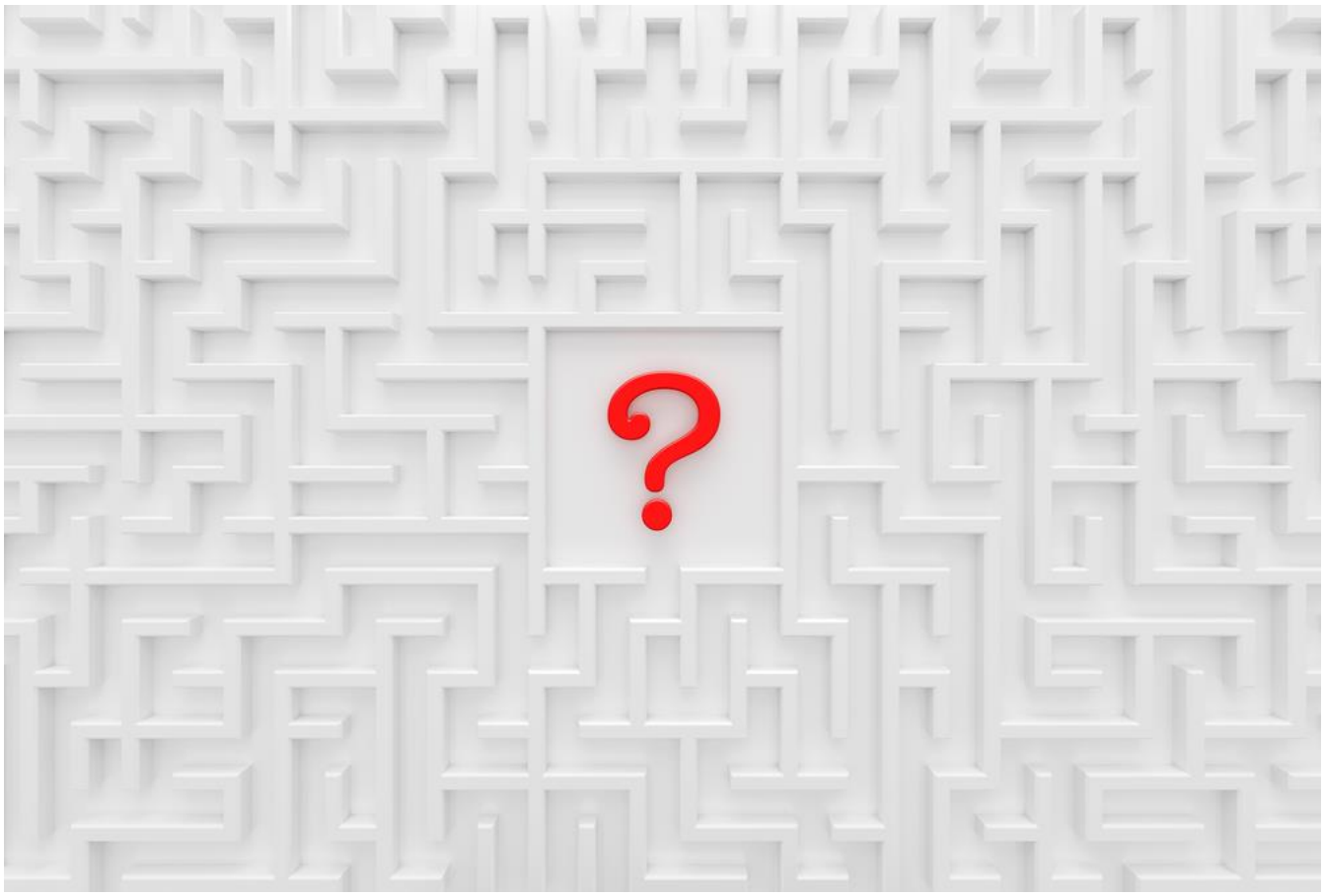

THE PUBLIC HEALTH MEDICAL NEGLIGENCE CLAIMS CONUNDRUM

Abstract

A comprehensive analysis of the problem of medical negligence claims in the public sector and a discussion of proposed solutions to address the issue. It is one which has rapidly escalated to crisis proportions and needs to be addressed.

Prof. Hennie Klopper

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1. Introduction

From 1991 medical negligence claims in South Africa have been steadily increasing in both numbers and damages recovered.[1] Since 2010 medical negligence claims, especially against the public sector, have rapidly escalated and have become a burning issue. Crisis proportions have been reached where the public health sector budget has come under severe pressure because of ever-increasing numbers of claims for medical negligence and the consequential enormous financial burden. The Government's contingency liability for medical negligence claims in 2021 tops R100 billion.[2] The financial crisis this liability represents, becomes clear if the 2020/21 Public Health budget of R249 billion is considered.[3] The government's liability for public healthcare adverse events is based on vicarious liability.[4]

2. Causes

Research suggests that the increase in medical negligence claims may be ascribed to diverse reasons:

- Shortages of medical health practitioners in especially the public health sector, and inadequate funding.[5]
- Poor management, lack of accountability and bad record keeping.[6]
- Healthcare Associated Infections.[7]
- Greater actualisation of constitutional rights resulting in increased access to information, transparency, and accountability through newly enacted legislation.[8]
- As far as the typical conduct and negligence in medical negligence claims is concerned, the following can be identified:
    - Failure to diagnose a patient's medical condition and failure to follow medical protocols.
    - Patient injury during treatment, often resulting in disability or death.
    - Failure to treat a patient's condition.
    - Misreading or ignoring laboratory results.
    - Unnecessary surgery.
    - Surgical errors or wrong site surgery.
    - Improper medication or dosage.
    - Poor follow-up or aftercare.
    - Premature discharge.
    - Disregarding or not taking in to account appropriate patient history.
    - Failure to order proper testing.

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

[2] Spotlight "In-depth: This is how health departments (mis)spend public funds" at *https://www.spotlightnsp.co.za/2021/04/19/in-depth-this-is-how-health-departments-misspend-public-funds/*.

[3] BUDGET 2021 - National Treasury *http://www.treasury.gov.za › 2021 › review › FullBR* PDF

[4] For the requirements for this liability see: Neethling, J., "State (Public Authority) Liability Ex Delicto (2)" (May 5, 2013). Journal of Contemporary Roman-Dutch Law, Vol. 76, p. 115-131, 2013, Available at SSRN: https://ssrn.com/abstract=2363904 .

[5] LC Coetzee & PA Carstens "Medical Malpractice and Compensation in South Africa" *Chicago-Kent Law Review* 2011 Volume 86:3 1299; National Department of Health (NDoH). *2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage. Pretoria:* Government Printers, 2020 at *https://www.spotlightnsp.co.za › uploads › 2020/08* PDF.

[6] Coetzee and Carstens 1300

[7] Dramowski, A. & Whitelaw, A., 2017, 'A framework for preventing healthcare-associated infection in neonates and children in South Africa', *South African Medical Journal* 107, 192–195. *https://doi.org/10.7196/SAMJ.2017.v107i3.12035*

[8] Coetzee and Carsten 1301.

- Failure to recognize symptoms.[9]

2.1 Shortages in medical personnel, hospital beds, medical equipment, and inadequate funding

Personnel

One of the primary reasons for negligence in the health sector may be the circumstances under which medical health professionals are required to render medical services. It was reported by the Health Professions Council of South Africa (HPCSA) in 2012 that there were 165,371 qualified health practitioners in South Africa. Of these, 38,236 were doctors.[10] In the public health sector one doctor treated 4 219 patients and a private doctor saw 243 patients. When these facts are considered, the probable reason for the 80/20 split between public and private in medical negligence claims becomes a bit clearer. The South African Health Review (SAHR) periodically undertakes a review of doctor/patient ratios. In 2016 there were 14 036 general practitioners and 4 737 specialists. The public health care patient numbers were based on 2016 data and calculated by subtracting the number of persons who had medical aid. About 16% of the population have medical aid which currently translates to 10,3 million people.

This means that the potential public health patient pool is about 49 million people. Using this factor, the doctor/patient ratio stands at 40,7 medical practitioners per 100 000 population or in the public health sector, one doctor for 2 457 people.[11] A more recent (2019) survey sets the number of public sector doctors at 14 046 and specialists at 4 827. This is 13,3 doctors and 6,6 specialists per 100 000 population. The recommended WHO ratio is 1 doctor per 1 000 population.[12] The figure for professional nursing staff is 147,95, enrolled nurses 12,7 and nursing assistants 13,9 per 100 000.[13] The following table[14] shows that South Africa is at the bottom of the OECD pile as far as doctor/population ratio is concerned:

[9] Fierce Healthcare "The top 5 reasons for malpractice suits against doctors" at https://www.fiercehealthcare.com/practices/top-five-reasons-for-malpractice-lawsuits-against-docs. And American Board of Professional Liability Attorneys at https://www.abpla.org/what-is-malpractice. Errors cause at least one death every day and injure roughly 1.3 million people each year in the United States alone. There is a scarcity of South African data on medical negligence (see Coetzee and Carstens 1295-1299) to show the prevailing negligent medical conduct which causes most claims. The only inkling of these causes in South Africa is found in a newspaper report dealing with private medical negligence claims where the causes are listed as: "botched cosmetic surgery, children born with brain damage, birth defects not diagnosed timeously, and Caesarean sections not done when needed." See Subashni Naidoo, *Thousands of Doctors 'Negligent,'* SUNDAY TIMES, June 6, 2010, http://www.timeslive.co.za/sundaytimes/article489475.ece/Thousands-of-doctors-negligent. No similar information exists in the public sector even though 80% of claims originate here. See Edwin Naidu, *Botched Operations Blight SA,* THE SUNDAY INDEPENDENT, May 2, 2010, http://www.iol.co.za/news/south-africa/botched-operations-blight-sa-1.482422.

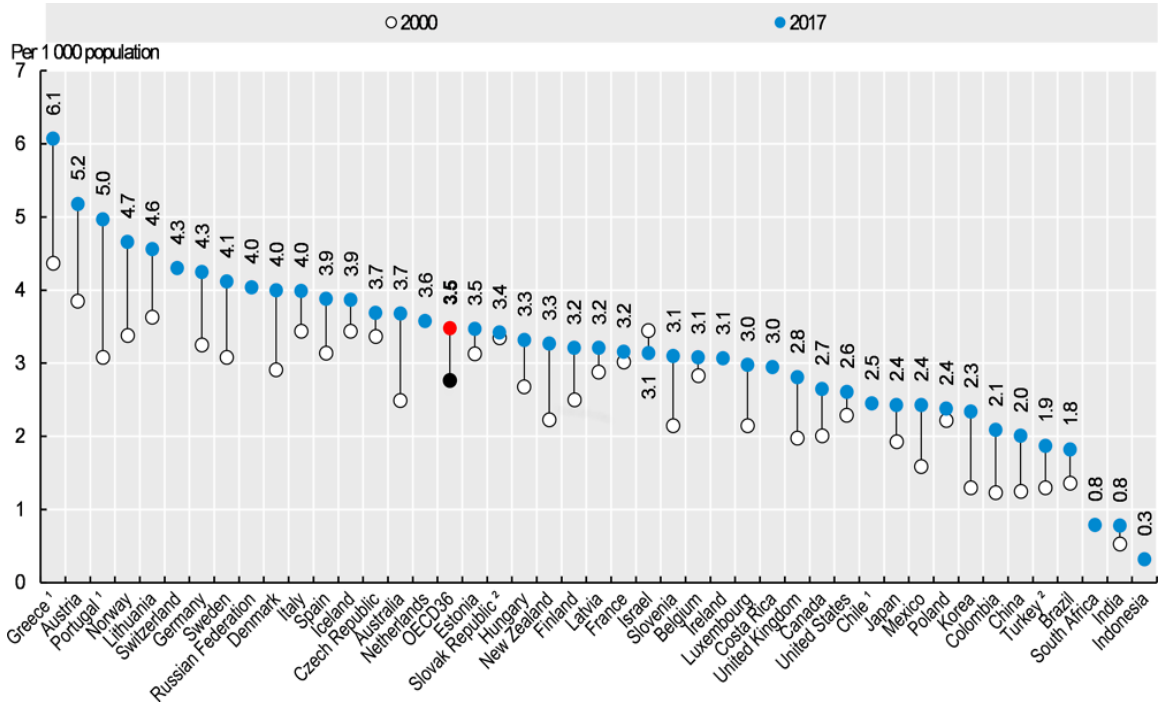
[10] Medical Brief August 2018 "Africa Check puts together the numbers on doctor-patient ratios" at https://www.medicalbrief.co.za/archives/africa-check-puts-together-numbers-doctor-patient-ratios/.

[11] Idem.

[12] Kumar "India achieves WHO recommended doctor population ratio: A call for paradigm shift in public health discourse" *J Family Med Prim Care*. 2018 Sep-Oct; 7(5): 841–844.

[13] Spotlight September 2020 "Government strategy shows billions needed to avert healthcare worker crisis" at https://www.spotlightnsp.co.za/2020/09/01/government-strategy-shows-billions-needed-to-avert-healthcare-worker-crisis/.

[14] Organisation for Economic Co-operation and Development Library: Health at a Glance 2019 : OECD Indicators at https://www.oecd-ilibrary.org/sites/b33ab4c1-en/index.html?itemId=/content/component/b33ab4c1-en.



The dismal picture regarding the number of health professionals and doctors in relation to the population in the public health sector paints, translates into a very heavy workload because of vacancies, an increase in the number of patients treated, and lack of resources. Exhaustion is common, junior doctors are forced to work without supervision and there is serious neglect in terms of nursing care. These conditions are the contributory causes of medical negligence claims in the public sector.[15]

Hospital beds and medical equipment

Apart from the human resource question there is also a scarcity of hospitals and equipment. Hospital beds per 1 000 of population provides a measure of the resources available for delivering services to inpatients in hospitals in terms of number of beds that are maintained, staffed and immediately available for use. There are 119 155 hospital beds in South Africa of which 85 362 are in the public sector.[16] The ratio of beds to population is 2.32 per 1 000.[17] The WHO recommendation is 5 per 1 000.[18]

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[15] Statement of chairman of SAMA as reported by Naidu *op cit* at http://www.iol.co.za/news/south-africa/botched-operations-blight-sa-1.482422. See Thomas LS, Valli A. "Levels of occupational stress in doctors working in a South African public-sector hospital." *S Afr Med J.* 2006 Nov;96(11):1162-8. PMID: 17167700; Govender "Stress among medical doctors working in public hospitals of the Ngaka Modiri Molema district (Mafikeng health region), North West province", *South Africa South African Journal of Psychiatry* Vol 18, no 1 (2012); Naidoo T, Tomita A, Paruk S (2020) "Burnout, anxiety and depression risk in medical doctors working in KwaZulu-Natal Province, South Africa: Evidence from a multi-site study of resource-constrained government hospitals in a generalised HIV epidemic setting." PLoS ONE 15(10): e0239753. https://doi.org/10.1371/journal.pone.0239753 accessible at *https://journals.plos.org › plosone › article › file PDF;* Liebenberg AR, Coetzee Jnr JF, Conradie HH, Coetzee JF. 'Burnout among rural hospital doctors in the Western Cape: Comparison with previous South African studies'. *Afr J Prim Health Care Fam Med.* 2018 May 24;10(1):e1-e7. doi: 10.4102/phcfm.v10i1.1568. PMID: 29943596 accessible at *https://pubmed.ncbi.nlm.nih.gov/29943596/*. The consequence of over utilisation of public health is graphically illustrated in an Sunday Tribune report of 25 July 2021 "Durban Magistrate accuses KZN hospital of 'playing God' as assault victim dies" at https://www.iol.co.za/sunday-tribune/news/durban-magistrate-accuses-kzn-hospital-of-playing-god-as-assault-victim-dies-b56f5db3-e1e8-4432-ade2-5b24e9b9f6d6 where doctors refused to treat an assault victim because his Glasgow Coma Scale reading was too low.

