across South Africa. The intention of these rules is to provide a process for the voluntary submission of civil disputes to mediation.[230]

Although voluntary mediation is also contemplated in the High Courts in terms of rule 37 of the Uniform Rules of Court, court-annexed mediation has been recently introduced in the High Courts. The Rules Board for Courts of Law (Rules Board) recently introduced an amendment to the Uniform Rules of Court by introducing rule 41A, a rule regulating the

[225] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 28.
[226] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 28.
[227] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 28.
[228] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 28.
[229] Amendment of Rules Regulating the Conduct of the Proceedings of the Magistrates' Courts of South Africa in GN 183 GG 37448 of 18 March 2014.
[230] Amendment of Rules Regulating the Conduct of the Proceedings of the Magistrates' Courts of South Africa in GN 183 GG 37448 of 18 March 2014.

procedure for referral to mediation of High Court cases.[231] The new rule is intended to be court-annexed and contemplates pre-litigation mediation like in the Magistrates' Court Rules.[232] The rule will require legal representatives to declare to the court that they have discussed and advised their client on mediation before instituting legal proceedings. It is not clear the extent in which the courts will be involved in assessing and/or scrutinising a litigant's refusal to participate in mediation as contemplated by rule 41A. However, flowing from what is seen in the case law in England, litigants that unreasonably refuse to participate in mediation, including legal representatives that fail to discuss and advise their clients on mediation may find themselves with adverse costs orders awarded against them. What follows below are principles that ought to be adopted when considering mediation.

4.4.1.1 The Role of the Mediator

Although parties to medical malpractice disputes should be given the opportunity to choose their own mediator, it is argued that the mediator would typically have to be professionals in either the legal or medical fields, or both. Letzler *et al* writes that these mediators would be professionals and seasoned experts in their respective field of expertise, with the necessary training in the processes involved during the mediation.[233] In this instance, mediators would not be required to make an informed decision based upon the parties' representations, but they would merely assist parties by facilitating discussions. The further role is that the mediator would evaluate the strengths and weaknesses of either parties' case, identify issues, predict potential outcomes should parties proceed to litigate, and explore compromise and options in an attempt to resolve the dispute.[234]

[231] Rule 41A of the Uniform Rules of Court: Rules Regulating the Conduct of the Proceedings of the Several Provincial and Local Divisions of the High Court of South Africa in GN R107 GG 43000 of 7 February 2020.

[232] While the proposed mediation in terms of the Uniform Rule 41A is commendable in terms of the use of ADR, it remains to be seen as to what extent the Rule will have an effect on matters in the High Court. It should be noted that no cases could be identified where rule 41A has been applied.

[233] Letzler M, Jacobs E & Marais L 'The Potential of Medical Negligence Mediation in the Public Sector with an Emphasis on the Practical Skills Implemented by Mediators to Reach a Satisfactory Solution' (2017) 30 *The South African Bar Journal* 36.

[234] Benjamin C 'Court-Annexed Mediation: Should it be Embraced by the Legal Profession' (2015) 551 *De Rebus* 25.

4.4.1.2 Promoting a Harmonious Relationship

Unlike litigation which is adversarial in nature and has a winner and loser, mediation, at its core, focuses on restorative justice and preservation of relationships of parties,[235] which may be strained or destroyed by litigation. Botes supports the argument that the perception of win-lose is neutralised through mediation[236] whilst Letzler *et al* agrees to further say that, through mediation, damaged relationships are contained, resulting in little or no impact on the relationship.[237] This study agrees with both writers and submits that this is the main objective of mediation.

4.4.1.3 Control over the dispute

While many argue that disputants that submit themselves to ADR processes may lose control over the process, the finding is that mediation has the opposite effect. Mediation empowers parties to the dispute to exercise their autonomy by having control over resolving the dispute and they remain in control of the process.[238] This consideration becomes of great value as autonomy would open the possibility of the healthcare practitioner and patient choosing to understand better, and choosing to treat each other with respect and greater empathy.

4.4.1.4 Confidentiality

The nature of mediation allows for the parties to properly ventilate the issues in a safe, fair, private and constructive atmosphere.[239] The parties are free from stresses of litigation and share their interests in a favourable atmosphere.[240] Whilst authors have written to say that healthcare practitioners often fear that their dispute will attract media attention[241] and hence

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[235] Rule 71(*b)* & Rule *71(c)* of the Amendment of Rules Regulating the Conduct of the Proceedings of the Magistrates' Courts of South Africa in GN 183 GG 37448 of 18 March 2014.

[236] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 29.

[237] Letzler M, Jacobs E & Marais L 'The Potential of Medical Negligence Mediation in the Public Sector with an Emphasis on the Practical Skills Implemented by Mediators to Reach a Satisfactory Solution' (2017) 30 *The South African Bar Journal* 36.

[238] McGregor L 'Alternative Dispute Resolution and Human Rights: Developing a Rights-Based Approach through the ECHR' (2015) 26(3) *The European Journal of International Law* 612.

[239] Havenga P, Havenga M & Kelbrick R et al *General Principles of Commercial Law* 5ed (2006) 259; Gitchell RL & Plattner A 'Mediation: A Viable Alternative to Litigation for Medical Malpractice Cases' (1999) 2(3) *DePaul Journal of Health Care Law* 438.

[240] *Cowl v Plymouth City Council* [2001] E.W.C.A. (Civil Division) 1935 (14 December 2001) para 1; Claassen N 'Mediation as an Alternative Solution to Medical Malpractice Court Claims' 2016 (9) *SAJBL* 9.

[241] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 29.

their reluctance to consider mediation, it is contended that mediation would typically be conducted with an emphasis on strict confidentiality and without prejudice negotiations.[242] The concept of strict confidentiality and without prejudice negotiations already exists in the Magistrates' Court Rules and is also identified in rule 41A of the Uniform Rules of Court. It is argued that if mediation were to be unsuccessful, the confidential information discussed at mediation would remain at mediation and not be exposed at litigation. The argument here is that there are processes currently in place that provide for effective enforcement of confidentiality and that this should negate the fear of disputes attracting unnecessary public scrutiny.

4.4.1.5 Punitive and adverse costs orders

Both the Magistrates' Court Rules and Uniform Rules of Court have anticipated the situation where a party unreasonably refuses to mediate a dispute. They give the presiding officers a wide discretion to award adverse costs orders on parties that fail to mediate. This becomes critical as healthcare practitioners are often either discouraged by legal practitioners to explore mediation, or it is never discussed and therefore mediation is viewed with scepticism.[243] This issue was addressed in the *Halsey* case[244] and it was stated that legal practitioners now open themselves to potential *de bonis propriis* costs orders[245] for failing to recommend or discuss mediation with their clients.

4.4.2 The adaptation of pre-trial proceedings

The Magistrates' Court Rules[246] and the Uniform Rules of Court[247] also provide for pre-trial proceedings. The pre-trial proceedings are aimed to promote the effective disposal of the

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[242] Rule 77(4)*(c)*(vii) of the Amendment of Rules Regulating the Conduct of the Proceedings of the Magistrates' Courts of South Africa in GN 183 GG 37448 of 18 March 2014.

[243] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ); Yee F 'Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis' (2007) 7(2) *Cardozo Journal of Conflict Resolution* 426.

[244] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.

[245] Costs *de bonis propriis* is a punitive cost award issued against legal representatives by a court to mark its displeasure for the manner the legal representative has conducted litigation. In this regard, legal representatives ought to ensure that their standard does not deviate from a standard of care expected of legal representatives. Such legal representative is required to pursue their client's rights and interests without undue regard for their personal convenience. *Multi-Links Telecommunications v Africa Prepaid Services Nigeria Ltd; Telkom SA Soc Limited and Another v Blue Label Telecoms Limited and Others* [2013] 4 All SA 346 (GNP) paras 34 – 35.

[246] Magistrates' Court Act 32 of 1944 s54.

[247] Rule 37 of the Uniform Rules of Court: Rules Regulating the Conduct of the Proceedings of the Several Provincial and Local Divisions of the High Court of South Africa in GN R181 GG 15464 of 1 March 1994.

litigation and investigating ways of avoiding costs at a stage when it can still be avoided.[248] The courts have gone on to say that the main object of pre-trial proceedings is to expedite litigation, to limit the issues in dispute, curtail the duration of a trial, narrow down issues, cut costs and facilitate settlements.[249]

Unfortunately, judges appointed to case manage the pre-trial proceedings for a particular case may not have the skills and knowledge required to manage complex medical malpractice disputes. A case is made out that the inclusion of qualified experts to assist judges at the pre-trial proceedings could potentially address frivolous and non-meritorious medical malpractice claims being instituted in the High Courts. Metzloff has suggested this to be as a possible gate-keeping tool.[250]

For purposes of this paper, ADR, in short, has been defined as a host of mechanisms which empower parties to resolve disputes outside of the traditional litigation system. It is in considering this definition that the pre-trial proceedings as envisaged in the Uniform Rules of Court and Magistrates' Court Rules, partially fits the definition of ADR. It is noted that further adaptation is required for pre-trial proceedings to be effective in facilitating the resolution of medical malpractice disputes.

4.4.2.1 Composition in pre-trial proceedings

Currently, the composition in pre-trial proceedings includes the judge, plaintiff's attorney and the defendant's attorney. The proposition is that the composition should extend to include a healthcare practitioner with expertise in the particular field in dispute. Metzloff argues that the involvement of the expert healthcare practitioners would assist the judge in assessing the parties' respective cases.[251] Macchiaroli suggests that the composition should only extend to two healthcare practitioners as a greater number would only increase administrative

[248] *Lekota v Editor, 'Tribute' Magazine* 1995 (2) SA 706 (W) at 708F.
[249] *Road Accident Fund v Krawa* 2012 (2) SA 346 (ECG) at 353H – 354A; *Huang v Bester NO* 2012 (5) SA 551 (GSJ) at 559G.
[250] Metzloff TB, 'Alternative Dispute Resolution Strategies in Medical Malpractice' (1992) 9(2) *Alaska Law Review* 437.
[251] Metzloff TB, 'Alternative Dispute Resolution Strategies in Medical Malpractice' (1992) 9(2) *Alaska Law Review* 437.

difficulties, delaying the process.[252] It is agreed that the smaller the composition, the better, however, there may be instances that warrant more than two healthcare practitioners depending on the nature of the medical malpractice dispute or particular expertise required, arising from the issues presented by the claim. The expert healthcare practitioners can assist the judges in determining the degree for reasonable standard of care and will also have the expertise to determine or assist in answering difficult questions relating to medical causation issues.

4.4.2.2 Findings at pre-trial proceedings

By operation, the judge would issue a non-binding decision in respect of liability with the aim of possibly inducing the plaintiff to drop the claim or induce the defendant to settle. Macchiaroli is of the view that the expert healthcare practitioners that assist the judges should not be called to testify at the subsequent trials[253] as a result of the findings of the pre-trial proceedings. It is put forward that, in order to encourage expert healthcare practitioners to express their own unencumbered expert opinions fully, without fear, favour or prejudice, they must be able to do so without the constant fear of being called to testify.