[16] Wikipedia "Healthcare in South Africa" at *https://en.wikipedia.org/wiki/Healthcare_in_South_Africa*.

[17] Our World in Data at *https://ourworldindata.org/grapher/hospital-beds-per-1000-people?tab=table*

[18] The Economic Times June 2015 at *https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/delhi-has-2-71-hospital-beds-per-1000-who-recommends-5/articleshow/47803958.cms?from=mdr*.

A contributory strain on the public health sector is the inordinate number of Road Traffic Crash injuries which further burdens the Public Health system. Annually there are 1 million RTC's with 14 000 fatalities, 200 000 injuries and 66 000 serious injuries.[19] The WHO estimates that 1 in 10 hospital beds are occupied by RTC injured. The figure for South Africa should be higher considering that the acceptable fatality rate[20] is 18 per 100 000 of the population while South Africa is at 32 per 100 000.[21] Research suggests that, based on casualty admissions to South African hospitals (an internationally recognised method used to establish casualty numbers – 43% of such casualties are road crash related), the number of injured persons being as high as 523 759 per annum can be postulated. This immediately suggests that the public health system is being burdened by crash victims[22] and that the consequences of RTCs may be an indirect additional contributory factor contributing to the state of public healthcare in South Africa.[23]

Considering critical medical equipment South Africa's ratio of critical diagnostic medical and other key medical equipment has regressed. At 2013 levels per million of the population the following pertains:[24]

Ratios of key medical equipment per million of the population			
Magnetic Resonance Imaging	0,23	Computed Tomography Units	0,97
Positron emission tomography	0,06	Nuclear medicine	0,53
Linear accelerator	0,4	Telecobalt unit	0,17
Mammography units	9,11		

Inadequate funding

Most health services in South Africa (about 86%) are provided through the public sector, yet only about 50% of health expenditure comes from the government. The private sector is small and tends to cater to people with medium to high incomes. South Africa has a two-tiered health system divided along socio-economic lines, resulting in inequitable access to healthcare. The country continues to

[19] RTMC "Cost of Crashes in South Africa – Research and Development Report" August 2016 at https://www.arrivealive.co.za › documents › Cost-...PDF.

[20] An indicator of probable RTC injury levels.

[21] IOL 28 December 2018 "SA has the world's poorest road safety records - WHO report" at https://www.iol.co.za/dailynews/news/kwazulu-natal/sa-has-the-worlds-poorest-road-safety-records-who-report-18631896. Considering that there are about 120 000 hospital beds in SA, the injured figures of 266 000 of which 66 000 are seriously injured (fn 20) and likely to be hospitalised, suggests that RTMC injury hospital bed occupancy is at least 5,5% overall (see fn 23). The probable Public Health RTMC injuries overall admissions could be as high as 64% after allowance is made for injured with medical aid (16%) being treated in private hospitals.

[22] The financial cost of RTC injuries to the public health sector based on the 2015 Statistics in the RTMC study (fn19) of 266 000 and allowing for RTC patients with medical aid at an average cost of R53 000 per RTC injury (fn 23) admission equates to R14 billion or 6% of the annual public health budget of R249 billion.

[23] A study done at Edenvale Hospital; KwaZulu-Natal has shown that there is a high burden of injury associated with RTCs. The potential patient count for this hospital is estimated at 1 664 patients per year, with 520 requiring admission and an estimated 166 deaths. This equates to 5 RTC patients per day and a fatality every second day. This constitutes a significant workload as most patients required at least 1 operation and spent, on average, 3 weeks in hospital. The major burden of this operative load falls on the orthopaedic service. However, the acute general surgical and critical care services also face a significant burden. The economic burden of these crashes to society is difficult to calculate. See F Parkinson *et al* "Road traffic crashes in South Africa: The burden of injury to a regional trauma centre" SAMJ, S. Afr. med. j. vol.103 n.11 Pretoria Jan. 2013 at http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742013001100022. The Edenvale and the study by Busisiwe Precious Matiwane & Ozayr Mahomed (2018) "Cost analysis of road traffic crashes in a tertiary hospital in Mpumalanga Province, South Africa", Cogent Medicine at 5:1,1549800, DOI: 10.1080/2331205X.2018.1549800 the shows that the average cost of a RTC injured admission is R53 000 and that 4,5% of all admissions are RTC injury related. Also Norman R, Matzopoulos R, Groenewald P, Bradshaw D. *The high burden of injuries in South Africa*. Bull World Health Organ 2007;85(9):695-702 at http://dx.doi.org/10.2471/BLT.06.037184.

[24] See OECD data at https://data.oecd.org/healthcare/hospital-beds.htm.

experience a high burden of HIV and AIDS and tuberculosis and a rising burden of non-communicable diseases. In 2015, 48.3% of the total health expenditure was from public sources, 49.8% from private sources, and 1.9% from donors. The national Department of Health accounts for 2.5% of gross health expenditure, and provincial departments for 87.0%.[25]

In South Africa, despite increases in public healthcare utilisation due to the high burden of disease and increased patient load over the period 1997–2010, the public health sector fell from second to fourth in the list of spending priorities.[26] Consequently, major health system challenges which occurred in this sector include negative staff attitudes, long waiting times, unclean facilities, medicine stock-outs, insufficient infection control and the compromised safety and security of both staff and patients.[27]

A compounding problem is the lack of financial management knowledge of health care workers and managers, commonly causing inaccurate budgeting, poor resource-allocation, unreliable budgets, and under-budgeting of services. This led to instances where funds for budgeted commodities would run out in the middle of the financial year. The poor track record of under-budgeting and unreliable payment of suppliers led to some of the critical suppliers refusing to deliver orders of medicines and devices due to delayed payments and non-payments beyond the agreed 90-day period.[28] This situation is exacerbated by unnecessary hospital admissions and over-prescription of medicines by especially inexperienced medical doctors.[29]

Consequences

All the above provide fertile ground for human error. The main causes of human error are:

- Ineffective supervision within the identified workplace.
- A lack of an accountability system.
- A distractive environment including low alertness and complacency amongst employees.
- Time pressure and work-related stress.
- Over-confidence in execution of duties.
- First-time task management.
- Imprecise and unclear communication.
- Incorrect and vague guidance.
- Deficiency in training.
- Introduction of new technology.
- Pressure to meet goals within the workplace can give rise to errors.
- Doctors and nurses daily make many mostly inconsequential errors. Consequential errors however are engendered by universal conditions within the system, including inadequate equipment, poor scheduling of staff members and under-staffing.
- Same situations can create the same type of error in different individuals and more emphasis should be placed on error-prone situations rather than error-prone people, as same situations cause staff members to become inheritors, rather than instigators of

[25] *Health Financing Profile: South Africa - Health Policy Project* at https://www.healthpolicyproject.com › pubs › Sou...PDF

[26] Doherty J, Kirigia D, Okoli C, Chuma J, Ezumah N, Ichoku H, et al. Does expanding fiscal space lead to improved funding of the health sector in developing countries?: lessons from Kenya, Lagos state (Nigeria) and South Africa. *Glob Health Action*. 2018;11:1461338. Also Malakoane, B., Heunis, J.C., Chikobvu, P. *et al.* Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening. *BMC Health Serv Res* 20**,** 58 (2020) at *https://doi.org/10.1186/s12913-019-4862-y*

[27] Department of Health, South Africa. National Health Insurance for South Africa. Towards universal health coverage. Pretoria: Department of Health; 2017; Malakoane, B., Heunis, J.C., Chikobvu, P. *et al.* "Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening." *BMC Health Serv Res* **20,** 58 (2020). *https://doi.org/10.1186/s12913-019-4862-y*.

[28] This has a knock-on effect on public medical service delivery and may even be the cause of liability for medical negligence, See eg *S M obo T M v MEC for Health and Social Development, Gauteng Province* (2017/9251) [2018] ZAGPJHC 630 (16 November 2018) where the unavailability of autoclaved theatre gowns was a leading cause of a serious adverse event.

[29] *Idem.*

adverse events. The common error producing thread amongst the individuals is the human condition which cannot be changed, but the conditions under which these individuals work which can.

- Error occurs when there is an unplanned deviation in treatment. These errors are classifiable as they occur in a particular context.[30]

In the healthcare environment errors and accidents lead to adverse outcomes and mortality.

2.2 Poor management, lack of accountability, and bad record keeping

Reports relating to healthcare outcomes in South Africa show a complete failure in public sector healthcare delivery. Outcomes are worse than that of some lower income countries.[31] This is the result of poor leadership and inadequate management, and is reflected in a lack of vision, clear philosophy and poor goal setting.[32] Lack of accountability in conjunction with corruption and misconduct by Department of Health officials is a leading cause of failure of government to comply with its constitutional mandate and obligation to deliver quality health care.[33] Key obstacles in the performance at local government level in South Africa are problems with institutional capacity, high levels of corruption and financial mismanagement, and a lack of public participation.[34]

Poor record-keeping causes unnecessary delays in patient treatment when patients' folders are missing or have been lost. Sometimes the medical history of the patient is lost, leading to incorrect diagnosis and in some cases, death of the patient.[35] It also detrimentally affects the ability to identify potential threats of delictual liability and to effectively defend claims based on medical negligence.[36]

2.3 Healthcare Associated Infections

About one in seven patients admitted to South African hospitals is at risk of acquiring a Healthcare Associated Infection (HAI) mainly because of poor waste management and handwashing techniques. Other causes of HAI are overcrowding in hospitals, high patient-to-staff ratios, lack of isolation facilities, ageing infrastructure, inadequate environmental cleaning, inter-hospital transfer of patients with drug-resistant infections and inadequate disinfecting of medical equipment. HAIs result in lengthened hospital stay, an increase in health care cost for already limited financial

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[30] Amy Williams "Investigation into the factors contributing to malpractice litigation in nursing practice within the private healthcare sector of Gauteng" Thesis presented in partial fulfilment of the requirements for the degree of Master of Nursing Science in the Faculty of Medicine and Health Sciences at Stellenbosch University, University of Stellenbosch 2018.

[31] Centre for Development and Enterprise 2011:45; Pillay-Van Wyk, V., Msemburi, W., Laubscher, R., Dorrington, R.E., Groenewald, P., Glass, T. et al., 2016, 'Mortality trends and differentials in South Africa from 1997 to 2012: Second National Burden of Disease Study', *The Lancet Global Health* 4, 642–653. https://doi.org/10.1016/S2214-109X(16)30113-9.

[32] Carney, M., 2009, 'Public health nurses perception of clinical leadership in Ireland: Narrative descriptions', *Journal of Nursing Management* 17, 435–445. https://doi. org/10.1111/j.1365-2834.2009.01015.x Pillau Vanwyk

[33] Siddle, A.M., 2011, 'Decentralisation in South African Local Government: A critical evaluation', Degree of Doctor of Philosophy, Doctoral thesis, University of Cape Town.

[34] Managa, A., 2012, *Unfulfilled promises and their consequences: A reflection on local government performance and the critical issue of poor service delivery in South Africa*, Policy Brief: Africa Institute of South Africa, Pretoria.

[35] Kama, Z.S., 2017, 'An evaluation of access to health care: Gugulethu Community Health Clinic', Master of Technology, Faculty of Business Cape Peninsula University of Technology, Cape Town.

[36] See e.g. *The Member of the Executive Council for Health, Eastern Cape v DL obo AL* (Case no 117/2020) [2021] ZASCA 68 (03 June 2021) where adequate records substantially contributed to a successful obstetric negligence claim defence and and *PG obo TG v MEC for Health, Gauteng Province* case no 6003/2013 (GLDJ) (unreported) 19-03-2021 where the defendant sought to take advantage of the absence of medical records.

resources and in some cases death of patients.[37] A study suggests that HAI may result in a larger financial burden than epidemical diseases such as tuberculosis and HIV/AIDS.[38]

2.4 Greater actualisation of constitutional rights resulting in increased access to information, transparency, and accountability through newly enacted legislation and legal and other developments.

Progressive patient-centred legislation, such as the Constitution of the Republic of South Africa, 1996 (the Constitution), National Health Act 61 of 2003, Consumer Protection Act 68 of 2008 and Children's Act 38 of 2005 raise awareness and thereby encourage patients to institute action. Equally important is the legal recognition of patient autonomy, informed consent, privacy of health information, and the best interests of a child in a medical context.[39] At best legislation and legal development is facilitative rather than causative.[40] It does not go to the root of the existence of medical negligence claims. Calls for legislative reform that do not properly address the root cause of increased medical negligence litigation,[41] should be viewed with scepticism.[42] Perceived contributory causes such as the amendment of the RAF Act in 2008[43] and the introduction of the Contingency Fees Act 66 of 1977 should be similarly dealt with.

[37] Dramowski, A. & Whitelaw, A., 2017, 'A framework for preventing healthcare-associated infection in neonates and children in South Africa', *South African Medical Journal* 107, 192–195. https://doi.org/10.7196/SAMJ.2017.v107i3.12035.

[38] Mohammed Mitha, E.Yoko Furuya, Elaine Larson "Risk of healthcare associated infections in HIV positive patients" *Journal of Infection Prevention* November 2014 VOL. 15 NO. 6.

[39] Van Zyl "An Analysis of Medical Negligence Claims against the State with Specific Reference to Proposals for Legislative Reform" Draft research proposal: LLD thesis UP; L Pienaar "Investigating the Reasons behind the Increase in Medical Negligence Claims" *PELJ / PER* 2016 (19).

[40] See

[41] See "2. Causes" above.

[42] P van den Heever "Medical malpractice: The other side" *De Rebus* October 2016 at 49; Oosthuizen and Carstens 'Medical Malpractice: The extent, consequences and causes of the problem' *THRHR* 2015 (78) 269.

[43] Legal practitioners are bound by a wide range of ethical rules and duties to both their clients and the court. If there was no malpractice no malpractice litigation is possible or likely. The real threat of adverse cost orders effectively deters baseless claims. It is unfair to criticise attorneys, when their actions are determined by the applicable legal liability and compensation system. See Oosthuizen and Carstens 'Medical Malpractice: The extent, consequences and causes of the problem' *THRHR* 2015 (78) 269.