4.4.2.3 Admissibility of findings at litigation stage

Similar to the *Halsey* case,[254] it is asserted that findings of liability at the pre-trial proceedings should be admissible at litigation for purposes of arguing costs only. In theory, a finding of liability that is unfavourable against a party at both the pre-trial proceedings and at trial, should warrant a severe punishment of an adverse costs order against that party. In short, parties should be discouraged from pursuing meritless or frivolous cases at pre-trial proceedings.

4.4.2.4 Mandatory or voluntary

Pre-trial proceedings in both the Magistrates' Courts and High Courts are mandatory, and it is argued that with the above-mentioned adaptations, it should remain mandatory. For the

[252] Macchiaroli JA 'Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills' (1990) 58(2) *George Washington Law Review* 243.
[253] Macchiaroli JA 'Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills' (1990) 58(2) *George Washington Law Review* 248.
[254] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.

process to function efficiently, it can only do so where it is mandatory.[255] The finding is that these adaptations would remove frivolous or non-meritorious claims from the overburdened South African judicial system. Simultaneously, it would be a ripe, convenient and ideal forum to encourage pre-litigation settlements. In addition, it would encourage lower settlement values and ultimately lower litigation costs, the number of disputes at litigation, and possibly, also lower the subscriptions paid by healthcare practitioners.

4.4.3 The Facilitation of Private Arbitration

Arbitration can be developed by fostering private arbitration agreements between patients and healthcare practitioners and/or healthcare providers. Although it is the least ideal mechanism when compared to court-annexed mediation and pre-trial proceedings because of its adversarial nature, it remains a consensual process, and does not depart from the Constitution[256] and offers several benefits above traditional litigation. The benefits include, *inter alia*; (i) referring the medical malpractice dispute to arbitration as soon as the dispute arises, (ii) it is cost effective,[257] (iii) the rules of evidence are less stringent,[258] (iv) the traditional court processes are non-existent[259] and (v) the process remains private and confidential much like the above-mentioned mechanisms.[260] The greatest advantage is the possibility of using an arbitrator that possesses the skills and/or scientific knowledge related to the nature of the dispute. The benefits accrue both to the healthcare practitioner and the patient who, under traditional litigation, are unable to access these benefits due to for

[255] Klein BF 'A Practical Assessment of Arizona's Medical Malpractice Screening System' (1984) 2 *Arizona State Law Journal* 335 – 368.
[256] Constitution of the Republic of South Africa, 1996.
[257] Faris J 'The Procedural Flexibility of Arbitration as an Adjudicative Alternative Dispute Resolution Process' (2008) 41(3) *De Jure* 518.
[258] Faris J 'The Procedural Flexibility of Arbitration as an Adjudicative Alternative Dispute Resolution Process' (2008) 41(3) *De Jure* 506.
[259] Faris J 'The Procedural Flexibility of Arbitration as an Adjudicative Alternative Dispute Resolution Process' (2008) 41(3) *De Jure* 506.
[260] Faris J 'The Procedural Flexibility of Arbitration as an Adjudicative Alternative Dispute Resolution Process' (2008) 41(3) *De Jure* 512; Ramsden P *The Law of Arbitration: South African and International Arbitration* (2009) 122 – 123.

example: (i) the high administrative costs associated with litigation;[261] (ii) difficulty in securing evidence;[262] and (iii) public scrutiny.[263]

To properly facilitate and encourage private arbitrations, it is considered that it would be ideal if parties in medical malpractice disputes, at the consent stage, would agree contractually that, if a dispute were to occur, that they would subject it to arbitration. This approach has already been, to an extent, adopted by SASOG, albeit it being in the form of mediation for now. The difference is that the medical malpractice dispute would be under the auspices and regulations of the Arbitration Act[264] which currently governs arbitration proceedings. The viewpoint is that, developing private arbitration in medical practice disputes would allow healthcare practitioners to render services on condition of acceptance of arbitration and would also create a flexible process in which parties can exercise their autonomy, because private arbitration allows the parties to retain control over the process.

It is difficult to anticipate whether healthcare practitioners are likely to take advantage of the benefit of having patients agree, at consent stage, to refer a dispute to arbitration. Therefore, there should be no restriction for patients to facilitate this process and take the initiative where the healthcare practitioner has failed to do so.

4.4.3.1 Legal competence and qualifications of the arbitrator

The Arbitration Act[265] provides for the appointment of the arbitrator or arbitrators by agreement of the parties.[266] Where parties cannot agree on the appointment of an arbitrator, such appointment can be made by the court or relevant body.[267] The assertion is that, for private arbitration to be successful, the healthcare practitioner and patient must be able to

[261] Schulze C, 'International Commercial Arbitration: An Overview' (2005) 46(2) *Codicillus* 49.
[262] Faris J 'The Procedural Flexibility of Arbitration as an Adjudicative Alternative Dispute Resolution Process' (2008) 41(3) *De Jure* 518.
[263] Faris J 'The Procedural Flexibility of Arbitration as an Adjudicative Alternative Dispute Resolution Process' (2008) 41(3) *De Jure* 512.
[264] Arbitration Act, 42 of 1965.
[265] Arbitration Act, 42 of 1965.
[266] Arbitration Act, 42 of 1965 ss 9 and 10.
[267] Arbitration Act, 42 of 1965 s12.

trust the arbitrator and not have doubts in respect of the arbitrator's skill, competence and qualification.

4.4.3.2 Impartiality and independence

The most important factor is that the person appointed to arbitrate a medical malpractice dispute must be independent,[268] impartial[269] and competent. The arbitrator would have a duty to disclose a circumstance that is likely to give rise to justifiable doubt to his or her impartiality or independence or recuse themselves.[270] This becomes particularly important in instances where an arbitrator is a healthcare practitioner and holds a particular view towards a fellow healthcare practitioner's decision making regarding the treatment of a patient. In order to avoid allegations of partiality and bias of arbitrators, an arbitration program with an appropriate selection criterion for arbitrators that would generate arbitrators with reliable and consistent results would need to be introduced.

4.4.3.3 Appointment of expert

To overcome the hurdle of a potentially biased arbitrator that is by profession a healthcare practitioner, parties to the dispute may appoint an expert to assist the arbitrator. The most important factor will rely on whether the arbitrator exercises his or her own judgment to coming to the arbitration award.[271] It is affirmed that whilst the arbitrator may require assistance, he or she would still be in control over the process and must apply his or her own mind when chairing an arbitration hearing.

4.4.3.4 Privacy and confidentiality

Generally, parties to arbitration agreements wish to keep their disputes private and away from public scrutiny.[272] This is often the case in medical malpractice disputes where parties' fears and interests become a dominant consideration, especially in sensitive medical malpractice cases. It is advanced that healthcare practitioners and patients are likely to freely

[268] Ramsden P *The Law of Arbitration: South African and International Arbitration* (2009) 65.
[269] Ramsden P *The Law of Arbitration: South African and International Arbitration* (2009) 65.
[270] *Appel v Leo and Another* 1947 (4) SA 766 (W).
[271] *Total Support Management (Pty) Ltd and Another v Diversified Health Systems (SA) (Pty) Ltd and Another* 2002 (4) SA 661 (SCA).
[272] Ramsden P *The Law of Arbitration: South African and International Arbitration* (2009) 122.

participate in the arbitration hearing, knowing that the outcome will remain private and confidential. Having discussed various ADR mechanisms above and the call for the development of ADR to address medical malpractice litigation, its feasibility and factors that impede its success also needs to be taken into account. Below is a discussion of cases that emphasise the importance of mediation.

4.5 PRACTICAL CASE STUDY APPLICATION

As discussed above, this chapter is of the view that court-annexed mediation, pre-trial proceedings and private arbitration are the ideal ADR processes to effectively address the increase in medical malpractice litigation, the size of medical claims and the court's inability to manage the current medical malpractice litigation caseload in South Africa. In order to give effect to ADR, it is important to test the feasibility of ADR processes to eliminate common impediments to the achievement of effective ADR between the patient and healthcare practitioners. What follows is an investigation into court-annexed mediation by using two court cases as examples that emphasised the need to mediate. It is accepted that whilst compulsion by the court to mediate is rare, there may be risks of cost sanctions against parties and legal representatives that unreasonably refuse to mediate. The fine line between whether a compulsion to mediate or court-annexed mediation would violate the right of access to court is also discussed.

The cases of *Brownlee v Brownlee*[273] and *Halsey v Milton Keynes NHS Trust*[274] both recognise the advantages which mediation has over traditional litigation and will be discussed briefly below. In considering the courts approach in *Brownlee v Brownlee,*[275] the court placed a duty on legal representatives to recommend mediation to their clients.[276] In this case, the court expressed its displeasure towards both legal practitioners due to their apparent failure to consult their clients on the benefits of mediation. The courts annoyance with the legal practitioners was made clear when the judge made the following remark:

[273] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ).
[274] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.
[275] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ).
[276] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ) para 59.

> 'For this they are to blame and they must, I believe, shoulder the responsibility that comes from failing properly to serve the interests of their clients.'[277]

Apart from the manner in which the legal practitioners dealt with the matter, the court was most aggrieved by the time it had taken to resolve the issues between the parties and the aggregate legal costs collected, which was as much as R750 000.00, in which the court referred to as a 'tragedy.' [278]

As previously discussed, emotions in medical malpractice disputes are often high between the parties and create barriers for the resolution of disputes. Fortunately, in *Brownlee v Brownlee,*[279] the court recognised the advantage of mediation and stated that mediation is apposite where the nature of a dispute has a gamut of emotions which act as complete barriers to settlement.[280]

Finally, although the court noted its displeasure towards the legal practitioners and ordered that the parties bear their own costs, taxed on a party and party scale, it is the view of this study that this was unfortunate. The circumstances in *Brownlee v Brownlee*[281] warranted a severe adverse costs order against the legal practitioners, much like was highlighted in *Halsey v Milton Keynes NHS Trust.*[282]

In the case of *Halsey v Milton Keynes NHS Trust*,[283] the court expressed that legal practitioners have a duty to routinely consider with their clients whether their disputes are suitable for ADR, failing which, such legal practitioners would be susceptible to a punitive adverse costs order in appropriate circumstances.[284] Therefore, it appears that both judgements partially align and the principles in both judgments should be embraced in South African law.

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[277] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ) par 59.
[278] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ) par 48.
[279] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ).
[280] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ) par 52 – 54.
[281] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ).
[282] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.
[283] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.
[284] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920 para 11.

4.5.1 Constitutional consideration

Naturally, court-annexed mediation or the suggested compulsion of mediation would be regarded as unconstitutional as it would be a restriction on litigants' rights to access the courts, and therefore a violation of s 34 of the Constitution.[285]

Section 34 of the Constitution reads as follows:

> '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.'[286]

Considering the Constitution and what was stated in the *Halsey case,*[287] wherein the court stated that:

> '[C]ompulsion of ADR would be regarded as an unacceptable constraint on the right of access to the court and, therefore, a violation of Art 6 of the European Convention on Human Rights.'[288]

It can thus be inferred that compulsory court-annexed mediation would infringe on the constitutional right of access to courts.

The finding is that this view cannot be accepted. This is as a result that an order for mediation does not necessarily interfere with the right of the parties to proceed to litigation. Where a settlement agreement is not reached at mediation, parties would still have an opportunity to access the courts. At most, court-annexed mediation merely delays accessing the courts in order to allow an opportunity for settlement, which is a very small price to pay.

[285] Constitution of the Republic of South Africa, 1996 s34.
[286] Constitution of the Republic of South Africa, 1996 s34.
[287] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.
[288] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920 para 9.

In any event, rights in the Constitution[289] can be limited in terms of s 36 of the Constitution[290] and therefore, the provision potentially allows for a limitation of the right to access the courts. It states that:

> '(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including-
> *(a)* the nature of the right;
> *(b)* the importance of the purpose of the limitation;
> *(c)* the nature and extent of the limitation;
> *(d)* the relation between the limitation and its purpose; and
> *(e)* less restrictive means to achieve the purpose.
> (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.'

This limitation of rights, particularly the right to access the courts was dealt with in the judgment in *Lesapo v North West Agricultural Bank and Another*[291] wherein the court agreed that certain rules or processes can limit the right of access to court, to the extent that the limitation is justifiable in terms of s 36 of the Constitution. [292]

Therefore, it is suggested that court-annexed mediation, which is perceived to limit the right of access to court, is a reasonable justification in achieving early and cost-effective settlement of medical malpractice disputes. Furthermore, the limitation cannot be unreasonable because parties would still have a further opportunity to take the dispute to litigation, should court-annexed mediation be unsuccessful.

[289] Constitution of the Republic of South Africa, 1996.
[290] Constitution of the Republic of South Africa, 1996.
[291] *Lesapo v North West Agricultural Bank and Another* 1999 (12) BCLR 1420 CC.
[292] *Lesapo v North West Agricultural Bank and Another* 1999 (12) BCLR 1420 CC, paras 22 & 29.

4.6 CONCLUSION

Mere procedural reform on its own is unlikely to address South Africa's litigation system in relation to medical malpractice litigation. However, the increase in the use and variety of ADR mechanisms will contribute positively towards addressing this issue. The view is to encourage parties to settle disputes at an early stage by adopting the ADR mechanisms. This chapter identified and set forth ADR mechanisms suitable in resolving medical malpractice disputes outside of the traditional litigation system and considered criterions associated with each ADR mechanism.

Although some of the ADR mechanisms may not be the ideal solution for all medical malpractice disputes, they should, nonetheless be embraced by all legal practitioners and disputants.[293] The echoing reminder of risk of adverse and punitive costs orders will undoubtedly encourage parties to consider the ADR mechanisms.

Based upon the current increase in medical malpractice litigation, the increase in the size of medical claims over the most recent years and the court's inability to handle the medical malpractice litigation load, court-annexed mediation system and pre-trial proceedings are likely to offer a litigation system that will be self-sufficient, consistent and cost effective.[294] In order to ensure that they yield success through effective implementation and regulation, government needs to provide financial and legislative support.

The implementation of various ADR mechanisms in addressing medical malpractice litigation in other jurisdictions has been exemplary. What follows is whether ADR mechanisms would be suitable to address medical malpractice litigation in South Africa. In order to investigate this possibility, it is necessary to assess the ADR mechanisms mentioned above and others in jurisdictions that have experienced similar challenges to South Africa. In this regard, the jurisdiction of Australia and the USA will be analysed in the next two chapters.

[293] See chapter 4.4.3.
[294] See chapter 4.4.1 and 4.4.2.

CHAPTER 5

ANALYSIS OF THE APPLICABLE ADR MECHANISMS IN AUSTRALIA

5.1 INTRODUCTION

The previous chapter discussed the traditional ADR mechanisms applicable to disputes, and identified the ADR mechanisms and accompanying principles to be applied specifically to medical malpractice disputes. The following chapter discusses the ADR mechanisms that have been developed and adopted over time in Australia to address medical malpractice disputes. A brief history of the development of ADR in Australia is first considered before discussing these ADR mechanisms.

The global widespread phenomena of increased medical malpractice litigation is nothing new and is certainly not a uniquely South African problem.[295] Australia has recognised that compulsory court-annexed mediation may be suitable in certain cases[296] and has thus, adopted statutory measures to deal with claims based on medical malpractice. Like South Africa, Australia has experienced a proliferation in medical malpractice litigation, size of medical malpractice claims and subscriptions, albeit during different periods.[297]

This chapter seeks to examine developments in Australia in relation to the promotion of ADR in medical malpractice claims. Furthermore, this chapter discusses mechanisms in Australia which have been implemented for the early and effective resolution of medical malpractice claims that can potentially be implemented in South Africa.

5.2 THE HISTORY OF ADR IN AUSTRALIA

Australia has experienced a range of ADR mechanisms for thousands of years.[298] It is only recently that there has been support by the judiciary, legal profession, healthcare providers, patients and healthcare practitioners for compulsory court-annexed mediation and other ADR

[295] Pepper M & Slabbert M 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 *SAJBL* 29.
[296] *Remuneration Planning Corp Pty Ltd v Fitton* [2001] NSWSC.
[297] Wallace E, Lowry J & Smith SM et al 'The epidemiology of malpractice claims in primary care: a systematic review' (2013) 3(7) *BMJ Journals* 1.
[298] Condliffe P *Conflict Management: A Practical Guide* 5ed (2016) 128.

schemes to address the increase in medical malpractice litigation, size of medical claims and surge in subscriptions. In order to comprehend the provisions regarding compulsory court-annexed mediation in the legislations, it is necessary to consider the history of Australian ADR.

As early as the 1980s, ADR projects were being piloted throughout Australia in the form of Community Justice Centres (CJCs) which were aimed at providing dispute resolution and conflict management services, training of mediators and the promotion of ADR.[299] Although these CJCs were first formed in New South Wales, they have expanded into Queensland and Victoria, albeit being state funded in Queensland.[300] The CJCs are inclusive of industrial, government and private centres which have developed ADR processes to encourage the settlement of disputes outside the courts and tribunals.[301] In 1987, the equivalent of the CJCs were introduced in Victoria and re-named, the Neighbourhood Mediation Centres.[302] The expansion of ADR extended to various categories of disputes, including farm[303] and retail lease disputes.[304]

In the 1990s, it was recognised that the traditional civil litigation contributed to a very expensive and very slow delivery of justice to parties.[305] This led to the creation of the National Alternative Dispute Resolution Advisory Council (NADRAC) which was aimed at promoting ADR. According Alexander, most disputes in Australia now are resolved before entry into the litigation system and most issues surrounding ADR have been explored and are

[299] Condliffe P *Conflict Management: A Practical Guide* 5ed (2016) 300; Faulkes W 'The Modern Development of Alternative Dispute Resolution in Australia' (1990) *Australian Dispute Resolution Journal* 61-8.
[300] King M, Freiberg A & Batagol B et al *Non-Adversarial Justice* (2009) New South Wales: The Federation Press; Faulkes W 'The Modern Development of Alternative Dispute Resolution in Australia' (1990) *Australian Dispute Resolution Journal* 61, 65.
[301] In 2001, NADRAC reported that there were at least 114 organisations in Australia involved in providing or formally referring parties to ADR. These include *inter alia* the Australian Commercial Disputes Centre (ACDC), the Australian Mediation Association (AMA), Chartered Institute of Arbitrators Australia, the Dispute Settlement Centre of Victoria (DSCV) and National Alternative Dispute Resolution Advisory Council (NADRAC). See Alexander NM 'Global Trends in Mediation' (2002) 13(10) *World Arbitration and Mediation Report* 274.
[302] Faulkes W 'The Modern Development of Alternative Dispute Resolution in Australia' (1990) *Australian Dispute Resolution Journal* 61, 65.
[303] Farm Debt Mediation Act, 1994 (NSW).
[304] Retail Leases Act, 2003 (Vic), s 87.
[305] Down C 'Crying Woolf? Reform of the Adversarial System in Australia' (1998) 7(4) *Journal of Judicial Administration* 213, 223.

a non-issue.[306] Having considered the history of ADR in Australia, the thesis will now consider in detail, Australia's position on the right of access to court.

5.3 CONSTITUTIONAL RIGHT OF ACCESS TO COURT IN AUSTRALIA

The constitutional right of access to court is not guaranteed in Australia.[307] It has been argued that the introduction of compulsory court-annexed mediation has made the right of access to courts less attainable to some in Australia.[308] Furthermore, there has been a number of successful compulsory mediation initiatives which have resulted in a strong foundation and motivation for support for it by courts and the legal profession, without challenge of this right. The federal system in Australia has created various ADR models in respect of legislative and court initiatives which vary from each state.[309] It appears that, through legislative and court initiatives, compulsory court-annexed mediation has had the impact of limiting the right of access to courts in Australia, whilst successfully resolving disputes between parties.

As is apparent from above, Australia has a federal system which means that the various legislative and court initiatives vary from state to state.[310] Australia has six states, namely New South Wales, Victoria, Queensland, South Australia, Western Australia and Tasmania, with each state having a lower court, the Magistrate's Court or local court, intermediate courts like the District Court or Country Court, and high court like the Supreme Court.[311] According to Sourdin, Victoria has one of the oldest and most developed court-annexed mediation processes in Australia.[312] The state of Victoria will be the centre of discussion in this section.

5.4 THE COURT SYSTEM AND COURT-ANNEXED MEDIATION IN THE STATE OF VICTORIA

The state of Victoria has three different levels of courts, and as a result, the development of compulsory court-annexed mediation in these courts has been introduced through various

[306] Alexander NM 'Global Trends in Mediation' (2002) 13(10) *World Arbitration and Mediation Report* 273.
[307] Commonwealth of Australia Constitution Act, 1900.
[308] Bathurst TF 'The Role of the Courts in the Changing Dispute Resolution Landscape' (2012) 35(3) *University of New South Wales Law Journal* 870.
[309] Ficks E 'Models of General Court-Connected Conciliation and Mediation for Commercial Disputes in Sweden, Australia and Japan' (2008) *Journal of Japanese Law* 137.
[310] Ficks E 'Models of General Court-Connected Conciliation and Mediation for Commercial Disputes in Sweden, Australia and Japan' (2008) *Journal of Japanese Law* 137.
[311] Ficks E 'Models of General Court-Connected Conciliation and Mediation for Commercial Disputes in Sweden, Australia and Japan' (2008) *Journal of Japanese Law* 137.
[312] Sourdin T *Alternative Dispute Resolution* 5ed (2016) 307.

legislations. Compulsory court-annexed mediation in the state of Victoria has been very successful and the consideration of the legislations empowering the different levels of the Victorian courts to order parties to mediate is explored in further detail below.