3. Medical negligence: Typical adverse events and frequency

What follows is a selection of empirical data as reflected in Amy Williams' thesis "Investigation into the factors contributing to malpractice litigation in nursing practice within the private healthcare sector of Gauteng". [44]

3.1 Typical adverse events

Ward	Description of event
General	Central venous pressure line in neck removed and resulted in hemiplegia due to air in sub-arachnoid space after cardio-thoracic surgery.
	Hypothermia and hypotension due to intra-abdominal bleeding after laparoscopy.
	Injection of Morphine, Zofran and Methylnaltrexone bromide was given within one hour after sigmoid colectomy procedure resulting in severe hypoxic brain damage.
	Severe pain in left flank. Intramuscular injection in gluteus resulted in permanent sciatic nerve damage after admission for drainage of splenic abscess.
	Management of the patient between two hospitals subsequent to rib fractures resulted in the patient sustaining various pressure sores and rendering the patient a quadriplegic.
	Patient in hypoglycaemic coma fell out of bed and sustained fracture of right hip requiring hip surgery.
Paediatric	Intravenous infusion allowed to extravasate into the soft tissue of child's hand and wrist resulting in swelling and blistering and requiring a skin graft.
	Minor admitted with diarrhoea and dehydration, intravenous infusion resulting in swollen hand requiring skin graft.
	Minor child sustained severe hypoxic-ischaemic encephalopathy as a consequence of severe dehydration.
	Minor child admitted for pneumonia, was treated with endotracheal tube incorrectly positioned, resulting in cerebral palsy due to oxygen deprivation.
Labour	Cerebral palsy secondary to birth asphyxia, due to mismanagement of labour process.
	Sphincters being destroyed after misdiagnosis of 3rd or 4th degree perineal tear as a second-degree tear after a normal vaginal delivery with an episiotomy.
	Intramuscular injection for pain control for pre-eclampsia resulting in pain at injection site and with cellulitis in right gluteal area diagnoses.
	Foetus born with cerebral palsy following transfer from clinic and failed attempt of MacRobert's manoeuvre and increased waiting time in labour ward.
	Foetus not surviving the hypoxia after abdominal pains were medically mismanaged and resulting in foetal distress at 32 weeks gestation.
	Baby diagnosed with cerebral palsy secondary to birth asphyxia due to mismanagement of labour process.
	Caesarean section, patient discharged with symptoms of pyrexia and tachycardia; admitted the same day with small bowel perforation and abdominal sepsis.

[44] Thesis presented in partial fulfilment of the requirements for the degree of Master of Nursing Science in the Faculty of Medicine and Health Sciences at Stellenbosch University, University of Stellenbosch 2018.

Neonatology unit	Pulse oximeter was placed on a neonate's foot and not adequately monitored for pressure care resulting in necrosis and amputation of the right small toe.
	Arterial line inserted and child developing gangrene necessitating an amputation.
	Severely (due to diarrhoea) dehydrated minor prematurely discharged resulting in permanent brain damage and left sided spastic hemiplegia.
	Per ventricular leukomalacia in premature baby caused by ventilation and continuous oxygen therapy.
	Bilirubin-induced neurological dysfunction in readmitted baby after dehydration and pyrexia following birth.
Intensive Care Unit	Pressure sores in gluteal area developing during treatment for malaria resulting in permanent damage of sciatic nerve and permanent loss of function of lower limbs.
	Compromised circulation and above knee amputation after coronary artery bypass grafting procedure.
	Klebsiella pneumonia and various viruses within the clinical environment after admission for gastric condition.
	Cauda equina syndrome due to insufficient drainage and ongoing haemorrhage in the operation site after a spinal operation.
	Permanent nerve damage caused by poor circulation monitoring in lower limbs following surgical procedure.
	Paralysis caused by incorrect management following a spinal decompression and fusion procedure.
Theatre	Incorrectly diagnosed abdominal pain resulting in a colostomy.
	Ischaemic brain damage after cardiac arrest occurring during orthopaedic surgery.
	Decompression of lumbar spine performed at wrong level.
	Permanent damage to infra-orbital nerve on left side of face after injection with Perlane into naso-labial folds.
	Abdominal swab left inside after exploratory laparotomy for small bowel obstruction.
	Inadequate vascular repair of gunshot wound by surgeon resulting in death.
High Care	Intramuscular injection in right gluteus resulted in nerve ischiadicus after developing pneumonia subsequent to laparoscopy for gastrointestinal obstruction.
	Severe sepsis resulting in septic shock and death after discharge of caesarean section patient with signs of pyrexia and tachycardia.
Post-natal	Fat necrosis after intramuscular injection on lateral aspect of left thigh formed a hard lump subsequent to a caesarean section.
Casualty/Trauma	Intravenous medication administered results in thrombophlebitis after bee sting allergic reaction'
	Badly scarred and mutilated arm due to an iatrogenic infection and no homecare instructions after an incorrectly diagnosed arm wound.
	Delay in surgical treatment resulting in amputation of leg after gunshot wound.
Renal transplant clinic	Oral medication Ketaconazole omitted from prescription chart and not dispensed by pharmacy subsequent to renal transplant resulting of rejection of transplant by body.

3.2 Frequency of omissions leading to adverse events

Omission	Percentage
Clinical manifestations not responded to	76%
Poor monitoring	68%
Failing to apply guidelines/protocols	93%
Failing to give treatment as prescribed	78%
Incorrect treatment	34%
Accumulation of omissions	44%
Accumulation of errors	17%
System failures	15%
Behavioural	22%
Lack of supervision	12%
Lack of training	46%
Lack of knowledge	44%

3.3 Consequences of and responsibility of adverse events

Adverse events led to 49% of patients requiring additional surgery. The vast majority (92%) suffered loss of quality of life and 7% died as a result. Data shows that adverse events were primarily (70%) ascribable to deficient nursing care. Doctors were responsible for 29% of adverse events and doctors and nurses for 29%.

3.4 Summary

Williams[45] summarises the reasons for the existence of medical negligence as follows: "The results have indicated that the clinical management of the patient is the predominant factor contributing to adverse events. Factors included are clinical manifestations not responded to and the failure to apply the necessary protocols and guidelines when providing care. As a result, the majority of the patients suffered an adverse event that is extreme in severity, according to the SAC Matrix and had their quality of life permanently affected." Despite Williams' research dealing with the private health sector only, the position displayed by her research may be a snapshot of medical negligence in South Africa. Considering that only 20% of medical negligence claims occur within the private sector, the state of the public health sector and the conditions under which public health workers must operate, it can at the very least be said that similar reasons and the factor of adverse events are even more so to be expected in the public health sector.

4. Litigated public health claims: Adverse events and causes

4.1 Adverse events and medical negligence identified

In a 2021 comprehensive data-based study commissioned by the Actuarial Society of South, Whittaker[46] surveyed and analysed 206 high court judgments to determine the nature and extent of adverse events and causes of medical negligence claims in the public health sector. The use of these cases cannot be considered as definitive because they exclude damage-causing adverse events not disputed and settled out of court and where the damages claimed exceed R300 000. In the latter instance these cases are brought before regional courts. Generally, settlements (direct or through mediation) and lower value claims are not reported.[47] This means that the extent of

[45] Fn 29.

[46] Whittaker, G.A. 2021. *Medical Malpractice in the South African Public Sector*. Cape Town: Actuarial Society of South Africa.

[47] Generally, the provincial health departments' annual reports do not show the number of new claims received but tend to only refer to amounts paid for medico-legal claims. In 2015-2017 the Gauteng Provincial Government

medical negligence in the public health sector and its consequences are even more pervasive and serious than the analysis of case law may suggest.

Based on these cases, Whittaker's research reflects that medical negligence in the public health sector was based on the causes as reflected in Table 1.[48]

Table 1

Type of claim (n=206)		
Not stated or not applicable	18	8.7%
Birth related injury/death to mother	14	6.8%
Cerebral palsy	81	39.3%
Death of a newborn/still born/miscarriage	11	5.3%
Death of a patient	5	2.4%
Emergency medicine	25	12.1%
Erb's palsy/ROP/other birth injuries	4	1.9%
General medicine	4	1.9%
Other	8	3.9%
Surgery	36	17.5%

settled 185 medical negligence cases at a cost of R1 billion. See News 24 of 21 July 2015: "More than R1bn paid in medical negligence pay-outs by Gauteng Health – DA" at https://www.news24.com/news24/SouthAfrica/News/more-than-r1bn-paid-in-medical-negligence-payouts-by-gauteng-health-da-20170523. According to the 2018/19 KZN Provincial Department of Health Annual Report (at http://www.kznhealth.gov.za/reports.htm) received 450 new medico-legal claims during 2018/19 and paid R427 418 595.22 in compensation. No new claim information appears in its 2019/20 annual report. Eastern Cape health reported an 88% increase in medico legal pay-outs for 2018/19. See 2018/19 annual report at *http://www.echealth.gov.za › document-library › annua...*. The EC 2020/21 annual report is not available. As shown below, EC and Gauteng are the provinces where adverse events are most prevalent. In a Daily Despatch report of 26 July 2021 "Bhisho to challenge medico-legal payments" at https://dispatch.pressreader.com/article/281479279444362 it is reported that the department faces hundreds of medico-legal claims.

[48] Whittaker fn 47.

Furthermore, the Whittaker analysis shows an increase in litigation from 3% in 2006 to 16% in 2020. Negligence in public health sector claims is identified as set out in Table 2.[49]

Table 2

Reason(s) cited for negligence where stated (n=130)	
Lack of record keeping	36
Delay in treatment	79
Misdiagnosis	23
Improper treatment	108
Lack of consent	7
Lack of professional qualifications	13

The split in medical negligence cases among the provinces is as follows:[50]

Table 3

Province (n=206)	**Number**	**Percentage**
Eastern Cape[51]	59	28.6%
Free State	21	10.2%
Gauteng [52]	72	35.0%
KwaZulu-Natal [53]	12	5.8%
Limpopo	5	2.4%
Mpumalanga	10	4.9%
Northwest	14	6.8%
Northern Cape	5	2.4%
Western Cape	8	3.9%

[49] *Idem.* Also see the comments on the use of litigated claims and the extent of medico legal claims in par 4.1 and fn 48.
[50] *Idem.*
[51] In the 2018/19 financial year settlements of medico legal claims in the EC increased by 88% from the previous year. See EC Health Department Annual report 2018/19 at 13 accessible at *http://www.echealth.gov.za › document-library › annua...* The value of medico legal claims settled by the department grew from R75.6 million R797 million in 2018/19.
[52] In Gauteng, the contingent liability for claims increased from R20 932 408 to R24 754 605. Gauteng Health department annual Report at 256 accessible at *https://provincialgovernment.co.za › 2019-gauteng-...*PDF.
[53] In the 2018/19 financial year a total of 450 new medico-legal claims were received in KZN during the 2018/2019 financial year. The breakdown of the claims was as follows:- Promotion of Access to Information Act (PAIA) requests = 110, General = 28, Obstetrics and Gynaecology = 188 Ophthalmology = 6, Orthopaedics = 1, Paediatrics = 9, Surgical = 94, Medical records = 14, The total amount paid was R427 418 595.22. 2018/19 KZN Department of Health Annual Report accessible at *http://www.kznhealth.gov.za/reports.htm*.

Whittaker's analysis identifies the type of case and the basis for negligence but does not investigate the different adverse events and classify the negligence in medical professional terms as was done by Williams. An analysis of 63 cases[54] brought against provincial health authorities for the period 2012-2021 was analysed by the author using the matrix applied by Williams and yielded the following results:

Figure 1

Discipline	Number	Percentage
General	13	20.63%
Nursing care	1	1.587%
Neurology	2	1.587%
Obstetric	37	60.22%
Orthopaedic	10	15.87%
Radiology	1	1.87%

Figure 2

Claims per Province							
	General	Nursing care	Neurology	Obstetric	Orthopaedic	Radiology	Percentage
Eastern Cape	6	1	1	14	2	0	38.1%
Free State	1	0	0	1	1	0	0.05%
Gauteng	2	1	1	13	0	0	26.98%
Kwazulu Natal	0	0	0	6	1	1	0.13%
Limpopo	0	0	0	1	0	0	0.02%
Mpumalanga	1	0	0	2	0	0	0.05%
Northern Cape	1	0	0	0	2	0	0.05%
Northwest	0	0	0	1	1	0	0.03%
Western Cape	2	0	0	0	0	0	0.03%

[54] Both reported and published by SAFLII. See List of Cases at the end of this article.

Birth rate per province (Wikipedia)

Rank	Province	2001–2006	2006–2011	2011–2016	2016–2021 (est.)
1	Eastern Cape	3.25	3.26	3.08	2.88
4	Northern Cape	3.10	3.02	2.72	2.67
5	North West	3.09	3.25	2.84	2.65
2	Limpopo	3.00	3.25	3.06	2.87
3	KwaZulu-Natal	2.94	2.98	2.71	2.70
6	Mpumalanga	2.91	2.96	2.62	2.54
7	Free State	2.72	2.86	2.57	2.34
8	Western Cape	2.33	2.46	2.22	2.00
9	Gauteng	2.15	2.38	2.09	1.91

Negligence in Obstetrics		
Conduct	**Number**	**Percentage**
Clinical manifestations not responded to	29	78.33%
Poor or no monitoring	6	16.22%
Protocols not adhered to	30	81.08%
Insufficient records	2	5.41%
Records lost	1	0.03%

The provinces which generate the most medical negligence cases in the public health sector are the Eastern Cape and Gauteng. Of the medical disciplines involved, obstetrics is the leading discipline with cerebral palsy being the prevalent adverse event. The predominant causes of the obstetric claims and cerebral palsy are clinical manifestations not heeded and failure to follow protocols. It is also noteworthy that although Gauteng has the lower birth rate, it is second to the Eastern Cape in prevalence of obstetric medical negligence.

4.2 Cerebral palsy

4.2.1 Cause, frequency, and consequences

No South African data on the cause of damages claims for cerebral palsy other than newspaper reports and the survey of judgments previously referred to, is available. A Swedish study revealed that the most common errors in Cerebral Palsy (CP) cases were:

- Failure to supervise foetal well-being (98%).
- Neglect of signs of foetal asphyxiation (71%).
- Incautious use of oxytocin (71%).
- Choosing a nonoptimal mode of delivery (52%).[55]

[55] Oyebode F. "Clinical Errors and Medical Negligence" *Medical Principles and Practice* 2013, Vol.22, No. 4 at https://www.karger.com/Article/Fulltext/346296# .

The international prevalence of CP is 2 out of 1000 births. CP frequency in South Africa is astonishingly high topping out at 10 per 1000 births.[56] Cerebral Palsy is the most prevalent cause of action in public health medical negligence claims. In the UK 20% of CP births resulted in malpractice claims while in South Africa up to 60% of negligent adverse event claims are for CP. The average CP damages settlement according to Whittaker ranges between R4 and R25 million.[57]

This phenomenon is noteworthy not only for its frequency and financial implications but rather for its absolutely devastating personal, dignity destroying and other consequences. Cerebral palsy affects each person differently and it can be difficult to predict what the outlook will be for both child and caregiver. Most children live into adult life, and some can live for many decades. The condition may limit a child's activities and independence, although many people go on to lead full, independent lives. Many children go to a mainstream school, but some may have special educational needs and benefit from attending a special school. The original problem with the brain does not get worse over time, but the condition can put a lot of strain on the body and cause problems, such as painful joints in later life. The daily challenges of living with cerebral palsy can be difficult to cope with, which can lead to problems such as depression in some people. Outward manifestations of CP may be:

- Feeding, drooling and swallowing difficulties,
- Constipation,
- Problems with speaking and communication,
- Seizures or fits (epilepsy),
- Difficulty falling asleep and/or staying asleep,
- Gastro-oesophageal reflux disease (GORD) – where acid from the stomach leaks up into the oesophagus (gullet),
- An abnormally curved spine (scoliosis),
- Hips that pop out (dislocate) easily,
- Difficulty in bladder control (urinary incontinence),
- A learning disability – about half of children with cerebral palsy have a learning disability,
- Eye problems – including reduced vision, a squint or uncontrollable eye movements,
- Hearing loss.[58]

4.2.2 Prevalent causes

The obstetric negligence analysis in this section, suggests the main causes as being:[59]

- Clinical manifestations not responded to,

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[56] Donald KA, Samia P, Kakooza-Mwesige A, Bearden D. "Pediatric cerebral palsy in Africa: A systematic review." *Semin. Pediatr. Neurol.* 2014;21:30-35; Couper J: "Prevalence of childhood disability in rural KwaZulu-Natal." S Afr Med J 92:549-552, 2002; *I Bhorat, E Buchmann, P Soma-Pillay, E Nicolaou, L Pistorius, I Smuts*: "Cerebral Palsy and Criteria Implicating Acute Intrapartum Hypoxia in Neonatal Encephalopathy – An Obstetric Perspective for the South African Setting" *South African Medical Journal* 2021;111(3b):277-279. DOI:10.7196/SAMJ.2021.v111i3b.14923. Based on a population of 59 million and an annual birth rate of 20 per 1000 (see *https://www.macrotrends.net/countries/ZAF/south-africa/birth-rate*) of the population, CP annually affects 118 000 South African children.