5.4.1 The Supreme Court of Victoria

The Supreme Court of Victoria, which is also known as the highest court in the state of Victoria is governed by the Supreme Court Rules 1996 (General Civil Procedure) of Victoria. Provision for compulsory court-annexed mediation is provided for in Rule 50.07 of the Supreme Court Rules 1996 (General Civil Procedure) of Victoria which reads that 'at any stage of a proceeding the court may, with or without the consent of any party, order that the proceeding or any part of the proceeding be referred to a mediator.'[313] The Supreme Court of Victoria has a significant success rate in mediated cases. In its annual report for 2005/2006, it reported a staggering 70 per cent of mediated cases having reached settlement.[314] This has led to parties to disputes and courts being relieved from the burden of having to endure trials.[315] It is contended that, this statistic speaks to the quality of the settlement agreements being entered into by the parties and the mutual satisfaction of the parties.

5.4.2 Country Court of Victoria

In the Country Court of Victoria, which is the second highest court in the state after the Supreme Court of Victoria, compulsory court-annexed mediation is regulated by the Country Court Civil Procedure Act of 2010[316] and the Country Court Civil Procedure Rules of 2008.[317] Much like Rule 50.07 of the Supreme Court Rules 1996 (General Civil Procedure) of Victoria, Rule 34A.21 of the Country Court Civil Procedure Rules of 2008, empowers the court to refer the whole dispute or part thereof to mediation with or without the consent of the parties. The procedure is set out in Rule 50.07.[318]

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[313] Supreme Court Rules 1996 (General Civil Procedure) of Victoria rule 50.07.
[314] Victorian Law Reform Commission *Civil Justice Review Report 14* (2008) 213.
[315] Victorian Law Reform Commission *Civil Justice Review Report 14* (2008) 213.
[316] Country Court Civil Procedure Act, 2010 s 47A.
[317] Country Court Civil Procedure Rules, 2008 rule 34A.21.
[318] The Country Court Civil Procedure Rules of 2008, Rule 50.07 states that, '(1) The power and discretion of the Court as to mediation under section 47A of the Act shall be exercised subject to and in accordance with this Rule. (2) An order for reference to mediation may be made at any stage of a proceeding. (3) Except so far as the Court otherwise orders, an order for reference to mediation shall not operate as a stay of the proceeding. (4) Where a reference is made under paragraph. (2) The mediator shall endeavour to assist the parties to reach a settlement of the proceeding or settlement of that part of the proceeding referred to the mediator. (5) The

5.4.3 Magistrates Court of Victoria

In the Magistrates Court of Victoria, the lowest court in the state of Victoria, compulsory court-annexed mediation is regulated by s 108 of the Magistrate's Court Act, 1989. Again, like the higher courts, the courts are empowered to refer the whole or any part of a dispute to mediation, with or without the consent of the parties.[319] Similar to the Supreme Court of Victoria, the success rate of settled disputes through mediation in the Magistrates' Court is significant. In its annual report of 2005/2006, it was reported that 70 per cent of the cases referred to mediation in the Magistrates Court of Victoria were finalised during mediation.[320]

Having regard to the above statistics, both the Magistrates Court and Supreme Court in Victoria have had great success with the implementation of compulsory court-annexed mediation, boasting a 70 per cent success rate of mediated cases. Therefore, it is clear that the impact of compulsory court-annexed mediation resolving disputes is significant and highly successful throughout the state of Victoria. It is averred that the reasons for this success can be attributed to the uniformity and certainty in the legislations,[321] it can also be attributed to the nature of the dispute and attitude of parties.[322] The next section deals with the events that led to the adoption of ADR in addressing medical malpractice litigation in Australia, as well as some of the legislations that have introduced compulsory and voluntary court-annexed mediation.

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mediator may and shall if so ordered report to the Court whether the mediation is finished. (6) The mediator shall not make any report to the Court other than a report under paragraph (5). (7) Except as all the parties who attend the mediation in writing agree, no evidence shall be admitted of anything said or done by any person at the mediation. (8) The agreement may be made at the mediation or later. (9) The Court may determine the remuneration of the mediator, and by what party or parties and in what proportion the remuneration is to be paid either in the first instance or finally. (10) The Court may order any party to give security for the remuneration of the mediator.'

[319] Magistrate's Court Act, 1989 s 108.

[320] Victorian Law Reform Commission *Civil Justice Review Report 14* (2008) 213.

[321] They all speak to the courts ability to refer disputes 'with or without' the consent of the parties to mediation.

[322] Bathurst TF 'The Role of the Courts in the Changing Dispute Resolution Landscape' (2012) 35(3) *University of New South Wales Law Journal* 876.

5.5 RESPONSE TO MEDICAL MALPRACTICE LITIGATION THROUGH IPP REFORMS

The pinnacle point to the rise in the adoption of ADR in the Australian medical legal system was experienced in the early 2000s as result of a medical insurance 'crisis' caused by the rise in frequency of medical malpractice claims and the hefty compensation payments.[323] It is appreciable that the medical insurance crisis could be identified as the source for the adoption of ADR in the medical arena in Australia. In response to the medical insurance crisis, the Australian Federal Government established and tasked the Review of the Law of Negligence Panel (Ipp Panel) in 2002 to investigate legal reforms to tort law and provide legal reform recommendations that would be consistent with the approach to tort reform.[324] The Ipp Panel commissioned the Review of the Law of Negligence Report (Ipp Report)[325] which led to reforms to each state's civil liability legislation.

Since the commissioning of the Ipp Report, Australian states have reacted to the crisis by introducing various legislative amendments in respect of civil liability legislations. In Victoria, the Wrongs Act, 1985 (Vic) has been amended to introduce a capping on general damages[326] and a restriction in the amount of compensation paid to victims of medical malpractice.[327] The amendments have also led to the creation of compulsory court-annexed mediation which has proven to be highly successful, reporting at 79.35 per cent of successfully mediated disputes through compulsory court-annexed mediation.[328] The amendments dealing with compulsory court-annexed mediation are discussed in further detail below..

5.5.1 Frameworks promoting Compulsory Court-annexed Mediation since the Ipp Report

As discussed previously, the Supreme Court Rules 1996 (General Civil Procedure) of Victoria empowers the court to order parties to participate in mediation without the consent of the

[323] McDonald B 'Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia' (2005) 27(3) *Sydney Law Review* 443.
[324] Australia Treasury *Review of the Law of Negligence Final Report* (2002).
[325] Australia Treasury *Review of the Law of Negligence Final Report* (2002).
[326] Wrongs Act, 1958 (Vic) s 28G.
[327] Wrongs Act, 1958 (Vic) s 72.
[328] Hilmer S.E'Mandatory mediation in Hong Kong: A workable solution based on Australian experiences' (2012) 1 *China-EU Law J* 68; Sourdin T and Balvin N 'Mediation in the Supreme and County Courts of Victoria: A Summary of the Results' (2009) 11(3) *Alternative Dispute Resolution Bulletin* 1, 2.

parties to the dispute, when considered appropriate.[329] Similar provisions exist and can be found throughout Australian legislation such as s 34 of Federal Magistrates Act, 1999, s 27 of the Civil Procedure Act, 2005 (NSW) and s 102 of the Supreme Court of Queensland Act, 1991. Although these provisions permit the courts to order parties to participate in mediation, the parties are not necessarily bound to agree to the terms of the settlement at mediation. Therefore, the parties can opt out of the mediation process at any time. It is contended that this links to the right of parties to proceed to trial at any stage of the mediation process.

In addition to the above argument, coercing parties to participate in a process that is ordinarily known for its voluntariness, autonomy and informal nature can stifle its true objective and give rise to various difficulties. In 2000, the Honourable Chief Justice of the Supreme Court of New South Wales, Justice Spigelman, referred to amendments in the legislations that allowed for court-annexed mediation without the consent of the parties.[330] Here, the Honourable Chief Justice Spigelman recognised the difficulty with compulsory court-annexed mediation and stated that:

> 'No doubt it is true to say that at least some people, perhaps many people compelled to mediate will not approach the process in a frame of mind likely to lead to a successful mediation. There is, however, a substantial body of opinion albeit not unanimous that some persons who do not agree to mediate, or who express a reluctance to do so, nevertheless participate in the process often leading to a successful resolution of the dispute.
>
> I am advised that in Victoria no difference in success rates or user satisfaction between compulsory and non-compulsory mediation has been noted. Not all research or anecdotal evidence is to this effect.' [331]

[329] Rule 50.07(1) of the Supreme Court Rules 1996 (General Civil Procedure) of Victoria reads that: 'At any stage of a proceeding the court may, with or without the consent of any party, order that the proceeding or any part of the proceeding be referred to a mediator.'
[330] Spigelman JJ 'Mediation and the Court' (2001) 39(2) *Law Society Journal* 63 – 66.
[331] Spigelman JJ 'Mediation and the Court' (2001) 39(2) *Law Society Journal* 63.

Therefore, despite scepticism, the difficulties associated with the compulsory court-annexed mediation provisions, and the Australian Constitution being silent on the right of access to court, courts appear to be of the view that parties still maintain autonomy and voluntariness throughout the mediation process. However, there is one exception to the court-annexed mediation provisions which is that, despite the courts view, parties can be subjected to adverse costs orders should they unreasonably refuse to consider mediation. Like in the case of *Halsey v Milton Keynes NHS Trust*[332] in the United Kingdom, provisions have been introduced in Australia where parties that unreasonably refuse to consider mediation or do not take appropriate steps to resolve their dispute before trial, open themselves to costs orders.[333] This begs the question of whether the compulsory court-annexed mediation provisions in Victoria are constitutional. In the absence of a right of access to court and a limitation of rights clause as found in the South African Constitution,[334] it can be argued that compulsory court-annexed mediation provisions are not unconstitutional in the framework of the Australian Constitution.

In the later years, significant amendments are still seen regarding the regulation of compulsory court-annexed mediation. In 2010, amendments were made to the Victorian Civil Procedure Act 2010 (Vic) which introduced the implementation of court-annexed mediation where presiding officers were empowered to order parties to participate in ADR processes to resolve disputes.[335] The provisions are silent on whether the presiding officer can order parties to ADR without their consent. Depending on interpretation, the presiding officer can facilitate compulsory court-annexed mediation without the parties' consent. In any event, the Victorian Civil Procedure Act 2010 (Vic) maintains that a dispute is unlikely to proceed to trial unless the parties first attempt mediation. The next section will consider legislation introducing voluntary court-annexed mediation.