[57] Whittaker 81.

[58] See National Health System UK at *https://www.nhs.uk/conditions/cerebral-palsy*. See eg See *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* (4314/15) [2019] ZAGPJHC 504; 2020 (2) SA 567 (GJ); [2020] 2 All SA 177 (GJ) (18 December 2019) for an example of the extensive treatment required for cerebral palsy children. This includes speech therapy, ear, nose and throat surgical management of hyper salivation, orthopedic treatment (possible hip reconstruction; x-rays to monitor scoliosis; possible surgical scoliosis correction; surgical treatment of possible fractures; monitoring of osteoporosis; Botox therapy, and annual assessments by an orthopedic surgeon), physiotherapy (routine and special sessions, portable aspirator, nebulizer, suction catheters and plinth), dental services, urology services, dietary supplements, psychiatric treatment, pediatric neurology services, orthotics and wheelchairs, occupational therapy and equipment, care givers, specialised schooling, vehicle and mobility claims, alterations to home, insurance for wheelchairs and equipment and a case manager.

[59] For the causes according to Swedish research, see Oyebode fn 61.

- Insufficient monitoring,
- Inadequate record keeping,
- Protocols not being adhered to.

Clinical manifestations not responded to

Identifying clinical manifestations is a crucial factor in the context of CP prevention. It starts by the early identification of possible risk during pregnancy and labour and enables the tailoring of a suitable delivery plan.[60] It continues when signs of stress in the monitored foetus are noted but ignored and when important clinical manifestations do not result in appropriate action.[61]

Insufficient or no monitoring

The monitoring of mother and foetus is an important part of the labour process providing vital information regarding the well-being of both mother and foetus. Insufficient or no monitoring may lead to undetected maternal and foetal stress, delayed diagnosis and/or no appropriate or delayed corrective treatment, and moreover the endangerment of the safety and well-being of mother and foetus. Monitoring during various stages of labour is an obligation imposed in terms of the *Guidelines for Maternity Care in South Africa*[62] and the *Rules of the South African Nursing Council*

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[60] See eg *Ntsele v MEC for Health, Gauteng Provincial Government* (2009/52394) [2012] ZAGPJHC 208; [2013] 2 All SA 356 (GSJ) (24 October 2012); *V v MEC for Health: Gauteng Province and Others* (2014/69026) [2020] ZAGPPHC 223 (28 April 2020); *D v MEC For Health For The Province of KwaZulu-Natal* (8700/2013) [2019] ZAKZPHC 13 (13 March 2019); *C P v MEC Health of Provincial Government of the Free State* (A53/2019) [2020] ZAFSHC 216 (8 October 2020); *Luyanda v Member of the Executive Council for Health, Eastern Cape* (114/2014) [2019] ZAECBHC 7 (15 March 2019)

[61] See eg *D[....] obo D[....] v Member of the Executive Committee Responsible for the Department of Health* (2998/2018) [2021] ZAECMHC 5 (26 January 2021); *K v MEC for Health, Eastern Cape (*3180/2014) [2018] ZAECGHC 21 (15 March 2018); *Siwayi v MEC For Health, Eastern Cape Province* EL 876/2015, ECD 1676/2015) [2018] ZAECGHC 104 (1 November 2018); *MM obo EM v MEC for Health Eastern Cape* (517/2015) [2019] ZAECBHC 24 (19 November 2019); *Ntsele v MEC for Health, Gauteng Provincial Government* (2009/52394) [2012] ZAGPJHC 208; [2013] 2 All SA 356 (GSJ) (24 October 2012); *Hoffmann v MEC for Department of Health, Eastern Cape and Another* (1037/2007) [2011] ZAECPEHC 39 (9 September 2011); *Ndisane v MEC, Department of Health, Eastern Cape Province* [2019] JOL 41682 (ECM); *S M obo T M v MEC for Health and Social Development, Gauteng Province* (2017/9251) [2018] ZAGPJHC 630 (16 November 2018); *M T obo M M v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government* (20454/2014) [2018] ZAGPJHC 540 (27 September 2018); *HN v MEC for Health, KZN* (1287/2014) [2018] ZAKZPHC 8 (4 April 2018); *PS obo AH v MEC for Health for the Province of KwaZulu-Natal* (14197/2014) [2017] ZAKZPHC 37 (24 August 2017); *D[....] obo D[....] v Member of the Executive Committee Responsible for the Department of Health* (2998/2018) [2021] ZAECMHC 5 (26 January 2021); *K v MEC for Health, Eastern Cape* (3180/2014) [2018] ZAECGHC 21 (15 March 2018);

[62] See Department of Health. 2016. *Guidelines for Maternity Care in South Africa.* Pretoria: Department of Health 41, accessible at https://www.knowledgehub.org.za/elibrary/guidelines-maternity-care-south-africa-2016 . The purpose of the guidelines is stated as follows: "These guidelines have been prepared by the Sub directorate: Maternal Health for the guidance of health workers (doctors and midwives) providing obstetric, surgical and anaesthetic services for pregnant women in district clinics, health centres and district hospitals. These guidelines are intended for use in clinics, community health centres and district hospitals where specialist services are not normally available. The guidelines deal mainly with the diagnosis and especially the management of common and serious pregnancy problems. The assumption is made that the reader has a basic knowledge and understanding about the care of pregnant women. With a few exceptions (e.g. pre-eclampsia), there is no mention of aetiology and pathogenesis of the conditions described. The emphasis is on the practical identification and correct management of problems, including referral to higher levels of care. The approach is unashamedly dry, and reduced to point format, so that a management plan can be quickly assimilated and enacted. For certain clinical problems, algorithms (flow diagrams) have been prepared. The guidelines are based on the best available evidence from published research, modified where necessary to suit local conditions. References are not given, but are available from the authors on request. Specifics of management and drug dosing are not cast in stone, and can be modified according to the experience and new evidence." Also see rule 31 of the *Rules of the South African Nursing Council issued under the Nursing Act 50 of 1978* accessible at https://www.sanc.co.za/r386/.

issued under the Nursing Act 50 of 1978 and non-compliance is taken as sub-standard care giving rise to delictual liability.[63]

Inadequate record keeping

Record keeping is a crucial part of diagnosis and treatment of patients. No or inaccurate record keeping may in some cases be the genesis of serious adverse events.[64] The existence of adequate and reliable records can be a determinant of a successful or unsuccessful defence[65] of claims for medical negligence. Even though adequate record keeping is a statutory as well as a professional

[63] See eg *Mbhele v MEC for Health, Gauteng* (355/15) [2016] ZASCA 166 (18 November 2016); *Khoza v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government* (2012/20087) [2015] ZAGPJHC 15; 2015 (3) SA 266 (GJ); [2015] 2 All SA 598 (GJ) (6 February 2015); *Ndisane v MEC, Department of Health, Eastern Cape Province* [2019] JOL 41682 (ECM); *Ndisane v MEC, Department of Health, Eastern Cape Province* [2019] JOL 41682 (ECM); *M obo M v Member of the Executive Council for Health of the Gauteng Provincial Government* (2014/32504) [2018] ZAGPJHC 77 (20 April 2018); *S M obo T M v MEC for Health and Social Development, Gauteng Province* (2017/9251) [2018] ZAGPJHC 630 (16 November 2018); (2017/9251) [2018] ZAGPJHC 630 (16 November 2018); *Goliath obo O v MEC Department of Health Northwest Provincial Government* (29/2015) [2019] ZANWHC 31 (28 February 2019); *LM obo M v Member of the Executive Council for Health of the Limpopo Provincial Government* (31261/2015) [2021] ZAGPPHC 139 (8 March 2021); *HN v MEC for Health, KZN* (1287/2014) [2018] ZAKZPHC 8 (4 April 2018); *HN v MEC for Health, KZN* (1287/2014) [2018] ZAKZPHC 8 (4 April 2018); *Member of the Executive Council for Health of KwaZulu-Natal v Mqadi* (AR 501/2018) [2020] ZAKZPHC 79 (15 December 2020); *PS obo AH v MEC for Health for the Province of KwaZulu-Natal* (14197/2014) [2017] ZAKZPHC 37 (24 August 2017); *Mpanza v MEC for Health for the Province of KwaZulu-Natal* (6375/2017) [2019] ZAKZDHC 6 (7 May 2019); *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal* (14275/2014) [2016] ZAKZPHC 27 (14 March 2016); *C P v MEC Health of Provincial Government of the Free State* A53/2019) [2020] ZAFSHC 216 (8 October 2020); *N v Member of the Executive Council for Health, Eastern Cape* (2571/13) [2015] ZAECMHC 77 (9 July 2015); *Member of the Executive Council for Health, Eastern Cape Province v YN obo EN* (3651/15) [2020] ZAECMHC 46 (23 July 2020); *Ndisane v MEC, Department of Health Eastern Cape Province* (789/2016) [2019] ZAECMHC 19 (5 March 2019); *Member of the Executive Council for Health, Eastern Cape v Neliswa Mbola obo Asavela Mbola* (4521/18) [2019] ZAECMHC 21 (18 March 2019); *P obo P v Member of the Executive Council for Health, Eastern Cape, Province (*121/2016) [2018] ZAECMHC 28 (22 May 2018); *S v Member of the Executive Counsel for the Department of Health, Eastern Cape* (2930/13) [2017] ZAECMHC 5 (28 March 2017); *K v MEC for Health, Eastern Cape* (3180/2014) [2018] ZAECGHC 21 (15 March 2018); *Luyanda v Member of the Executive Council for Health, Eastern* Cape (114/2014) [2019] ZAECBHC 7 (15 March 2019): "[12] According to the unit records (delivery register), on the 3rd December 2005, Miss. Zimbini Mpetsheni, 18 years, IP No. 2743/05, gave birth to a male infant, apgar score was 2/10 in 1 minute to 7/10 in five minutes, birth mass 3230gms. Mode of delivery was normal vertex delivery. Labour was conducted by registered midwife Ngoloma B.G; After five years of shelf life due to space limitation, I decided to remove the patient files of up to the year 2005 from the unit to a place called Cellar, underneath General ward. The Hospital does not have a formal, Archive structure. I have tried to look for the file in Cellar as requested but only found 10 files out of which 08 were deliveries, that of Zimbini Mpetsheni is not amongst those." (Sic) [13] The absence of the hospital records was a most unfortunate situation and is becoming an all too regular feature of similar actions against the defendant in this court, leaving much to conjecture and speculation to the great disadvantage of the plaintiff litigant in my view. Mr. Brown who together with Ms. Mduba appeared for the plaintiff urged upon me to make an adverse costs order to indicate the disapproval of this court and to put a halt to the common refrain by the responsible custodians of records of the provincial departments of health that these have been destroyed despite a statutory prohibition on such destruction of these records, but the adverse costs order which I issued when I refused the defendant's application for a postponement on the first day of trial was in part to ameliorate this anomaly already." Also see *X[....] v Member of the Executive Council for Health, Western Cape* (5088/2017) [2021] ZAWCHC 200 (13 October 2021); *M on behalf of L, a child v Member of the Executive Council for Health: Gauteng Provincial Government* (A5015/2020) [2021] ZAGPJHC 501 (8 October 2021); *Funda v MEC for the Department of Health, Eastern Cape* (307/2018) [2021] ZAECBHC 16 (14 September 2021).

[64] Kama, Z.S., 2017, 'An evaluation of access to health care: Gugulethu Community Health Clinic', Master of Technology, Faculty of Business Cape Peninsula University of Technology, Cape Town.

[65] *The Member of the Executive Council for Health, Eastern Cape v DL obo AL* (Case no 117/2020) [2021] ZASCA 68 (03 June 2021; *Magqeyga* v *Member of the Executive Council for Health, Eastern Cape* [2018] ZASCA 141.

duty[66], cases where there are no records[67] or where records have disappeared occur disadvantaging both plaintiff and defendant.[68] Absence of records invariably makes the adjudication of ensuing litigation extremely difficult,[69] is a recurring problem in medical negligence litigation against provinces[70] and can in exceptional circumstances be the basis for liability of a provincial health department.[71]

Disregard of protocols

Protocols[72] describing the duty of doctors[73] and nurses[74] attending to labour exist. On reflection, protocols set the accepted standard of conduct of medical professionals and disregarding of protocols is regarded as sub-standard healthcare and is taken as constituting and proving medical negligence.[75]

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[66] See ss 13 and 17 of the National Health Act 61 of 2003 and Health Professions Council's Guidelines on the keeping of patient records Booklet 9 accessible at https://www.hpcsa.co.za › Uploads › Ethics_Booklet. Also *Khoza v MEC for Health and Social Development, Gauteng* 2015 (3) SA 266 (GJ). Also see rule 31 of the *Rules of the South African Nursing Council issued under the Nursing Act 50 of 1978* accessible at https://www.sanc.co.za/r386/.

[67] See eg *S v Member of the Executive Counsel for the Department of Health, Eastern Cape* (2930/13) [2017] ZAECMHC 5 (28 March 2017); *Luyanda v Member of the Executive Council for Health,Eastern Cape* (114/2014) [2019] ZAECBHC 7 (15 March 2019); *M v Member of the Executive Council for Health of the Gauteng Provincial Government* (38426/14) [2018] ZAGPJHC 538 (15 August 2018); *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal* (14275/2014) [2016] ZAKZPHC 27 (14 March 2016).

[68] See eg *Madida obo M v Mec for Health for the Province of Kwa-Zulu Natal* (14275/2014) [2016] ZAKZPHC 27 (14 March 2016); *PS obo AH v MEC for Health for the Province of KwaZulu-Natal* (14197/2014) [2017] ZAKZPHC 37 (24 August 2017); *Sifuba v MEC for Health, Eastern Cape* (2314/13) [2015] ZAECMHC 62 (7 August 2015).

[69] *M obo M v Member of the executive Council for Health of the Gauteng Government* 2014/32504 [2018] ZAGPGJHC 77 (20 April 2018); *Mbola obo M v Member of the Executive Council for Health, Eastern Cape* (4521/18) [2018] ZAECMHC 67 (6 December 2018).