[332] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.
[333] National Alternative Dispute Resolution Advisory Council *The Resolve to Resolve – Embracing ADR to Improve Access to Justice in the Federal Jurisdiction: A Report to the Attorney-General* (2009) 37.
[334] Constitution of the Republic of South Africa, 1996 s 36.
[335] Civil Procedure Act, 2010 (Vic) ss 7, 47 & 47(3)(d)(iii).

5.5.2 Frameworks promoting Voluntary Court-annexed Mediation since the Ipp Report

As mentioned above, there are various legislations which give rise to compulsory court-annexed mediation to address medical malpractice disputes in Australia. However, legislation has also been promulgated for the inclusion of voluntary court-annexed mediation. For example, the Medical List in the County Court of Victoria, established in terms of the County Court Civil Procedure Rules 2018 which hears proceedings claiming compensation for death or bodily injury as a result of negligent medical treatment or advice,[336] provides parties an opportunity to participate in mediation prior to trial.[337] Whilst the directives in the Medical List in the County Court of Victoria stipulate in clear terms that all proceedings in the Medical List must be subjected to mediation it does not mandate attendance by healthcare practitioners.[338] It appears that the Medical List in the County Court of Victoria potentially does not serve its purpose to encourage healthcare practitioners to attend mediations and their meaningful participation. This thesis holds the view that healthcare practitioners should attend and participate in mediations in order to learn from their clinical errors. As a means to address attendance of healthcare practitioners, practice directives should be passed to mandate their attendance.

5.6 ADR MECHANISMS ADOPTED TO DEAL WITH MEDICAL MALPRACTICE DISPUTES IN AUSTRALIA

It is outside the scope of this thesis to address all the reforms brought about by the Ipp as this section is limited specifically to compulsory court-annexed mediation. However, it has been found necessary to extend the scope to briefly discuss other forms of ADR which have been implemented in the State of Victoria to respond to the surge in medical malpractice disputes and subscriptions. These are early disclosure and apology legislations and pre-dispute mediation agreements.

[336] County Court Victoria *Practice Note: Common Law Division – Medical List No 1* of 24 July 2015.
[337] County Court Victoria *Practice Note: Common Law Division – Medical List No 1* of 24 July 2015 pn 66.
[338] County Court Victoria *Practice Note: Common Law Division – Medical List No 1* of 24 July 2015.

5.6.1 Early Disclosure and Apologies

All states in Australia have introduced early disclosure and apology legislations wherein disclosures and apologies associated with medical malpractice, enjoy statutory protection.[339] There is empirical evidence which shows that apologies in medical malpractice litigation cases can reduce litigation and promote the early resolution of disputes.[340]

An important aspect regarding early disclosure and apologies was found in the release of the Victorian Government's Access to Justice Review Report (the Review) in 2016.[341] The Review recognised that ADR was used throughout the State of Victoria by government entities, courts, independent statutory bodies, as well as practitioners from different backgrounds.[342] However, it recognised the reluctance towards apologies and highlighted that although some jurisdictions, such as New South Wales offer protection against admission of liability when an apology is made, meaning that an admission of liability made during an apology is not admissible in a court proceeding as evidence of fault or liability, the same could not be said for Victoria where the protection is limited only to cases of death or serious injury.[343] What this means is that, in the case of non-serious injuries, an apology which consists of an admission of liability does not enjoy statutory protection and could be used as evidence in future litigation.

This paper argues that the Wrongs Act 1958 (Vic) in Victoria ought to be amended to extend beyond death or serious injury, to ensure that apologies that are made outside these circumstances are protected and do not constitute an admission of liability. The probability of a patient that is not dead or seriously injured instituting a claim is very high, and it is necessary to takes steps to ensure that the early disclosure and apology arising from such claims enjoys statutory protection.

[339] This is regulated in the Civil Law (Wrongs) Act, 2002 (A.C.T.) ss 12 – 14; Civil Liability Act, 2002 (N.S.W.) ss 67 – 69; Civil Liability Act, 2002 (Tas.) ss 6 – 7 and the Civil Liability Act, 2002 (W.A.) ss 5A, F – H.
[340] British Columbia Ministry of the Attorney General *Discussion Paper on Apology Legislation* (2006) 2.
[341] Victoria State Government *Access to Justice Review Report and Recommendations* (2016).
[342] Victoria State Government *Access to Justice Review Report and Recommendations* (2016) 197.
[343] Wrongs Act, 1958 (Vic) s 14J.

5.6.2 Pre-Dispute ADR

Court-annexed mediation through pre-dispute processes is evident in Australia and at federal level, judges are empowered to refer proceedings to ADR.[344] Its evolution is prevalent in malpractice disputes through the introduction of the Supreme Court Fast Track Rules 2014 which requires parties to attempt to resolve their dispute through mediation or other appropriate steps prior to commencing litigation proceedings.[345]

Despite the legislative frameworks and guidelines that exist such as the Legal Profession Uniform Law Australian Solicitors Conduct Rules 2015 and the Civil Dispute Resolution Act 2011 (Cth), there is still some resistance towards pre-dispute mediation. The former requires that legal representatives inform clients about ADR[346] and the latter places a duty on legal representatives to advise and assist clients when filing a genuine steps statement, which indicates the genuine steps taken by a party to attempt to resolve a dispute[347] and the advantages associated with pre-dispute ADR. It has been found that contributory factors to the resistance include legal representatives serving their own needs instead of adopting mediation processes preferred by their clients in the Supreme and County Courts of Victoria.[348] Whilst it may be easy to blame legal representatives, other factors contributing to the resistance may include; the risk of parties incurring significant costs before a trial has commenced, lack of training and knowledge regarding mediation, and the possibility of increased disputes surrounding the pre-dispute mediation procedure.

Australia does not appear to have introduced pre-dispute mediation agreements. Pre-dispute mediation agreements are entered into where parties agree before receiving medical care to contractually bind themselves to first participate in mediation in an attempt to resolve any dispute arising from the medical relationship, before commencing legal proceedings.[349] The introduction of pre-dispute mediation agreements would aid the Medical List in the County Court of Victoria as they would address the non-existent practice directives in relation to

[344] Federal Court of Australia Court Act, 1976 (Cth) s 53A; Federal Court Rules 2011 (Cth) rule 28.01.
[345] Supreme Court Fast Track Rules 2014 rules 3 & 21.
[346] Legal Profession Uniform Law Australian Solicitors Conduct Rules 2015 rule 7.2.
[347] Civil Dispute Resolution Act, 2011 (Cth) ss 6 – 7.
[348] Sourdin T *Mediation in the Supreme Court and County Courts of Victoria* (2009) iv.
[349] Jenkins RC, Firestone G & Aasheim KL et al 'Mandatory Pre-Suit Mediation for Medical Malpractice: Eight-Year Results and Future Innovations' (2017) *Conflict Resolution Quarterly* 3.

mandating attendance at mediations in the Medical List in the County Court of Victoria. In sum, it can be argued that pre-mediation agreements would encourage participation in the mediation process as the process would fall outside the court's jurisdiction and parties would remain in control.

5.7 CONCLUSION

It has been shown that Australia has a strong history and foundation of ADR mechanisms that date back thousands of years. A focus of the State of Victoria revealed that there is great level of success of ADR mechanisms in Australia. It was argued that the Australian Constitution does not guarantee the right of access to court and this has allowed the federal government to create various ADR mechanisms, such as mediation, through legislative and court initiatives. Whilst there is no guarantee of the right of access to court, it was revealed that the adopted ADR mechanisms have a high success rate in resolving disputes and therefore, the right of access to justice, without trials, is still being realised.

Furthermore, it was noted that regardless of whether the ADR measures are mandatory or voluntary, they seem to be a positive contribution to encouraging efficient resolution of disputes. The various legislations and initiatives not only make provision for compulsory court-annexed mediation in medical malpractice disputes, but also provide for adverse cost orders against parties that unreasonably refuse to consider mediation. The next chapter will consider the USA. The USA also provides meaningful contribution to policy and practice in ADR and medical malpractice in its application of compulsory court-annexed mediation, and other ADR mechanisms. The application of these ADR mechanisms in the USA are discussed in the next chapter.

CHAPTER 6

ANALYSIS OF THE APPLICABLE ADR MECHANISMS IN THE USA

6.1 INTRODUCTION

The previous chapter discussed the ADR mechanisms adopted by Australia, particularly the State of Victoria in an attempt to address medical malpractice disputes. It considered the history of ADR and the events that led to its legal reform. Further, this chapter brought to the surface the criticisms endured by the Australian ADR reform. This following chapter will consider ADR mechanisms adopted in the USA to curb medical malpractice disputes. It is apparent that Australia and the USA have slight similarities and differences in the manner in which they have introduced ADR mechanisms to address medical malpractice disputes. These similarities and differences will be highlighted very briefly in the chapter.

Like Australia, the USA experienced a proliferation of medical malpractice disputes and surge in subscriptions in the mid-to-late twentieth century.[350] The direct cause remains unknown,[351] however, the consequence led to movements towards compulsory court-annexed mediation and other ADR reforms. The courts in the USA have taken a robust approach in ordering that ADR be considered despite resistance from parties.[352] This was further elaborated in *Re Atlantic Pipe Corporation*[353] where the court stated that:

> 'In some cases, a court may be warranted in believing that compulsory mediation could yield significant benefits even if one or more parties object. After all, a party may resist mediation simply out of unfamiliarity with the process or out of fear that a willingness to submit would be perceived as a lack of confidence in her legal position. In such an instance, the party's initial reservations are likely to evaporate as the mediation progresses, and negotiations could well produce a beneficial outcome, at reduced cost and greater speed, than would a trial. While the possibility that parties

[350] Mohr JC 'American Medical Malpractice Litigation in Historical perspective (2000) 283(13) *The Journal of the American Medical Association* 1731.
[351] The direct cause is unknown. See Mello MM, Studdert DM & Brennan TA 'The New Medical Malpractice Crisis' (2003) 348 *New England Journal of Medicine* 2281, 2282 – 2283.
[352] *Re Atlantic Pipe Corporation* 304 F.3d 135 (1st Cir.2002).
[353] *Re Atlantic Pipe Corporation* 304 F.3d 135 (1st Cir.2002).

will fail to reach agreement remains ever present, the boon of settlement can be worth the risk.'[354]

The USA's civil courts are not a palatable option in resolving medical malpractice disputes. Patients that decide to go to trial wait at least an average of 5 years and they have less than 10 per cent success rate.[355] As a consequence, early attempts of legal reform have provided patients with alternatives to the traditional civil litigation system. Before considering these alternatives, it is important to first consider the history of ADR in the USA.