[70] *Luyanda v Member of the Executive Council for Health, Eastern Cape* (114/2014) [2019] ZAECBHC 7 (15 March 2019): " [13] The absence of the hospital records was a most unfortunate situation and is becoming an all too regular feature of similar actions against the defendant in this court, leaving much to conjecture and speculation to the great disadvantage of the plaintiff litigant in my view. Mr. Brown who together with Ms. Mduba appeared for the plaintiff urged upon me to make an adverse costs order to indicate the disapproval of this court and to put a halt to the common refrain by the responsible custodians of records of the provincial departments of health that these have been destroyed despite a statutory prohibition on such destruction of these records, but the adverse costs order which I issued when I refused the defendant's application for a postponement on the first day of trial was in part to ameliorate this anomaly already." It also leads to several PAIA applications. See *Paul v MEC for Health,Eastern Cape Provincial Government and Others ; Mbobo v MEC for Health ,Eastern Cape Provicial Government and Others; Ncumani v MEC for Health, Eastern Cape Province and Others* (5031/2018; 5108/2018; 5689/2018) [2019] ZAECMHC 18; [2019] 3 All SA 879 (ECM) (29 March 2019).

[71] By applying the maxim *res ipsa loquitur.* See *Ntsele v MEC for Health, Gauteng Provincial Government* 2009/52394 [2012], also available in ZAGPJHC 208 and [2013] 2 All SA 356 (GSJ) (24 October 2012).

[72] See Department of Health. 2016. *Guidelines for Maternity Care in South Africa.* Pretoria: Department of Health 41, accessible at https://www.knowledgehub.org.za/elibrary/guidelines-maternity-care-south-africa-2016 . The purpose of the guidelines is stated as follows: "These guidelines have been prepared by the Sub directorate: Maternal Health for the guidance of health workers (doctors and midwives) providing obstetric, surgical and anaesthetic services for pregnant women in district clinics, health centres and district hospitals. These guidelines are intended for use in clinics, community health centres and district hospitals where specialist services are not normally available. The guidelines deal mainly with the diagnosis and especially the management of common and serious pregnancy problems. The assumption is made that the reader has a basic knowledge and understanding about the care of pregnant women. With a few exceptions (e.g. pre-eclampsia), there is no mention of aetiology and pathogenesis of the conditions described. The emphasis is on the practical identification and correct management of problems, including referral to higher levels of care. The approach is unashamedly dry, and reduced to point format, so that a management plan can be quickly assimilated and enacted. For certain clinical problems, algorithms (flow diagrams) have been prepared. The guidelines are based on the best available evidence from published research, modified where necessary to suit local conditions. References are not given, but are available from the authors on request. Specifics of management and drug dosing are not cast in stone, and can be modified according to the experience and new evidence."

[73] See *Health Professions Council's Guidelines* accessible at *https://www.hpcsa.co.za › Uploads › Ethics_Booklet*

[74] See *Rules of the South African Nursing Council issued under the Nursing Act 50 of 1978* accessible at https://www.sanc.co.za/r386/.

[75] See eg *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal* (14275/2014) [2016] JOL 35522; [2016] (KZP) ZAKZPHC 27 (14 March 2016); *Khoza v Member of the Executive Council for Health And Social*

5. Public health medical negligence litigation

5.1 Abuse of litigation

In some public health medical negligence cases, comments made by judges seem to indicate that Health MECs of Provinces are abusing litigation and the litigation process to delay the inevitable. Thus contributing to the inordinate delay in completion of cases and to the prejudice of deserving plaintiffs' compensation needed to alleviate their desperate situation.[76] In *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal*[77] Pillay J states:

> "[73]: This case is a microcosm of a greater social phenomenon. It is no secret that with RAF (Road Accident Fund) cases waning medical malpractice is the new source of revenue for enterprising practitioners. Medical malpractice cases now occupy the space on the court roll vacated by RAF claims. Whilst RAF cases generated much abuse by some claimants and the legal, medical and other professionals who assisted them, not all practitioners exploited the system. Many claimants would have been left destitute without professional assistance given the statutory regime that operated at the time. Foreseeably, a similar experience as in RAF matters could replicate itself in medical malpractice suits. And when commercial interests become entrenched change will be harder to implement, as the experience in RAF matters shows. [74] In another matter against the defendant[7] set down for trial two days before this case a child had suffered brain damage, seizures and was mentally handicapped allegedly on account of the medical negligence of the defendant's employees. The defendant sought and obtained an adjournment with an order to pay huge, wasted trial costs because its officials initially deposed to affidavits stating that they did not have medical reports only to discover days before the trial that they did. The defendant's counsel had no instructions to explain to the court how this catastrophe arose. Hence I directed that the person(s) responsible should depose to affidavits explaining how the records were initially unavailable and then available. The affidavits had to be submitted to the National Minister of Health and the defendant for further action and copied to the registrar for the court's information. My reason for doing so was, in deference to the separation of powers principle, to alert the political heads of a chronic administrative deficit in health services that is also impacting on the efficiency of the courts as time is lost in trial matters being adjourned. The problem of medical and hospital records being unavailable timeously or at all is a recurring feature in medical malpractice cases that result in adjournments and extraordinary waste of legal and experts' costs at the expense of the public purse. [75] A quick survey of claims against the defendant enrolled for hearing from August 2015 to February 2016 is attached as an appendix to my judgment to give some statistical support for why medical malpractice is a matter of public interest law and why we should all be concerned. The survey reveals the following:
>
> a. Fifty-eight (58) matters were set down for pretrial, trial and/or applications to compel between August 2015 to February 2016.
>
> b. Forty-three (43) set-downs were for applications to compel (discovery, pre-trial information) against the defendant.
>
> c. In 10 matters the defendant was ordered to pay the costs.

Development of the Gauteng Provincial Government (2012/20087) [2015] ZAGPJHC 15; 2015 (3) SA 266 (GJ); [2015] 2 All SA 598 (GJ) (6 February 2015); *Gura v MEC for Health, Free State Province* (4632/2015) [2019] ZAFSHC 184 (3 October 2019); *C P v MEC Health of Provincial Government of the Free State* (A53/2019) [2020] ZAFSHC 216 (8 October 2020).

[76] The average completion period for litigated public health medical negligence claims is 8,5 years. See Whittaker 45. Also see eg *B.E.M v MEC For Health, Free State Provincial Government* (104/2018) 2021 ZAFSHC 164 (12 August 2021). Also see *PG obo TG v MEC for Health, Gauteng Province* case no 6003/2013 GLDJ (unreported) 19-03-2021.

[77] (14275/2014) [2016] JOL 35522; [2016] (KZP) ZAKZPHC 27 (14 March 2016).

d. Of the 15 set-downs for trial 4 were adjourned with the defendant paying the costs in all these matters; in 3 of the 4 the defendant agreed to or was ordered to pay the whole or a portion of the plaintiffs' claims plus costs.

e. Costs were reserved, not ordered or undecided in 35 matters.

f. The defendant was ordered to pay attorney client costs in 1 matter.

g. Costs ordered against the defendant included experts and 2 counsel in 11 matters.

h. In 10 cases the claimants were born severely handicapped mentally and physically. These claims range between R11m and R20m.

i. In only 1 matter the plaintiff withdrew the action and tendered the defendant's costs.

[76] A disturbingly large number of matters are postponed with the MEC having to pay costs. It has not been possible to assess the amount of costs awarded as the bills are not left in the court file for taxation. On average plaintiffs engage three experts and two counsel. When matters are adjourned with the defendant having to pay the wasted costs the disbursements alone are therefore huge. [77] Medical malpractice cases against the defendant are escalating rapidly. A knee jerk dispute resolution response instead of a problem-solving approach is unlikely to yield sustainable institutional reform. On the contrary it is likely to increasingly compromise the delivery of efficient health services as the health budget is drained to meet malpractice claims and costs. [78] One approach to minimising legal costs and litigating more efficiently is for either party to initiate a conference between the parties and, if necessary, before a judge in chambers as soon as summons is delivered to identify the issues in dispute, what needs to be proved and how that might best be accomplished. Availability of medical and hospital records and the possibility of engaging experts jointly can be canvassed at an early stage. Unlike traditional commercial litigation medical malpractice suits is a matter of public interest law. The approach should as far as possible be investigative with a view to problem solving. However, if plaintiffs make fraudulent claims or the defendant does not plead in good faith as I have found in this case, the litigation will be adversarial. [79] Although they present as a bipolar dispute between a plaintiff and a defendant with the remedy being findings on liability, compensation and costs the problem of malpractice remains institutional. Malpractice suits are retroactive in the sense that they seek to remedy past wrongs.

In *Mbokodi v Member of the Executive Council for the Department of Health, Eastern Cape*[78] (1950/2015) [2020] ZAECMHC 25 (30 June 2020) Brooks J says the following:

"[28] …The second infringement is the denial of access to justice which characterises the defendant's conduct of this matter. The cause of this infringement lies much closer to home. Both infringements amount to a serious dereliction by the defendant of his constitutional duties.[29] In another similar matter, where inactivity on the part of the defendant led to unnecessary postponements and the issue of orders directing the defendant to furnish instructions in relation to specific issues which had been addressed successfully at a pre-trial conference,[15] the court stated:"In light of the injunction contained in the order of this court of 25 May 2017, the

[78] (1950/2015) [2020] ZAECMHC 25 (30 June 2020). Also see [78] *Luyanda v Member of the Executive Council for Health, Eastern Cape* (114/2014) [2019] ZAECBHC 7 (15 March 2019): "[14] The defendant was also tardy in making discovery, doing so only after the plaintiff had launched an application to compel same. The schedule to the only discovery affidavit filed on her behalf reveals however that all that she discovered, additional to the usual pleadings and notices in the action, were the same notes from the maternity unit of the hospital, which do not take the matter any further. Even absent anything of substance to discover however, the defendant appears to have little appreciation of the vital role she is expected to meet in defending medical malpractice suits in a manner that is both respectful to the court and its rules and mindful of the limited resources of the State. This disrespect does not end there but continued throughout the pre-trial processes as I demonstrate below."

> defendant's apparent failure to settle this matter begs some enquiry. Mr TSHITSHI was hard pressed to explain this failure. It was disclosed that the defendant had made two offers of settlement to the plaintiff. The second, remarkably, was less than the first. Both were substantially less than the recommendations of the defendant's experts and legal team. No explanation for this phenomenon emerges from the evidence placed before the court. The temptation to indulge in speculation is there, but in the exercise of an objective judicial discretion this is to be avoided. It is, however, readily apparent that, for whatever arbitrary reason, the defendant refused to accept the guidance of his own experts and his legal team. Such an approach is deserving only of the censure of this court. On questions of factual causation the defendant and his legal team were to be advised by the opinion of the experts employed by the defendant. On questions relating to legal causation, the defendant was to be guided by his legal team. This process culminated eventually in a concession of liability on the merits of the plaintiff's claims. The same cannot be said of the proceedings relating to quantum. Here, the defendant appears to have adopted an arbitrary, inexplicable and apparently cavalier attitude towards his own experts' advice and the joint minutes which were produced by the parties' experts acting jointly and in the interests of justice. Mr TSHITSHI's frustration in being unable to obtain meaningful instructions on the settlement of the quantum in this matter was justifiably expressed in a heartfelt manner. He is to be commended on his display of integrity as an officer of this court in the manner in which he approached the presentation of his case in terms of rule 33 of the Uniform Rules of Court and the argument in court associated therewith. The glaringly obvious failure on the part of the defendant to address the procedures associated with the assessment of an appropriate quantum award in this matter is lamentable and a cause for concern. It can only be hoped that it is an attitude which will not emerge again in the future."[30] As can be seen from *Mvumbi**[16]* the issue of a rule *nisi* in this matter on 23 March 2020 does not constitute a phenomenon which is unique to the present trial proceedings. It would be accurate to state that the issue of rules *nisi* which are similar in form and content to that issued on 23 March 2020 in this matter is a practice born of necessity out of the defendant's history of inadequate performance in the conduct of litigation to which she is a party in this court[17]. Despite the inevitable increase in costs which it brings with it as a consequence, the practice is now a well-entrenched feature of the litigation landscape in this court. The issue of final orders on the various return dates is commonplace. The challenge offered on behalf of the defendant to the issue of a final order in the present matter is unique."

The quoted judgments are from KZN and EC. There appears to be no other similar judgments regarding other provinces for 2017 to 2021.[79] However, the abuse of litigation moved a Gauteng High Court judge to order that the MEC of Health for Gauteng and/or officials responsible for spurious litigation pay the costs *de bonis propriis*.[80] It follows that the financial impact of this approach to litigation must be determined. The various provincial health departments were during 2007 to date involved in approximately 209 litigated claims.[81]

[79] However, for Mpumalanga Province see, *Lochner v MEC for Health and Social Development, Mpumalanga* (2012/25934) [2013] ZAGPPHC 388 (27 November 2013).
[80] *Lushaba v MEC for Health, Gauteng* 2015 (3) SA 616 (GJ); 2017 (1) SA 106 (CC).
[81] These claims increase annually. See fn 47 and 48 above for details.

5.2 Legal fees and interest incurred

According to the 2018/19 provincial health departments' annual reports the following amounts were spent on legal fees and interest on late payments:[82]

Province	Legal fees	Interest	Total
Eastern Cape	R46 000 000,00	R1 224 000,00	R47 224 000,00
Free State	R4 110 000,00	Nil	R4 110 000,00
Gauteng	R18 000 000,00	R7 794 000,00	R25 794 000,00
KwaZulu Natal	R49 934 000,00	R4 142 000,00	R54 076 000,00
Limpopo	R110 000,00	Nil	R110 000,00
Mpumalanga	R22 182 000,00	Nil	R22 182 000,00
Northern Cape	Nil	Nil	Nil
Northwest	R4 559 000,00	R1 584 000,00	R6 143 000,00
Western Cape	R2 881 000,00		
Total	**R147 776 000,00**	**R14 744 000,00**	**R159 639 000,00**

The legal fees are indicative because it is not clear whether legal fees are part of medico legal claim settlements. The legal fees are as reflected in the annual reports. It must be said that, taking the above-cited judgments into account, the expenditure by EC and KZN on legal fees seem to reflect what these judgments state.[83]

6. Legal obligation to render and standard of public health services

The Government's obligation to deliver public healthcare is found in section 27 of the Constitution.[84] The standard of care is not described but section 9 (the right to equality), section 10 (the right to dignity), section 11 (the right to life) of the Constitution of the Republic of South Africa, Act 1996 creates a legal duty to ensure the rendering of medical care, treatment and advice with such skill, care and diligence as could reasonably be expected of medical practitioners and nursing staff in similar circumstances, obliging health departments to ensure proper, sufficient and reasonable health services are provided to members of the public, particularly those who were obliged to make use of such services of a public hospital.[85] In contrast the relationship between doctor and patient

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[82] To allow for possible influence of the Covid 19 pandemic the 2018/19 reports are used. No breakdown of specific legal services is given, and these are the totals for a province as reflected in their department of health annual provincial reports. The interest liability for EC includes abuse of vehicles.

[83] *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal* (14275/2014) [2016] JOL 35522; [2016] (KZP) ZAKZPHC 27 (14 March 2016) and *Mbokodi v Member of the Executive Council for the Department of Health, Eastern Cape*[83] (1950/2015) [2020] ZAECMHC 25 (30 June 2020).