6.2 THE HISTORY OF ADR IN THE USA

The ideology of mediation in the USA has always been its voluntariness and as such, most policies and practice directives have defined mediation as a voluntary process.[356] The clear paradigm shift in society has influenced a move toward an interest-based approach which has allowed for decision-making power to remain in the hands of the involved parties. However, the difficulties experienced in medical malpractice disputes, cost of litigation, delays, political climate and attitudes by the legal profession, judiciary and public have influenced the development of non-voluntary ADR mechanisms such as compulsory court-annexed mediation.[357]

What first followed in the USA was the enactment of the Administrative Dispute Resolution Act[358] in 1990 which required federal and state agencies to utilise ADR processes to handle their caseloads and resolve disputes.[359] In this regard, the main objective of the Administrative Dispute Resolution Act of 1990 was for federal and state agencies to ensure that they facilitate the internal training and appointment of personnel to use and implement ADR processes. In passing the Administrative Dispute Resolution Act,[360] Congress mandated that it expire in 1995 for review before permanent creations of federal and state ADR

[354] *Re Atlantic Pipe Corporation* 304 F.3d 135 (1st Cir.2002) para 144.
[355] Sohn DH & Bal SB 'Medical Malpractice Reform: The Role of Alternative Dispute Resolution' (2012) 470(5) *Clinical Orthopaedics and Related Research* 1370.
[356] Nolan-Haley J 'Mediation Exceptionally' (2009) 78(3) *Fordham Law Review* 1253.
[357] Hanks M 'Perspectives on Mandatory Mediation' (2012) 35(3) *University of New South Wales Law Journal* 929.
[358] Administrative Dispute Resolution Act, 1990.
[359] Stone KVW *Private Justice: The Law of Alternative Dispute Resolution* (2000) 5.
[360] Administrative Dispute Resolution Act, 1990.

agencies[361] and as a result, it was replaced by the Administrative Dispute Resolution Act of 1996 upon its expiration. It is submitted that the mandating of expiration of Administrative Dispute Resolution Act of 1990 was important because it was limited by the Freedom of Information Act[362] and therefore, did not emphasise on confidentiality which was later addressed with the enactment of the Administrative Dispute Resolution Act of 1996. Despite movements towards the development of ADR, compulsory court-annexed mediation did not feature in the Administrative Dispute Resolution Act of 1990 until the enactment of the Civil Justice Reform Act of 1990 (CJRA).

The first step to the promotion and legitimisation of compulsory mediation in the US was prompted by the Law and Public Policy Committee of the Society of Professionals in Dispute Resolution when it issued a report in the 1990s, stating that mandatory participation in non-binding dispute resolution processes was often appropriate.[363] Flowing from this, was the promulgation of the CJRA, which stated that each US District Court must consider referring appropriate cases to ADR programs, in an attempt to manage litigation, costs and delays. Over and above referring disputes to ADR programs, the CJRA encouraged federal district courts to also create these programs in order to implement compulsory ADR processes.[364] It is clear that the legislatures recognised the need to involve courts to regulate their own processes by empowering courts to facilitate and create ADR programs. Furthermore, it recognised that this was an advantage as courts would be able to regulate their processes based on its caseloads, experiences and needs.

Interestingly, under the CJRA programs, parties to a dispute were entitled to request a trial to start de novo after ADR.[365] It is argued that this provision creates a risk of delays as the probability of parties changing their cases having faced their strengths and weaknesses of their cases at mediation, albeit at an early stage in the context of a trial is high. Furthermore,

[361] Senger J 'Turning the Ship of State' (2000) *Journal of Dispute Resolution* 81.
[362] Senger J 'Turning the Ship of State' (2000) *Journal of Dispute Resolution* 81.
[363] Society of Professionals in Dispute Resolution 'Dispute Resolution as it Relates to the Courts: Mandated Participation and Settlement Coercion' (1991) 46(1) *Arbitration Journal* 38, 40.
[364] Holbrook JR & Gray LM 'Court-Annexed Alternative Dispute Resolution' (1995) 21 *Journal of Contemporary Law* 5.
[365] Bernstein L 'Understanding the Limits of Court-Connected ADR: A Critique of Federal Court-Annexed Arbitration Programs' (1993) 141(6) *University of Pennsylvania Law Review* 2182.

this provision does not create an environment where parties enter the mediation process in good faith with the view to reach settlement but will use the process as an opportunity to test the strengths and weaknesses of their cases and still end up in court once the 'farce' of court-annexed mediation has run its course. Therefore, it would appear that the ADR programs simply replicate what would be achieved at trial, except parties would have an option to pursue their case through trial should mediation fail. This thesis argues that this cannot be the objective of mediation.

As mentioned previously, the Administrative Dispute Resolution Act of 1990 was replaced with the Administrative Dispute Resolution Act of 1996[366] which, in principal, still focused on the objectives of the previous Act, in that it encouraged agencies to utilise their own employees, other employees in other agencies, private sector services and federal, state municipal and private organisations for the purpose of facilitating dispute resolution arrangements. The difference between these legislations is that the Administrative Dispute Resolution Act of 1996 placed greater emphasis on confidentiality by creating exemptions to the Freedom of Information Act. The enactment of the Administrative Dispute Resolution Act of 1996 mirrored the extraordinary transformations experienced in employment systems and educational systems by adopting policies promoting interest-based rather than rights-based approaches to discipline and justice.[367] As a result, the Administrative Dispute Resolution Act of 1996 has seen the creation of various ADR agencies such as the Agricultural Mediation Program, Equal Employment Opportunity Commission and the Environmental Protection Agency.

The impetus for ADR was further reinforced with the adoption of the Uniform Mediation Act[368] (UMA) by the National Conference of Commissioners on Uniform State Laws in 2001. It was approved and recommended with the aim of enactment by all the states in the USA for the purpose of regulating dispute resolution[369] and establishing the same regulations on

[366] Administrative Dispute Resolution Act, 1996.
[367] Mayer B *The dynamics of conflict: A Guide to Engagement and Intervention* 2 ed (2012).
[368] Uniform Mediation Act, 2001.
[369] Uniform Mediation Act, 2001.

mediation and uniformity of the provisions of the UMA among the various states.[370] Since its enactment in 2001, it regulates all states in the USA and provides uniform standards for conducting mediation in civil disputes. Other than being applicable in all states in the USA, the UMA is applicable to all types of mediations, except those relating to a collective bargaining[371] and proceedings conducted by judicial officers.[372] The component associated with mediation in terms of the UMA is confidentiality.[373] It is asserted that the purpose of this is to ensure that the communication is facilitated in an open environment to facilitate settlement.

Unlike the Wrongs Act 1958 (Vic), which offers limited statutory protection over disclosures and draws a distinction between the disclosures made in relation to serious injury and non-serious injury, the UMA does not have such limitation or distinction. The UMA makes provision for the protection of disclosure and admissibility of information and documentation referred to during mediation under the caucus of privilege.[374] This means that parties cannot use communication in discovery or admit it as evidence at trial and as such, parties may object or allow the disclosure of prejudicial information exchanged during mediation[375]. In the circumstances, the UMA is this thesis' preferred legislation for purposes of regulating disclosures and the admissibility of evidence obtained during mediation.

The components of confidentiality and privilege mentioned above are a far cry from what the Administrative Dispute Resolution Act of 1990 provided in respect of confidentiality. Furthermore, the UMA demonstrates the shifts made by the USA in the twenty first century since the proliferation of medical malpractice disputes in the mid-to-late twentieth century. As noted above, the development of ADR in the USA is similar to that of Australia and has been strong, with societal movements towards voluntary, non-voluntary mediation and now compulsory court-annexed mediation.

[370]Uniform Law Commission 'What is a Uniform Act?' available at *https://www.uniformlaws.org/acts/overview/uniformacts* (accessed 11 April 2019).
[371] Uniform Mediation Act, 2001 ss 3(b)(1) – (2).
[372] Uniform Mediation Act, 2001 s 3(b)(3).
[373] Uniform Mediation Act, 2001 s 8.
[374] Uniform Mediation Act, 2001 s 4(a).
[375] Uniform Mediation Act,2001 s 5.

6.3 ADR MECHANISMS ADOPTED TO DEAL WITH MEDICAL MALPRACTICE DISPUTES IN THE USA

Like Australia, the development of ADR in the USA has been further influenced by its federal system, which has introduced mechanism that differ from each state through legislative or court initiatives. These mechanisms include voluntary pre-dispute ADR, voluntary post-dispute ADR, compulsory court-annexed mediation and early disclosure and apology. These are discussed in further detail below.

6.3.1 Voluntary Pre-Dispute ADR

Unlike Australia, the inclusion of ADR provisions in contracts entered into by the contracting parties, namely, healthcare practitioners, patients and federal agencies is not a new phenomenon in the USA and according to de Ville, this was a common practice in the nineteenth century but by the 1840s, it was an uncommon practice.[376] Unlike the state of Victoria where the Medical List in the County Court of Victoria anticipates a situation where a party has already instituted a medical malpractice claim and may have become entrenched in his or her position, in the USA, pre-dispute ADR agreements are triggered prior to the institution of a medical malpractice claim. Therefore, it is not used at a stage where parties are to first be subjected to mediation before trial but even sooner, with the aim to regulate future medical malpractice disputes.

Although pre-dispute mediation agreements in the USA indicate significant developments in ADR, certain role players will always hamper the process due to their lack of knowledge or unwillingness of the medical process. For example, Welsh argues that there has been resistance in the USA by the judiciary, court administrators, clients and legal representatives, caused by the unfamiliarity in the mediation processes.[377] However, within this view, it is argued that the resistance extends beyond unfamiliarity as stated by Welsh and includes lack of trained, skilled and qualified mediators. It must be stressed that ADR in the medical arena is still a very new phenomenon and requires further development.

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[376] De Ville KA *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* (1990) 47.

[377] Welsh N 'The Thinning Vision of Self-Determination in Court-Connected Mediation: The Inevitable Price of Institutionalization?' (2001) 6 *Harvard Negotiation Law Review* 24.

Despite the unfamiliarity and difficulties experienced in adjudicating disputes that are regulated by a pre-dispute mediation agreement, pre-mediation agreements are increasingly being implemented by healthcare providers. For example, the University of Michigan, Johns Hopkins, Rush-Presbyterian Medical Center and the University of Pittsburgh Medical Center, have adopted a system of entering into pre-dispute mediation agreements with patients.[378] In addition, the Supreme Court in the USA has sanctioned mediations which are fostered by pre-dispute mediation agreements.[379] In sum, the benefits associated with pre-dispute mediation agreements, namely its private and social benefits outweigh the resistance by the judiciary, court administrators, clients and legal representatives as mentioned by Welsh. The pure nature of it being untainted by animosity that normally exists in trials, makes it appealing. Whilst pre-dispute mediation agreements attempt to regulate disputes prior to the institution of medical malpractice claims, a further ADR mechanism that attempts regulating disputes subsequent to the institution of a medical malpractice claim is discussed below.

6.3.2 Voluntary Post-Dispute ADR

In the absence of a pre-dispute mediation agreement, parties may agree to use mediation after a dispute and/or litigation has commenced. Unfortunately, this is a further development not found in Australia. Parties can participate in mediation mechanisms encouraged by the courts whilst pursuing their claims.[380] This is triggered by the Federal Rules of Civil Procedure[381] which empowers courts to encourage parties to consider ADR.[382] Seemingly, like pre-dispute mediation agreements, parties still have a choice to employ mediation when encouraged by the courts under the Federal Rule of Civil Procedure.

Unlike the various legislations in the State of Victoria which empower the courts to order parties to consider mediation with or without the parties' consent, the insistence of employing ADR in terms of the Federal Rule of Civil Procedure is limited as the parties to the dispute can choose whether or not to take advantage of the court's mediation service before going to trial. As discussed previously, a parties' decision making is often tainted by their self-

[378] Sohn DH & Bal SB 'Medical Malpractice Reform: The Role of Alternative Dispute Resolution' (2012) 470(5) *Clinical Orthopaedics and Related Research* 1373.
[379] *Gilmer v Interstate/Johnson Lane Corp*., 500 U.S. 20 (1991).
[380] Federal Rules of Civil Procedure (as amended 1 December 2018) rule 16.
[381] Federal Rules of Civil Procedure (as amended 1 December 2018).
[382] Federal Rules of Civil Procedure (as amended 1 December 2018) rule 16.

interest[383] and a party cannot be given expansive powers to choose to proceed to mediation. A different scenario is presented where parties are coerced to employ compulsory court-annexed mediation as considered below.

6.3.3 Compulsory Court-Annexed Mediation

The previous ADR processes highlighted above were indicative of voluntary mediation processes between parties, meaning that the parties are entitled to refuse to participate in the mediation process. However, like Australia, courts in the USA are now empowered to force parties to consider mediation under the influence of compulsory court-annexed mediation.[384] Legislatures in the USA have introduced compulsory court-annexed mediation provisions in legislations, empowering judges to utilise mediation to facilitate settlements between parties. It is noteworthy that, depending on the interpretation of Federal Rules of Civil Procedure Rule, judges can facilitate compulsory court-annexed settlements through negotiation, mediation, arbitration, summary jury trial or mini trials.[385] Similarly, this is a feature that also exists in legislation in Australia, as courts are empowered to refer disputes to other forms of ADR, which would include some of those found in the Federal Rules of Civil Procedure Rule.[386]

With the number of legislations introduced in the USA, compulsory court-annexed mediation is mandatory in many states, such as Wisconsin,[387] Washington,[388] Michigan[389] and North Carolina.[390] These states have introduced compulsory court-annexed mediation in respect of

[383] Botes M 'Mediation: A Perfect Solution to Health Care Disputes' (2015) 551 *De Rebus* 29.
[384] Federal Rules of Civil Procedure (as amended 1 December 2018) rule 16(a)(5). This rule reads that, 'in any action, the court may in its discretion direct the attorneys for the parties and any unrepresented parties to appear before it for a conference or conferences before trial for such purposes as: (1) expediting the disposition of the action... and; (5) facilitating the settlement.'
[385] Federal Rules of Civil Procedure (as amended 1 December 2018) rule 16.
[386] Supreme Court Rules 1996 (general Civil Procedure) of Victoria rules 50.07, 50.08.
[387] In terms of Wisconsin Statute and Annotation, s 655.44(5) states that, no court action may be commenced unless a request for mediation has been filed and until the expiration of the mediation period which is 90 days or within a longer period agreed to by the parties.
[388] In terms of the Revised Code of Washington, s 7.70.100 provides that, before trial, all healthcare claims shall be subject to mandatory court-annexed mediation.
[389] In terms of the Michigan Compiled Laws, s 600.4903 states that, disputes alleging medical malpractice shall be mediated and the judge assigned, or the chief judge shall refer the dispute to mediation and be heard by a mediation panel selected.
[390] In terms of the North Carolina General Statutes, s 7A – 38.1 requires that all superior court civil actions be referred to a system of court-annexed mediated settlement conference to facilitate settlements.

all medical malpractice disputes and healthcare claims. Unfortunately, compulsory court-annexed mediation has attracted criticisms in the USA. The argument made is that it coerces parties to participate in a process they have not chosen which hinders the components of mediation, namely, open communication, autonomy and voluntariness.[391] Notwithstanding this, and in support of the previous argument, it is reported that there is lower participation in voluntary mediation because parties remain in control of the process,[392] and are tainted by self-interest. Therefore, compulsory court-annexed mediation in the USA remains the ideal process to ensure that parties participate in mediation before trial.

Although compulsory court-annexed mediation can productively deal with medical malpractice disputes at an early stage, much like pre-dispute mediation agreements, the process cannot be expected to prevent medical malpractice disputes from reaching trial as there are various variables to take into account. Furthermore, it is this thesis' view that having legislation that allows for conflict management can cause more problems if not properly implemented. For example, Dauer and Becker argue that in the USA, healthcare managers, healthcare practitioners and judges are often tasked with mediating medical malpractice disputes.[393] The submission is that healthcare managers, healthcare practitioners and judges do not always possess the training and expertise necessary to facilitate mediation and therefore, the effective implementation or adjudication of compulsory court-annexed mediation cases can be stifled if the person tasked to mediate does not possess the necessary skills.

In addition to the above arguments, the role of legal representatives is also significant in influencing the nature of compulsory court-annexed mediation. A study done in private hospitals in the USA found that plaintiff legal representatives were more willing to mediate than the defendant legal representatives.[394] This could be attributed to the attitudes of the

[391] Shaw D 'Mediation Certification: An Analysis of the Aspects of Mediator Certification and an Outlook on the Trend of Formulating Qualifications for Mediators (1998) 29(2) *University of Toledo Law Review* 338.
[392] Shaw D 'Mediation Certification: An Analysis of the Aspects of Mediator Certification and an Outlook on the Trend of Formulating Qualifications for Mediators (1998) 29(2) *University of Toledo Law Review* 338.
[393] Dauer EA & Becker DW 'Conflict Management in Managed Care' in Dauer EA, Kovach KK & Liang BA, et al (eds) *Health Care Dispute Resolution Manual: Techniques for Avoiding Litigation* (2000) 35.
[394] Hyman CS, Liebman CB & Schechter CB et al 'Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?' 35(5) (2010) *Journal of Health Politics, Policy and Law* 804 – 805.

legal representatives differing in that, the plaintiff legal representative seeks only to reach settlement in favour of their clients as early as possible without delays and without incurring unnecessary legal costs. Therefore, in sum, an appropriate balance is required to effectively implement compulsory court-annexed mediation by ensuring that there are skilled and trained mediators, legal representatives and judges and the attitudes of legal representatives are heeded to counter the different variables. An example of an ideal process with less variables is an early disclosure and apology system.

6.3.4 Early Disclosure and Apology

Like Australia, early disclosure and apology legislations have also been introduced in the USA. According to Sohn and Bal, there are thirty-five states in the USA that have passed early disclosure and apology legislations allowing healthcare practitioners to make confidential and inadmissible apologies.[395] Unfortunately, a detailed review of each state's apology statute is beyond the scope of this thesis.

Similar to Australia, these early disclosure and apology legislations differ from state to state, in that in other states, the disclosure of liability is not protected, while in others, both the disclosure of liability and apology is protected. For example, in Colorado, both the apology as well as any admission of liability is protected whilst in Indiana, only the apology is protected.[396] The legislation enacted in Colorado is ideal because it facilitates a bona fide apology in which the healthcare practitioner finds security in his or her disclosure, knowing that there is guaranteed protection of his or her disclosure. Furthermore, a protected disclosure and apology is likely to be accompanied with elements of vulnerability and sincerity, which makes the legislation in Colorado appealing.

A pilot study in New York in 2004 in which the participants' mediation satisfaction was measured, revealed that the facilitation of an apology had an important advantage in mediation wherein settlement occurred 2.42 times more frequently when an apology was

[395] Sohn DH & Bal SB 'Medical Malpractice Reform: The Role of Alternative Dispute Resolution' (2012) 470(5) *Clinical Orthopaedics and Related Research* 1372.
[396] Sohn DH & Bal SB 'Medical Malpractice Reform: The Role of Alternative Dispute Resolution' (2012) 470(5) *Clinical Orthopaedics and Related Research* 1372.

offered.[397] Although this statistic is good, in reality, nothing would prevent an aggrieved patient from proceeding to institute a claim after an apology. For example, after the University of Illinois had implemented an early disclosure and apology system, it saw a reduction of malpractice filings by 50 per cent and of the 37 medical malpractice cases where the hospital acknowledged their fault and apologised, there was still one patient that instituted a claim.[398] Aside from this, the progress made in implementing early disclosure and apology systems in the USA remain significant and there is clearly a strong association between apologies and settlements in medical malpractice disputes.

6.4 CONCLUSION

This chapter discussed the history of the adoption of various ADR mechanisms in the USA. A comparative review was explored to offer insight into the various ADR disciplines practised in the USA which can potentially be implemented in South Africa. Although there are problems associated in relation to court-annexed mediation and early disclosure and apology, it is clear that, if properly regulated, they should be the ideal mechanisms adopted by South Africa in order to facilitate dispute resolution processes effectively. Furthermore, these mechanisms are less adversarial, which better accommodate the economic and cultural realities in South Africa.

It has been argued that courts have a duty to ensure that ADR is integrated into the traditional litigation system by encouraging patients and healthcare practitioners to consider ADR where appropriate. It is further reiterated that the courts should be granted wide powers in medical malpractice disputes, mero motu or at the request of either party, to order parties to consider resolving the dispute through an ADR mechanism.

Whilst Australia and the USA differ from each other, the differences suggest that it is important for South Africa to develop and implement realistic mechanisms to address the increase in medical malpractice litigation, the size of medical claims and surge in subscriptions. Comparably, the USA and Australia suggest the importance of ADR to redress

[397] Hyman CS & Schechter CB 'Mediating Medical Malpractice Lawsuits Against Hospitals: New York City's Pilot Project (2006) 25(5) *Health Affairs* 1394.
[398] Sack K 'Doctors say 'I'm Sorry' before 'See You in Court'' *The New York Times* 18 May 2008.

medical malpractice disputes and have introduced ADR processes that depart from traditional civil litigation. Both countries have ideal processes that are suitable to accommodate South Africa. It is this thesis' view that neither country is a superior alternative to the other.

This thesis recognises that South Africa is certainly not a developed country and does not propose that South Africa impose mechanisms or values derived from developed countries blindly. Nevertheless, motivation can be drawn from Australia's and the USA's approaches that South Africa is ripe to embrace legal reform from other jurisdictions. The next chapter will conclude this thesis and provide recommendations.