[84] Constitution of the Republic of South Africa, 1996 S 27 : "(1) Everyone has the right to have access to – *(a)* health care services, including reproductive health care; *(b) … (c)* … (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.

[85] *M obo M v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Department* (2011/41603) [2018] ZAGPJHC 513 (1 October 2018); *N v Member of the Executive Council for Health, Eastern Cape* (2571/13) [2015] ZAECMHC 77 (9 July 2015): "[17] The Constitution enjoins the State to take reasonable and legislative and other measures within its available resources to achieve the progressive derealisation of the right of the people of South Africa to have access to health care services, including reproductive health care[1]. National Health Act 61 of 2003 was enacted in compliance with the provisions of section 27(2) of the Constitution (the Act). The Act was amended by the National Health Amendment Act 12 of 2013."; *M obo M v Member of the Executive Council for Dept. of Health, E. Cape, Province* (2035/2014) [2018] ZAECMHC 27 (24 May 2018): "[38] The circumstances of this matter demonstrate unequivocally a gross infringement of two basic human rights entrenched in the Constitution.[11] The first is the denial of access to adequate and effective healthcare experienced by the plaintiff at Z. Hospital in Mqanduli. The cause of the

in the private domain is that of contract.[86] A medical professional is obliged to render medical services with the level of skill and care that a reasonably competent practitioner in a particular branch of healthcare could be expected to demonstrate.[87]

Based on the preceding, medical negligence in the public sector cannot be based on contract although in practice medical negligence actions in the public sector are occasionally based on a fictional contract between the hospital and the patient to deliver adequate professional medical services in alternative conjunction with a delict.[88] On closer reflection, medical negligence in the public sector constitutes a breach the government's constitutional duty to render adequate and professional medical services to those citizens who cannot afford to pay for such services.[89] No contract is involved and consequently no breach of contract.[90] A breach if a legislative duty constitutes conduct which may found a delictual claim.[91] Added to this, a medical adverse event negligently caused is by itself sufficient for instituting a delictual claim. Just about all medical negligence claims are based on delict.[92]

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infringement was negligence and inefficiency on the part of the employees of the defendant over whom he had somewhat remote control but for which he is responsible in the discharge of his constitutional mandate. The result of the infringement was an unnecessary injury to an unborn child with devastating, permanent consequences. The second infringement is the denial of access to justice which characterises the defendant's conduct of this matter. The cause of this infringement lies much closer to home. Both infringements amount to a serious dereliction by the defendant of his constitutional duties."

[86] PA Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007) 283.

[87] *Idem* 607. Also see *Mitchell v. Dixon* 1914 AD 519 at 525.

[88] See e.g. *NM obo NM v MEC for Health, Eastern Cape* (1748/2017) [2019] ZAECMHC 44 (27 August 2019); *Zondo v MEC for Health of the Gauteng Provincial Government* (25644/2014) [2016] ZAGPJHC 243 (2 September 2016). This essentially a fictional/contrived contract as this obligation is derived from the Constitution. A patient who makes use of a public health facility derives his rights from the Constitution and not from a fictional/contrived contract.

[89] *Member of the Executive Council (MEC) for Health and Social Development, Gauteng v DZ obo WZ* Case (CCT 20/17) [2017] ZACC 37 (31 October 2017); *M obo M v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Department* (2011/41603) [2018] ZAGPJHC 513 (1 October 2018). The principle that breaches of the Constitution may result in a claim for damages was considered and confirmed in *Fose v Minister of Safety and Security* [1997] ZACC 6; 1997 (7) BCLR 851 (CC); 1997 (3) SA 786 (CC). Also see *Government of the Republic of South Africa and Others v Grootboom and Others* (CCT11/00) [2000] ZACC 19. 2001 (1) SA 46. 2000 (11) BCLR 1169 (4 October 2000); *Ngomane and Others v Johannesburg (City) And Another* [2019] 3 All SA 69 (SCA); 2020 (1) SA 52 (SCA); *RK and others v Minister of Basic Education and others (Equal Education as* amicus curiae*)* [2020] 1 All SA 651 (SCA).

[90] Carstens and Pearman 283 sidestep this distinction by concluding that the basis for medical negligence is rooted in the law of obligations. This is not helpful (the law of obligations consists mainly of contract and delict) and denies the fact that *both* the law of contract and the law of delict can be at play when medical negligence is considered. An act of medical negligence may simultaneously constitute a breach of contract and a delict. A prejudiced patient has the choice of basing his action on either contract (if it is a private medical professional) or delict. Almost invariably such an action will be based on delict due to the difficulty of recovering all damages with a contractual claim. See Neethling Potgieter Visser *Law of Delict* 7th edition LexisNexis (2015) 6 and *Lillicrap, Wassenaar and Partners v Pilkington Brothers (SA) (Pty) Ltd* 1985 1 SA 475 (A) 495–496 and Van der Walt and Midgley Delict 4; Stoop 1998 THRHR 10; *Administrator, Natal v Edouard* 1990 3 SA 581 (A) 597. The distinction between contractual and delictual damages is rooted in the object of the awarding the respective damages. Contractual damages are aimed in facilitating the fulfilment of a contract while delictual damages compensate for losses occasioned by an unlawful damage-causing event. See Neethling Potgieter Visser 6; Klopper *Damages* LexisNexis (2017) 9, 301 and see *Transnet Ltd v Sechaba Photoscan (Pty) Ltd* [2005] JOL 13495 (SCA), 2005 (1) SA 299 (SCA) 304.

[91] See Neethling Visser Potgieter 78; *Patz v Greene and Co* 1907 TS 427; *Da Silva v Coutinho* 1971 3 SA 123 (A) 140; *Knop v Johannesburg City Council* 1995 2 SA 1 (A) 31 33; *Lascon Properties (Pty) Ltd v Wadeville Investment Co* (Pty) Ltd 1997 4 SA 578 (W); *Faircape Property Developers (Pty) Ltd v Premier, Western Cape* 2002 6 SA 180 (C) 192–193; *Premier, Western Cape v Faircape Property Developers (Pty) Ltd* 2003 6 SA 13 (SCA) 30. Also see *Stedall v Aspeling* 2018 2 SA 75 (SCA); Scott "'n Resente aanwending van die nuwe onregmatigheidstoets vir deliktuele aanspreeklikheid – gewens of ongewens?" 2018 *TSAR* 906 *ff*..

[92] Carstens & Pearmain 284.

7. Proposed solutions

7.1 Introduction

The preceding dire situation has been met by responses and proposed solutions by government, academics and interested organisations. The proposals are:

- Delaying of payments to claimants with high value claims by forcing the payment in damages in instalments or by forcing claimants with a need for future medical care to make use of public healthcare facilities – referred to as *the public healthcare defence*;[93]
- Amendment of the State Liability Act 1957;[94]
- Solutions involving legal reform;[95]
- Revisiting the causes of cerebral palsy.[96]

In assessing proposed solutions, proposals must be subjected to critical scrutiny by establishing whether:

- Proposals contribute to or promote patient safety and prevent medical negligence liability.
- Ensure fair compensation to public health patients prejudiced by adverse events in public health care.
- Ensure accountability of those responsible for adverse events in public healthcare.[97]

7.2 Public healthcare "defence" and Amendment of the State Liability Act 1957

7.2.1 Basis

The basis for the "public healthcare defence" is that in the quantification of special damages in a claim for damages resulting from public healthcare damages the amount claimed as damages on is unreasonable because the plaintiff is likely to use public healthcare rather than private healthcare, the former being as good as, and cheaper than, the latter.[98] An added consideration is the impact that lump sum payments thus quantified and paid have on healthcare budgets and the adverse effect they may have on the provision of access to public healthcare for everyone.[99] It is abundantly clear from the preceding that the "public healthcare defence" is not a defence which goes to the root of the dispute but deals with the assessment of damages and the mode of payment of such damages.

7.2.2 Basis assessment of future medical costs and spending of damages awards after payment

Basis

The "defence" is really founded on a purely financial consideration in that the repetitive failure of the public health system to render adequate and professional medical services results in the

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[93] *Member of the Executive Council (MEC) for Health and Social Development, Gauteng v DZ obo WZ* Case (CCT 20/17) [2017] ZACC 37 (31 October 2017); *Phakama Ngalonkulu v The Member of the Executive Council for Health of the Gauteng Division Government* (217/2019) [2019] ZASCA 66 (17 June 2020); *PH (obo SH) v MEC for Health for the Province of Kwazulu-Natal* Case (11198/2016) [2020] ZAKZDHC 38 (31 August 2020); *TN obo BN v The Member of the Executive Council for Health, Eastern Cape* (36/2017) [2020] ZAECBHC 24 (17 November 2020);

[94] See State Liability Amendment Bill (B16-2018) *Government* Gazette No. 41658 of 25 May 2018 accessible at https://www.justice.gov.za › legislation › bills › 2...PDF.

[95] Patrick van den Heever Medical malpractice: The other side September 2016 *De Rebus*; Whittaker 47, 113.

[96] Whittaker, G.A. 2021. *Medical Malpractice in the South African Public Sector*. Cape Town: Actuarial Society of South Africa.

[97] Adapted from Frees, E.W. & Gao, L. 2020. "Predictive Analytics and Medical Malpractice". *North American Actuarial Journal*, 24:2, 211-227, DOI: 10.1080/10920277.2019.1634597 referred to in the context of malpractice systems by Whittaker 21.

[98] *Member of the Executive Council (MEC) for Health and Social Development, Gauteng v DZ obo WZ* Case (CCT 20/17) [2017] ZACC 37 (31 October 2017) [12].

[99] *Idem* [13].

payment of damages affecting the health system's ability to provide healthcare for all and is discriminatory.[100]

Assessment of future medical costs

Above all, the "public healthcare defence" is based on the mistaken premise that all future medical costs are to be assessed using private medical tariffs. The scale of tariffs on which medical expenses are assessed is not confined to that of the public health sector and depends on the circumstances of each case.[101] No claimant can be forced to be treated at a public health facility.[102] When assessing future medical costs, the measure is whether the costs claimed are reasonable both in respect of treatment and cost. The seriousness of the plaintiff's injuries and the nature of the treatment are considerations which co-determine the reasonableness of the medical treatment to be administered. Reasonable circumstances warranting private health care tariffs would be where a specific prescribed treatment cannot be obtained at a provincial or state facility or where admission to a provincial or state facility would under the circumstances be impracticable or impossible. [103] In any event a claimant is legally obliged to mitigate his damages and is not entitled

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[100] See eg *PH (obo SH) v MEC for Health for the Province of Kwazulu-Natal* Case (11198/2016) [2020] ZAKZDHC 38 (31 August 2020) [13], [22], [25]: "The essence of the public healthcare defence, in my view, is to put the cerebral palsy claimants who suffered damages as a result of the negligence of the employees of the State in the same category as those that could not attribute their injuries to any negligence on the part of the employees of the State. It may result in the State not taking proper measures to avoid cerebral palsy injuries in its facilities. Further, it discriminates against those who access healthcare through public healthcare facilities."

[101] *Ngubane v South African Transport Services* [1991] 4 All SA 22 (AD), 1991 (1) SA 756 (A) 784: "Though the *onus* of proving damages is correctly placed upon the plaintiff, this submission, which is really concerned with the duty to adduce evidence, is to my mind unsound. By making use of private medical services and hospital facilities, a plaintiff, who has suffered personal injuries, will in the normal course (as a result of enquiries and exercising a right of selection) receive skilled medical attention and, where the need arises, be admitted to a well-run and properly equipped hospital. To accord him such benefits, all would agree, is both reasonable and deserving. For this reason, it is a legitimate – and as far as I am aware the customary – basis on which a claim for future medical expenses is determined. Such evidence will thus discharge the *onus* of proving the cost of such expenses unless, having regard to all the evidence, including that adduced in support of an alternative and cheaper source of medical services, it can be said that the plaintiff has failed to prove on a preponderance of probabilities that the medical services envisaged are reasonable and hence that the amounts claimed are not excessive." See also *Maja v SA Eagle Ins Co Ltd* [1990] 3 All SA 103 (W), 1990 (2) SA 701 (W); *Truter v Deysel* 2006 (4) SA 168 (SCA), [2006] JOL 16961 (SCA); *Munro v NEGI Co Ltd* QOD F2-3; *General Accident Ins Co SA Ltd v Uijs* [1993] 4 All SA 610 (AD), 1993 (4) SA 228 (A) 236. See *Williams v Oosthuizen* [1981] 2 All SA 369 (C), 1981 (4) SA 182 (C) where the stated criterion of equally good treatment at a lower cost is of importance. It is submitted that in view of the state of public health services, a plaintiff should be afforded the best possible treatment despite any concerns regarding mitigation of damages. The duty to mitigate does not include actions that may be prejudicial to the plaintiff. See *Jayber (Pty) Ltd v Miller* 1980 (4) SA 280 (W) 284; *Kinemas Ltd v Berman* 1932 AD 246; *Swart v Provincial Ins Co Ltd* [1963] 1 All SA 174 (A), 1963 (2) SA 630 (A); *Williams v Oosthuizen* [1981] 2 All SA 369 (C), 1981 (4) SA 182 (C) and in contrast *Ngubane v South African Transport Services* [1991] 4 All SA 22 (AD), 1991 (1) SA 756 (A) and *Maja v SA Eagle Ins Co Ltd* [1990] 3 All SA 103 (W), 1990 (2) SA 701 (W) 710. For mitigatory steps prejudicial to a plaintiff, see, eg, *Van Almelo v Shield Ins Co Ltd* [1980] 3 All SA 770 (C), 1980 (2) SA 411 (C); *Soar h/a Rebuilds for Africa v JC Motors* [1992] 2 All SA 302 (A), 1992 (4) SA 127 (A); *Orda AG v Nuclear Fuels Corporation of South Africa (Pty) Ltd* [1994] 4 All SA 552 (W), 1994 (4) SA 26 (W); *Paarlberg Motors (Pty) Ltd t/a Paarlberg BMW v Henning* 2000 (1) SA 981 (C) 988*; Adel Builders (Pty) Ltd v Thompson* [1998] 2 All SA 534 (SE), [2000] 4 All SA 341 (A), 1999 (1) SA 680 (SE), 2000 (4) SA 1027 (SCA) 1030. See further, Nortje 1999 *Annual Survey* 182–3; *Smit v Abrahams* [1994] 4 All SA 679 (AD), 1994 (4) SA 1 (A). Besides, it is to be doubted if equally good treatment is currently available at state medical facilities. This will be a question of fact. Judicial disapproval of attempts to limit medical expenses to a fixed tariff was expressed in *Law Society of South Africa and Others v Minister for Transport and Another* 2011 (2) BCLR 150 (CC), 2011 (1) SA 400 (CC) 433: "Lastly and perhaps more importantly, the evidence shows that in certain material respects the public health institutions are not able to provide adequate services crucial to the rehabilitation of accident victims who are permanently disabled", and at 436: "The public sector is not able to provide adequate services in a material respect. It must follow that the means selected are not rationally related to the objectives sought to be achieved. That objective is to provide reasonable health care to seriously injured victims of motor accidents."

[102] *Maja v SA Eagle Insurance* 1990 (2) SA 701 (W) where it was held that a statutory undertaking (currently s 17(4)(a) of the RAF Act, 1996) to pay future medical costs cannot be limited to public health facilities. Also *Ngubane v South African Transport Services* 1991 (1) SA 756 (A) 784D.