CHAPTER 7

CONCLUSION

7.1 INTRODUCTION

As has been discussed in this mini-thesis, evidence suggests that medical malpractice claims are being instituted more frequently in South Africa and the costs related to this have consequently increased.[399] This has been referred to as a healthcare crisis.[400] One of the consequences is the impact it has on the future availability of healthcare specialists.[401]

The purpose of this mini-thesis was to explore the use of ADR mechanisms, particularly compulsory court-annexed mediation as an approach to address the crisis.[402] It should be noted that the period and data considered in this mini-thesis was limited to the information available at the time. Tables of medical malpractice claims instituted against provincial public healthcare departments were used to illustrate the monies paid as compensation. The table focused on the period between 2011 and 2015, and showed that the state has no money and is possibly in dire financial constraints, with excessive claims that it cannot pay out.[403]

One of the main features seen in the crisis is the existing lack of basic service delivery and the socio-economic inequalities within present South African society.[404] Within the category of previously disadvantaged people, it is the poor living in rural areas that are the most significantly affected. It was discovered that there is a severe divide in respect of service delivery by the South African government between affluent provinces and previously disadvantaged provinces. As a result, this threatens the right of access to health care services and the recognition of this right. The concept of minimum core obligation, an international standard which requires, at the very least, a satisfaction of minimum essential levels of the

[399] See chapter 2.1, 2.2 and 2.3.
[400] Discussed in 1 above.
[401] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018). Also discussed in 2.3.2 above.
[402] See chapter 1.5 and 1.6.
[403] See chapter 2.1, 2.2, 2.3 and 2.4.
[404] See chapter 2.

right of access to health care[405] was introduced to emphasise governments' obligations in addressing the crisis. In this respect, the Constitutional Court in *Grootboom*[406] has expanded upon this concept, arguing that the government needs to address the predicament of those individuals deprived and in desperate need, as a priority.[407] It was therefore argued that the government has a minimum core obligation to address the socio-economic inequalities in the previously disadvantaged provinces which contribute to the increase in medical malpractice.

Theoretically, the existing legal frameworks are adequate and efficient to address medical malpractice, however in reality, there are a number of problems. It was found that the South African Constitution empowers courts to have regard to international law when interpreting and/or applying the Bill of Rights.[408] In this respect, the contention was that South Africa has the ability to adopt international law and introduce legal reforms that introduce ADR enabling legislation in medical malpractice. Therefore, this mini-thesis explored ADR mechanisms, and observed Australia and the USA as the level of analysis, adopting their experiences of medical malpractice litigation in engaging ADR mechanisms, legislation lessons and best practices implemented by both countries.

Like Australia and the USA, the threat of litigation and increased subscriptions paid by healthcare practitioners in South Africa is driving specialist healthcare practitioners, such as obstetricians, out of practice, further compounding to the existing problems. It was established that not all healthcare practitioners can afford to pay their subscriptions and thus are not able to provide certain healthcare services.[409]

It was held that the public healthcare departments' budgets are severely strained and the large pay-outs affect their ability to progressively realise the right of access to health care services.[410] Currently, there is no separate budget for medical legal claims instituted against

[405] United Nations Committee on Economic, Social and Cultural Rights *General Comment 3(10): The Nature of States Parties' Obligations* (1990) E/1991/23 Art. 2, para 1 of the Covenant.
[406] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC).
[407] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) para 29.
[408] Constitution of the Republic of South Africa, 1996 s39.
[409] See chapter 2.3.2.
[410] See chapter 2, and 2.4.

public health departments by patients[411] and this anomaly affects the delivery of healthcare services and South Africa's already severely burdened healthcare system.[412]

As a result, the position was that the current traditional adversarial litigation system in respect of medical malpractice should be reconsidered. The realisation is that the current medical malpractice system is not adequate and efficient, and, in this regard, it is recommended that ADR be considered. In this respect, there has been a call for legal reform in medical malpractice litigation.[413] The further position was that in response to this, ADR mechanisms, particularly court-annexed mediation needs to be implemented.

The authority mostly referred to in respect of compulsory court-annexed mediation is found in the decision by the appeal court in the case of *Halsey v Milton Keynes General NHS Trust*.[414] This court case was important because the question as to whether a costs order against a party who unreasonably refuses to participate in ADR is justified, albeit being a successful party, was answered. A clear principle derived from this case is that both parties and even legal practitioners open themselves to potential adverse costs orders for failing to participate in, recommend or discuss ADR. This case aligned itself with the principles highlighted in the case of *Brownlee v Brownlee,*[415] where the court expressed displeasure towards the legal representatives for their failures in consulting their clients on the benefits of mediation.[416]

Finally, it was put forward that court-annexed mediation cannot be regarded as unconstitutional, and does not restrict litigants' constitutional rights to access the courts.[417] In this regard, it was revealed that the safety net is found in s 36 of the Constitution which potentially allows for a limitation of the right to access the courts.[418] Therefore, the limitation

[411] Claassen N 'Mediation as an alternative solution to medical malpractice court claims' (2016) 9 *SAJBL* 7.
[412] South African Law Reform Commission Issue Paper 33 (Project 141) *Medico-legal claims* (2017) 15.
[413] Medico Legal Task Team 'Medico declaration - National Department of Health' available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?download=1392:medicodeclartion* (accessed 21 March 2018).
[414] *Halsey v Milton Keynes NHS Trust* [2004] 4 All ER 920.
[415] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ).
[416] *Brownlee v Brownlee* 2010 (3) SA 220 (GSJ) para 48.
[417] Constitution of the Republic of South Africa, 1996 s34.
[418] Constitution of the Republic of South Africa, 1996 s36.

of the right of access to court is a reasonable justification for the purpose of achieving early and cost-effective settlement of medical malpractice disputes.

Despite the criticisms and reluctance towards the implementation of compulsory court-annexed mediation, it was shown that compulsory court-annexed mediation has been successfully introduced and welcomed in Australia and the USA.[419] Both countries have significantly aided in eradicating the shortcomings previously experienced in their civil justice systems.[420] Therefore, the implementation of ADR will significantly contribute to addressing medical malpractice litigation and also promote the right of access to courts, as well as maintaining other rights such as the right of access to health care services .

7.2 RECOMMENDATIONS

This mini-thesis proposes ADR mechanisms, such as compulsory court-annexed mediation, early disclosure and apology and pre-dispute mediation agreements to facilitate approaches to reduce medical malpractice litigation with the view of ensuring that medical malpractice disputes do not escalate into court cases. These mechanisms have been successfully used in Australia and the USA to tackle medical malpractice.[421] It is advanced that the legislature, judiciary and legal profession in South Africa needs to transform the legal environment. It was found that compulsory court-annexed mediation has a high success rate in mediated cases having reached settlement.[422]

7.2.1 Compulsory court-annexed mediation

This mini-thesis recommends that compulsory court-annexed mediation be introduced in the Uniform Rules of Court[423] and each court divisions' practice directives. The reforms in Australia and the USA indicate that courts are increasingly encouraged to facilitate the participation of mediation. In order to facilitate this, mediation should not be recommended but be required prior to the institution of legal proceedings. Where parties unreasonably

[419] See chapter 5.5.1 and 6.3.3.
[420] See chapter 5 and 6 .
[421] See chapter 5.5 and 6.3.
[422] See chapter 5.4.1.
[423] Uniform Rules of Court: Rules Regulating the Conduct of the Proceedings of the Several Provincial and Local Divisions of the High Court of South Africa in GN R181 GG 15464 of 1 March 1994.

refuse to participate in mediation, adverse costs orders should be made against the refusing party. Undoubtedly, there will be a burden for the other party to show that mediation was appropriate in the circumstances and show that, but for the other party refusing mediation, both parties could have saved costs and time in resolving the dispute. As discussed, Australia and the USA[424] may be appropriate jurisdictions in the enactment of compulsory court-annexed mediation and therefore, should compulsory court-annexed mediation be implemented into legislation, lessons may be drawn from these countries.

Based on the lessons identified in this mini-thesis, the enabling legislation on compulsory court-annexed mediation should not be implemented in a vacuum. It should take into account that healthcare managers, healthcare practitioners and judges need to be trained and equipped with the necessary skills to facilitate mediation.[425]

7.2.2 Early disclosure and apology

It is also recommended that legislation that governs early disclosures and apologies in medical malpractice cases should be introduced. The aim of this legislation would be to facilitate disclosure and apology exchanges by the healthcare practitioner to the patient in an attempt to discuss the conflict at an early stage and seek to achieve a resolution prior to the institution of a medical claim. This has the potential to mitigate emotion and anger by providing a haven for parties to disclose matters fully without the fear that such disclosure or apology could potentially be used as an admission of liability at future legal proceedings.[426] Based on the lessons identified in this mini-thesis, it is further recommended that early disclosure and apology legislation should protect both disclosures and apologies, irrespective of the severity of the medical malpractice.

7.2.3 Pre-dispute mediation agreements

It is recommended that healthcare providers, healthcare practitioners and patients insist on concluding pre-dispute mediation agreements prior to providing and receiving medical

[424] See chapter 5.5.1 and 6.3.3.
[425] See chapter 6.3.1 and 6.3.3.
[426] Sohn DH & Bal SB 'Medical Malpractice Reform: The Role of Alternative Dispute Resolution' (2012) 470(5) *Clinical Orthopaedics and Related Research* 1372.

treatment. The attempt is to secure early negotiations between the healthcare provider, healthcare practitioner and the patient, without the involvement of legal practitioners. The prospect of concluding such agreements before treatment has garnered attention in developing countries, as well as organisations such as SASOG.[427] In this respect, a patient agrees to sign an agreement before receiving treatment which facilitates the participation in ADR before the institution of any future legal proceedings.

7.3 FINAL REMARKS

The need for clear ADR mechanisms to address the increase in medical malpractice litigation, size of medical malpractice claims and surge in subscriptions has led to this mini-thesis. The focus of this mini-thesis was the shortcomings of South Africa's current legal frameworks and the efforts by other countries to address the increase in medical malpractice litigation. It is against this background that this mini-thesis proposes the use of ADR in order to action an address on medical malpractice litigation in South Africa.

It is recommended that the current medical malpractice litigation system be reconsidered, and scrutinised and better reliable data be collected in respect of the medical malpractice claims filed in both the private and public healthcare sector, the cause for the increase, the costs involved in litigation, difficulties surrounding compensation payments and the period it takes to resolve medical malpractice cases. In this regard, policy decisions need to take place on the available research in order for government to implement the necessary reforms to meet the objectives of the constitutional and international instruments in relation to healthcare in South Africa. Joint commitment of the legislature, judiciary, legal profession and the public, in general, is necessary to ensure the success of ADR, particularly court-annexed mediation being implemented in South Africa.

[32 161 words]

[427] Van Waart J 'SASOG Better Obs Newsletter' (August 2017) *SASOG;* Van Waart J 'SASOG Better Obs Newsletter' (October 2017) *SASOG.*

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