[103] *Ngubane v South African Transport Services* [1991] 4 All SA 22 (AD), 1991 (1) SA 756 (A) 783.

recover private medical tariff costs where suitable and adequate and professional public health treatment is available.[104] It is clear that the tariff employed in assessment of future medical costs depends on the circumstances of each case and that private medical tariff is not the sole measure of such damages.

Utilisation of award by plaintiff

One of the arguments advanced in favour of structured payments is that plaintiffs are by and large financially incapable of managing the large awards accruing to them from the public health system. Furthermore, claimants may apply damages awards for other purposes than awarded. In addition, there is the danger of double dipping when a claimant exhausts a lump sum award and then requires medical treatment.

Where a claimant is a major and is vulnerable to a loss of a damages award through his own financial inexperience, ineptitude or the persuasion of others, the damages award should be protected by, for example, the purchase of an annuity or annuities. The court can merely make suggestions and only by consent of the major plaintiff order measures to protect the award. It is up to a plaintiff's legal adviser to persuade a plaintiff to some course of action that would not lead to the lump sum damages award being dissipated with little to show for it.[105] It is suggested that a legal adviser has a duty to his client to advise a client accordingly. Most high value negligent public health care awards are made to parents in their representative capacity in respect of damages suffered by minors.[106] In these circumstances the court as upper guardian of all children has inherent jurisdiction to order measures to protect the minor's award[107] against loss for various reasons.[108]

As far as the danger of double dipping is concerned, this can easily be countered by suitable administrative measures to ensure that this does not occur.

7.2.3 Payment in specie instead of a lump sum

The "public health defence" in claims where damages exceed R1 million extends to an order which compels a claimant's treatment at a public health facility.[109] As is the case for payment of medical costs on exclusively a public health tariff, the notion that public health institutions can provide similar and same-standard treatment at a lower cost than private health care, proceeds from a non-existent and/or warped appreciation of how future medical costs must be quantified[110] and, given the incidence of adverse events in the public health sector, the merit of such defence as an effective solution to solve the public health sector financial crisis is questionable.[111]

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[104] See *Williams v Oosthuizen* 1981 (4) SA 182 (C); *Dyssel NO v Shield Insurance* 1982 (3) SA 1084 (C).

[105] *Burns v National Employers' General Ins Co Ltd* 1988 (3) SA 355 (C) 365.

[106] 60% of high value claims exceeding R1 million are for CP children with quantum ranging from R9 – R25 million.

[107] Measures include the appointment of a curator, payment to the Guardian Fund, investment with a recognised registered financial institution and a specially formed trust to protect and administer the award. On practice the latter method is usually adopted.

[108] See *Southern Ins Association Ltd v Bailey* [1984] 1 All SA 360 (A), 1984 (1) SA 98 (A); *Burns v National Employers General Insurance Co Ltd* 1988 (3) SA 355 (C) 365; *Van der Rij NO v Employers Liability Assurance Corporation Ltd* [1964] 4 All SA 390 (W), 1964 (4) SA 737 (W) 739; *Dube NO v Road Accident Fund* 2014 (1) SA 577 (GSJ.

[109] See *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* (4314/15) [2019] ZAGPJHC 504; 2020 (2) SA 567 (GJ); [2020] 2 All SA 177 (GJ) (18 December 2019).

[110] See par 7.2.1 and fn 96.

[111] See par 4.1, fn 48. In 2018/19 Gauteng Provincial Health department reported 866 septic caesarean sections, 1148 cases of HIE and 2 307 recorded deaths of newborn babies. See IOL 30 Oct 2018 "Serious adverse events in Gauteng hospitals killed 3 832 patients in 2018" at https://www.iol.co.za/the-star/news/serious-adverse-events-in-gauteng-hospitals-killed-3-832-patients-in-2018-36291826. The treatment at a public facility is not without cost and no evidence of the cost differential or "saving" could be found. With the incidence of CP, facilities for the implementation will result in insustainability.

7.2.4 Payment of public healthcare claims in instalments

Damages must be paid in a lump sum. The insistence of public health authorities that the financial consequences of their serial breach of their constitutional duty to provide adequate and professional healthcare to those who cannot afford to pay for medical services entitles them to a deviation of the obligation to settle damages caused by their breach, is disingenuous and insufficient to justify the curtailment of poor and seriously prejudiced claimants' rights to lump sum payment of their damages.[112]

7.2.5 State Liability Amendment Bill[113]

Object

The Bill seeks to amend the State Liability Act, 1957 (Act No. 20 of 1957), to provide for structured settlements for the satisfaction of claims against the State because of wrongful medical treatment of persons by servants of the State; and to provide for matters connected therewith.[114]

Provisions

The Bill provides for:

- Compulsory Court orders structuring payment of claims exceeding R1 million in respect of:
    - past expenses and damages.
    - necessary immediate expenses.
    - cost of assistive technology or other aids and appliances.
    - general damages for pain and suffering and loss of amenities of life.
    - periodic payments for future costs.
- Compulsory court orders in respect of future care, future medical treatment and future loss of earnings ordering:
    - periodic payments at such intervals, which may not be less often than once a year;
    - during the lifetime of the injured party concerned; and
    - on such terms as the court considers necessary.
- Discretionary court orders in lieu of future medical costs payment
    - Treatment at a state facility.
- Future medical treatment in a private health establishment, limited to the potential costs that would be incurred if such care was provided in a public health establishment.
- Amount payable by way of periodic payments must increase annually in accordance with the average of the consumer price index.
- Periodic amounts subject to review and variation with a court order.

The Bill in its current form was rejected by the the Portfolio Committee on Justice and Correctional Services in January 2021 and referred to government. The committee with all the relevant

[112] See par 7.2.6 below.
[113] See State Liability Amendment Bill (B16-2018) *Government* Gazette No. 41658 of 25 May 2018 accessible at *https://www.justice.gov.za › legislation › bills › 2...*PDF.
[114] As stated in *Government* Gazette No. 41658 of 25 May 2018.

information at their disposal, felt a holistic approach should be followed in changing the Bill. Another reason for rejection was that the SA Law Reform Commission's report was still outstanding.[115]

7.2.6 Comment

The "public health defence" is based on purely financial and not any policy or legal considerations. It ignores legal principles used to assess future medical cost damages and constitutes an attempted coercive and legally unfounded measure to without legislation[116] sidestep common and case law to lessen the payment of proven damages without legislation. It essentially constructively condones serial negligently caused adverse events within the public health sector which constitute a breach of the government's constitutional duty to provide adequate and professional healthcare[117] and the use of the consequences of such breach to justify the curtailment of a judgment creditor's common law right to a final settlement of the judgment debt owed by the judgment debtor.[118] It deprives the claimant of choice of where and how he is to be treated[119] and does not fully take the claimant's peculiar needs and situation into account.[120] Furthermore, the "defence":

- Affects poor claimants who cannot afford to pay for medical health care.[121]
- Does not curtail the need for quantification of damages.[122]
- The public health defence over and above the mistaken basis of how damages for future medical costs is assessed, is premised on the contention that the payment of damages in lump sums prevents the compliance by health departments with their constitutional duty to provide health care for all. No evidence exists for the assumption that deferred payment will enable and/or promote the constitutional rights and duties on which the defendant relies to justify deviation from lump sum payments – the contrary holds true.[123]

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[115] See Polity "Justice Portfolio Committee Sends State Liability Amendment Bill Back To Department" at https://www.polity.org.za/article/justice-portfolio-committee-sends-state-liability-amendment-bill-back-to-department-2021-01-26. Much of the comment made in paragraph 7.2.6 below if not all, applies *mutatis mutandis* to this Bill. One peculiar aspect of the Bill is the use of the terminology "wrongful medical treatment". This clearly an error. It is not sufficient for conduct to be wrongful for delictual liability to exist, it must also be accompanied by fault in the form of intent or negligence and the other requirements of a delict must also be fully met. For the requirements for a delictual action and the meaning of "wrongfulness" and see Neethling Visser Potgieter 25, 33

[116] See *Premier, Western Cape v Kiewitz* 2017 (4) SA 202 (SCA) and compare s 17(4) of the Road Accident Fund Act 58 of 1996 which regulates undertakings for medical services and deferred payments of loss of income and maintenance. Also Law Reform Commission, Issue paper 33, Project 141 Medico-legal Claims, 20 May 2017, 44.

[117] Par 6 above. The defence can be likened to a situation where a child murders his parents, is found guilty of murder and then in mitigation pleads that he is now an orphan.

[118] See *Premier, Western Cape v Kiewitz* 2017 (4) SA 202 (SCA); *MEC for Health and Social Development of the Gauteng Provincial Government v Zulu* (1020/2015) [2016] ZASCA 185 (30 November 2016); *AD and Another v MEC for Health And Social Development, Western Cape Provincial Government* (27428/10) [2016] ZAWCHC 116 (7 September 2016) [64].

[119] Contrary to the Bill of Rights and section 8(1) of the National Health Act No. 61 of 2003 which in effect states that a patient has the right to choose a healthcare provider.

[120] *See Ngubane v South African Transport Services* [1991] 4 All SA 22 (AD), 1991 (1) SA 756 (A). For an extensive comparison of the advantages and disadvantages of periodic compared to lump sum payments, see Whittaker 128 ff.

[121] See fn 86.

[122] Whittaker 129: "(6) If periodic payments are based on a lump sum awarded by the Court or negotiated between the legal representatives then they retain all the difficulties of calculation and problems of proof associated with the present system."

[123] *AD and Another v MEC for Health And Social Development, Western Cape Provincial Government* (27428/10) [2016] ZAWCHC 116 (7 September 2016) [62]: [62] Whatever the pros and cons might be of more radical departures from the one-action rule or lump-sum rule, the proposed departure in the present case is not justified by its constitutional premise. The defendant accepts that it would not be fair or reasonable to have a clawback provision without a top-up provision. Furthermore the defendant does not say that its proposed solution relieves the court of the duty to assess damages conventionally. The defendant accepts that damages as conventionally assessed must be paid as a lump sum to the trust. No evidence was led to show that this type of solution would promote the constitutional rights and duties on which the defendant relies nor is such a conclusion self-evident, indeed it is counter-intuitive:

- Assails the claimant's dignity as he is now forced to use facilities which were the cause of his injury and the possibility of further injury.
- Exposes the claimant (given the current precarious financial state of the public health sector) to the possibility of further disputes and/or having to enforce his rights.[124]
- Does not enable provision for unforeseen capital expenditure needs.[125]
- Discriminates against public health care claimants.[126]
- Does in no way ensure or promote accountability and is no incentive to reduce negligent adverse events in the public health sector and constructively institutionalises such behaviour.[127]
- Is not without cost[128] and does not reduce the public health sector medical negligence liability.[129]
- Critically viewed and given the high incidence of CP,[130] it is a "defence" which in time will haunt those who raise it.[131]

· Private and public resources would still have to be expended on a full quantum trial, despite the fact that the top-up and clawback provisions might render the exercise largely academic
· The defendant and similarly placed organs of state would still have to pay damages, as conventionally assessed, in a lump sum. The money in question would thus not be available to meet state organs' obligations to the population at large.
· Although there would be some prospect of eventual clawback, in most cases that would lie many years in the future.
· In any given case there would be an even likelihood of the top-up and clawback provisions becoming operative. On average one would expect the financial benefit from clawback rights to be neutralised by the financial burden from top-up provisions.
[63] The first and second of these observations would not apply if one adopted a more radical departure from the lump-sum rule, namely substituting for a lump-sum award an obligation to meet future medical expenses as they arise. Such a regime might allow public funds to be better matched to current public needs and in a general sense this might enhance the constitutional rights and duties which the defendant invokes. The parties and the court would also be saved the time and expense of determining future medical costs."

[124] Whittaker 128, fn 10: Law Reform Commission of Hong Kong. 2018. *Periodical Payments for Future Pecuniary Loss in Personal Injury Cases*. Periodical Payments for Future Pecuniary Loss in Personal Injury Cases Sub-committee accessible at https://www.hkreform.gov.hk/en/projects/personalinjury.htm.

[125] Whittaker 128.

[126] *PH (obo SH) v MEC for Health for the Province of Kwazulu-Natal* Case (11198/2016) [2020] ZAKZDHC 38 (31 August 2020) [13], [22], [25]: "The essence of the public healthcare defence, in my view, is to put the cerebral palsy claimants who suffered damages as a result of the negligence of the employees of the State in the same category as those that could not attribute their injuries to any negligence on the part of the employees of the State. It may result in the State not taking proper measures to avoid cerebral palsy injuries in its facilities. Further, it discriminates against those who access healthcare through public healthcare facilities."

[127] *Idem.*

[128] The public health system still must provide treatment and that treatment is not without cost to the public health sector. Moreover, is not clear what the "cost saving" is and whether this saving warrants the curtailment of claimant's rights and there is no convincing evidence whether the payment of future medical costs is the leading cause of the public health sector financial predicament. A system of periodic payments will in view of the number of adverse events in the public health sector build an increasing contingent liability, requires an efficient administration, and will incur significant administrative costs. *Cf ADIB v The MEC for Health and Social Development Western Cape Provincial* Government (27428/10) [2016] ZAWCHC 116 (7 September 2016) [62]. See Whittaker 129 quoted in fn 122. Road crash victims have the option of agreeing to payment in instalments of their loss of income or maintenance damages in terms of section 17(4)(b) of the RAF Act, 1996. The public health "defence" and the Bill leaves a claimant no choice.

[129] Whittaker 128.

[130] Based on a population of 59 million and an annual birth rate of 20 per 1000 of the population (see *https://www.macrotrends.net/countries/ZAF/south-africa/birth-rate*) and an incidence of 10 per 1000 births, CP annually affects an estimated 118 000 South African children.

[131] Whittaker 129: "(5) Periodic payments will build over time and ultimately annual payments will increase to meaningful levels[12]. The burden of administrating these claims will add a significant cost element in addition to the original claim amounts. Before implementing a system such as the State Liability Amendment Bill, it is critical to obtain a proper estimate of administrative costs." In a Daily Despatch report of 26 July 2021 "Bhisho to challenge medico-legal payments" at https://dispatch.pressreader.com/article/281479279444362 the EC Health department intends to unilaterally implement measures that mirror the measures contained in the "public health defence" and the Bill. The Gauteng Health Department alone reported 1148 CP cases in 2018. See IOL 30 Oct 2018

- It is only beneficial where there is litigation. Only a small proportion of claims for negligent adverse events are litigated.[132]

Finally, the only real advantage derived from periodic payments is a saving of the unpaid portion of damage which falls away on the premature death of the plaintiff which then accrues to the defendant. It is seriously debatable given the object of extensive cost saving not to be realised by either the "public health defence" and the State Liability Amendment Bill and the small advantage it affords the public health system, if constitutionally regarded, sufficient cause to limit the rights of claimants who are unable to afford health care and who were prejudiced by the government's breach of its constitutional duty to provide adequate and professional health care.[133]

7.3 Other proposals

7.3.1 Introduction

A survey of sources displays a diverse collection of proposals to solve the public health negligent adverse event problem. The range from measures to clarify the basis for liability to legal reforms. The following is a representative list:

- Legal and legislative reform.
    - Revisiting causation
    - Special courts and assessors in medical negligence cases
    - Aspects of quantum
    - Reversionary trusts
- Clarification of medical requirements for cerebral palsy medico legal liability.
- CP treatment protocols.
- Solutions proposed by provincial departments of health.

7.3.2 Legal and legislative reform

7.3.2.1 Causation

Whittaker identifies the *conditio sine qua non* ("but for") factual test for causation as a problem when dealing with causation in cerebral palsy cases where cumulative causation is present.[134] It must be emphasised that the *conditio sine qua non* test for factual causation is not strictly logical and common sense plays a role in determining a factual causal link in the legal sense.[135] The

"Serious adverse events in Gauteng hospitals killed 3 832 patients in 2018" at https://www.iol.co.za/the-star/news/serious-adverse-events-in-gauteng-hospitals-killed-3-832-patients-in-2018-36291826. Kwazulu-Natal according to its 2018 annual report registered 188 new obstetric cases.

[132] See par 4.1.

[133] See s 9 of the Constitution of the Republic of South Africa 1996; Woolman and Bishop *Constitutional Law* Juta & Co (2013) 17-35. Also see Julia Evans "Public Protector investigation finds that hospitals violate South Africans' rights" Daily Maverick 3 October 2021 at *https://www.dailymaverick.co.za/article/2021-10-03-public-protector-investigation-finds-that-hospitals-violate-south-africans-rights/*.

[134] See Whittaker 32-42. On 42 he states: "Nuances to the "but for" test are undoubtedly required in order to ensure just results, especially where there are multiple competing causes of an event."

[135] See *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* [2002] 1 All SA 384 (A), 2001 (3) SA 1188 (SCA) 1201: "Finally, it must be borne in mind that expert scientific witnesses do tend to assess likelihood in terms of scientific certainty. Some of the witnesses in this case had to be diverted from doing so and are invited to express the prospects of an event's occurrence, as far as they possibly could, in terms of more practical assistance to the forensic assessment of probability, for example, as a greater or lesser than fifty per cent chance and so on. This essential difference between the scientific and the judicial measure of proof was aptly highlighted by the House of Lords in the Scottish case of *Dingley v The Chief Constable, Strathclyde Police* 2000 SC (HL) 77 and the warning given at 89D–E that '(o)ne cannot entirely discount the risk that by immersing himself in every detail and by looking deeply into the minds of the experts, a Judge may be seduced into a position where he applies to the expert

application of the *condition sina qua non* has been the subject of some analytical criticism and debate by jurists[136] but the weight of authority recognises this test as being a method to determine a link between a damage causing event and the ensuing damages.[137] Neethling Potgieter Visser suggest that when there are difficulties when the *conditio sina qua non* test is applied where cumulative causation is present, an element of legal causation be applied by asking whether: "there was a sufficiently close relationship between the defendant's negligent conduct and the victim's damage that the damage should be attributed to the defendant, taking into account policy considerations based on fairness, reasonableness and justice. To ascertain whether such a relationship existed, the negligent exposure to a risk of harm may play a significant part."[138] By and large, causation has not caused many problems and where problems may arise, the suggested adjusted test will meet most situations.[139]

Causation is primarily driven by proven facts and the current state of the law regarding causation. The law is sufficiently adaptable to deal with any complex causation issue. Although causation may conceivably be prejudicial to claims and/or cause unwanted liability, it is not factor that will significantly contribute to solving the serial incidence of negligent adverse events in the public health sector.

7.3.2.2 Special courts and assessors

Special courts

Whittaker[140] suggests that, given the often-complex nature of medical malpractice litigation and the fact that generally judges are unfamiliar with disputes involving medical science, that judges be medically trained to adjudicate medico-legal matters and be deployed in special medical courts. His suggestion is based on the existence of special courts for tax, trademarks, patents, labour, and land disputes. A similar proposal was made in 1986 in respect of road traffic crash injury compensation.[141] The commission found that despite the high number of claims, the low number of cases that proceed to trial, special courts were not warranted. The sample of two hundred and six cases from 2006-2020 reported by SAFLII used by Whittaker[142] indicates that there are approximately fifteen medico-legal trials per year over nine High Court divisions. This shows that there is no need of special medico-legal courts.[143]

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evidence the standards which the expert himself will apply to the question whether a particular thesis has been proved or disproved – instead of assessing, as a Judge must do, where the balance of probabilities lies on a review of the whole of the evidence". Also *Minister of Finance v Gore* 2007 1 SA 111 (SCA) 125: "With reference to the onus resting on plaintiff, it is sometimes said that the prospect of avoiding the [damage] through the hypothetical elimination of the wrongful conduct must be more than 50%. This is often followed by the criticism that the resulting all-or-nothing effect of the approach is unsatisfactory and unfair. A plaintiff who can establish a 51% chance, so it is said, gets everything, while a 49% prospect results in total failure. This, however, is not how the process of legal reasoning works. The legal mind enquires: What is more likely? The issue is one of persuasion, which is ill-reflected in formulaic quantification. The question of percentages does not arise … Application of the 'but for' test is not based on mathematics, pure science or philosophy. It is a matter of common sense, based on the practical way in which the ordinary person's mind works against the background of everyday-life experiences."

[136] See Van Rensburg *Juridiese Kousaliteit* \9lld thesis Unisa 1970) 3–65; Van der Walt and Midgley *Delict* 199 fn 8; Visser 1989 *THRHR* 558-569; Snyman *Strafreg* 86–87; Brand in Visser and Pretorius (eds) 49–50; Van Oosten 1982 *De Jure* 20; Du Plessis 1990 TSAR 750-75. Scott 2008 *THRHR* 329–330; Neethling 2005 *TSAR* 408.

[137] See Neethling Potgieter Visser *Delict* 189

[138] Neethling Potgieter Visser *Delict* 194. See *Lee v Minister of Correctional Services* 2013 2 SA 144 (CC) 174.

[139] See e.g. *Member of the Executive Council, Department of Health, North West v NAM obo TN* (035/2020) [2021] ZASCA 105 (26 July 2021); *MEC for Health and Social Development, Gauteng v MM on behalf of OM* (697/2020) [2021] ZASCA 128 (30 September 2021).

[140] Whittaker 49.

[141] See The Commission of Inquiry into the Handling of Litigation in terms of the Motor Vehicle Accidents Fund Act 84 of 1986, appointed by Government Notice 2058 in the *Government Gazette* of 19 September 1986 under chairmanship of Viviers J.

[142] Whittaker 43.

[143] These cases are High Court cases of high value that went on trial and consequently instances where a special court would probably be required.

Assessors

Lerm proposes the use of assessors in all complicated matters where dedicated knowledge and expertise may be required under certain defined conditions.[144] Because his proposal is not restricted to medico legal disputes but all disputes involving scientific knowledge or expertise not usually within a judge's experience, knowledge or competency, the suggestion has decided merit. However, the employing of assessors is not a solution substantially limiting public health sector liability for negligent adverse events.

7.3.2.3 Reversionary trusts

A reversionary trust is set up to deal with the award of future damages where a minor is the claimant. The distinguishing feature is that the award makes provision for the payment of damages into the trust. The settlement of damages on the trust is subject to special provisions protecting the future medical expenses in the form of a medical fund and contain an agreement that the defendant is obliged to supplement the medical fund and that in certain circumstances the defendant would be entitled to a refund from the medical fund.[145] The formation of a reversionary trust requires consensus between plaintiff and defendant regarding both the formation and the terms and conditions of the trust. It provides little saving because the amount to establish the trust fund must still be assessed in the traditional way. The financial benefit from clawback rights will probably be neutralised by the financial burden from top-up provisions. Finally, such an arrangement would conflict with section 66(1) of the Public Finance Management Act 1 of 1999 which prohibits an organ of state from borrowing money or issuing a guarantee, indemnity or security or entering any other transaction that binds the institution to a future financial commitment unless it is authorised by the and has been approved, in the case of a Provincial Revenue Fund, by the provincial MEC for Finance (s 66(2)).[146] In one instance an attempt was made to recover damages paid in a lump sum not utilised after a claimants premature death.[147]

7.3.2.4 Capping the time between the incident date and date of claim

Whittaker identifies the long intervening period between the damage causing event and the institution of claims for damages resulting from negligent adverse events[148] This causes difficulties in tracing witnesses and the obtaining of records. He recommends a shortened period within which CP claims must be instituted and the implementation of an early notification system for CP claims.[149] He comments that public health patients intending to sue provincial health departments are seemingly favoured in applications for condonation for non-compliance with ILPCOSA.[150] Also the average time of 9 years to finalise litigated claims is a factor which complicates the proving of damages, and the defence of such claims is identified as a problem.

The delay in pursuing CP claims seems to be for other than systemic reasons. It must be remembered that claimants in public health care negligence claims are from the poor and probably unsophisticated sector of the population. In addition, the consequences of CP take some time to manifest making it risky to institute action until a clear picture of consequences has emerged. Finally, protracted litigation is a consequence of public health departments' approach to litigation which raises a suspicion that litigation is being used to somehow manage the consequences of

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144 Lerm "Two heads are better than one" *De Rebus* Oct 2012 (Oct) at https://www.derebus.org.za/two-heads-better-one/.

145 Whittaker 133; *ADIB v The MEC for Health and Social Development Western Cape Provincial Government* (27428/10) [2016] ZAWCHC 116 (7 September 2016).

146 *ADIB v The MEC for Health and Social Development Western Cape Provincial Government* (27428/10) [2016] ZAWCHC 116 (7 September 2016) [60] – [64].

147 See *MEC for Health North West Province and Another v Josephs Incorporated and Others* (475/2016) [2017] ZANWHC 104 (26 October 2017).

148 Ascribable to the fact that in CP claims, claimants are minors, and their claims according to s 3(1)(c) of the Prescription Act 68 of 1996 prescribe three years after their 18th birthday.

149 Whittaker 48.

150 S 3(1)(a) of the Institution of Legal Proceedings against Certain Organs of the State Act 2002.

medico legal claims.[151] Setting up an early notification system in addition to the 6 months' notice required by ILPCOSA as recommended, will assist in management CP claims but will not reduce the incidence thereof.[152]

7.3.2.5 Aspects of quantum determination

Cost of caregiving in cerebral palsy cases

Whittaker reports that the cost of caregiving is the single most significant head of damage in compensation for damages in cerebral palsy claims.[153] He proposes that a table of damages for caregiving be set up and that damages for caregiving be capped.[154] Prospective damages are assessed on the facts of each case taking the circumstances of a claimant into consideration. Here the principle of reasonableness applies,[155] and the claimant is under a duty to mitigate his damages.[156] There is nothing significant in the ratio of awards between different heads of damage. Neither is the way the damages are to be applied a factor in the assessment of damages.[157] Notwithstanding, considering that the legal cost-causing elements of a delictual claim is the need to establish legal liability and also the quantum of damages arising from a delict, the suggestion of setting up a table of damages reflecting the base amount of damages in given circumstances has some merit subject to the reservation of a claimant's rights to prove that his damages exceed that of the amount suggested by the table. The capping of damages employing a tariff is problematical. The courts do not favour this route to limit the damages to which a claimant is entitled.[158]

The suggestion of a table and capping of caregiver costs is a suggestion that may assist to reduce public health care damages liability for negligent adverse events, but will not affect liability for the remaining heads of damages for negligent adverse events.

Net discount rate

Whittaker proposes a revisit of the applicable discount rate used to calculate future medical costs.[159] Lower rates are to the disadvantage if a claimant and the question is whether a change in discount rates to balance the government's public health's books is a sufficient reason for curtailing claimant rights. It is clearly a suggestion that deals with the consequences and not the cause of negligent adverse events.

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[151] See par 5.1 above. Like what occurred with the RAF. See Klopper "Is the Road Accident Fund's litigation in urgent need of review?" 2019 March *De Rebus* at https://www.derebus.org.za/is-the-road-accident-funds-litigation-in-urgent-need-of-review/.

[152] See PSI reporting in paragraph 7.6 below.

[153] Whittaker 83.

[154] *Idem* 84.

[155] Klopper *Damages* 91 *ff.*

[156] *Idem* 23 and see *Jayber (Pty) Ltd v Miller* [1980] 2 All SA 346 (W), 1980 (4) SA 280 (W) 286: "The onus of proving damages rests on the plaintiff and remains on it throughout. It seems to me that the content of the mitigation rule is that the defendant may prove that the amount claimed by the plaintiff does not represent the true amount because of a failure to take reasonable steps. An allegation of such failure is a positive one, such as naturally attracts an onus. But, once he has proved such failure, I do not see why he must, as it were, quantify the plaintiff's damages for him by proving how much has to be subtracted. Of course, he would have to prove that the failure complained of did in
fact increase the damages. It seems to me that, once he has proved a failure in that sense, the plaintiff's original proof has fallen away and it is then for the plaintiff to prove what its damages are, if any, in the light of the operation of the mitigation rule."

[157] *Blyth v Van den Heever* [1980] 1 All SA 148 (A), 1980 (1) SA 191 (A) 225; *Karpakis v Mutual and Federal Ins Co Ltd* [1991] 3 All SA 430 (O), 1991 (3) SA 489 (O).

[158] *Maja v SA Eagle Ins Co Ltd* [1990] 3 All SA 103 (W), 1990 (2) SA 701 (W); *Ngubane v South African Transport Services* 1991 (1) SA 756 (A) 784D; *Law Society of South Africa and Others v Minister for Transport and Another* 2011 (2) BCLR 150 (CC), 2011 (1) SA 400 (CC) 433.

[159] Whittaker 84.

Life expectancy

Life expectancy is an important factor ultimately influencing the amount of compensation paid for future damages.[160] Whittaker recommends setting up a life expectancy table to assist with the quantification of damages, for especially, CP claims. This recommendation, if implemented, will undoubtedly save both costs and provide more certainty in the assessment of future damages but is not a measure which addresses the causes of medico legal damages claims.

7.3.3 Inadequate or no CTG monitoring as proof of substandard care

A study shows that midwives are not adequately trained to use and interpret CTG. Whittaker suggests remedial action by training and appointing personnel to do CTG monitoring in problem health facilities.[161]

There appears to be inconclusive evidence of the advantage of using electronic foetal monitoring for the diagnosis and treatment of foetal distress in long-term foetal outcomes despite it being routinely used as evidence of substandard treatment in CP damages claims.[162] Placental pathologic examination provides a more accurate understanding of adverse foetal birth outcomes such as hypoxic brain injury, cerebral palsy, foetal growth restriction, stillbirth, and neonatal death. For this reason it is recommended that clear guidelines for the submission of the placenta for histopathological examination in the public sector must be formulated.[163]

These recommendations may potentially reduce medical negligence liability in CP.[164]

7.3.4 CP treatment protocols

Whittaker, based on research indicating ineffective treatment of CP outcomes of some treatment regimes, recommends extensive research to improve treatment protocols to prevent effectiveness and over-servicing.[165] Such measures will reduce liability but does not address the causes of CP.

7.3.5 Provincial Health Departments: Suggested solutions

Eastern Cape

The 2018/19 Eastern Cape Health Department Annual Report identifies medico-legal claims as the singular most pressing financial threat affecting the delivery of all health services.[166] To curb the incidence of medico legal claims it proposed:

- Package interventions to prevent cerebral palsy.
- Implementation of an electronic patient record management system.
- Promotion of early intervention strategies.
- Designated district hospitals to have the full package of services.
- Rationalization of contingent liability records.

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[160] *Idem* 136. Also see Brooks, Campbell and Whittaker "Survival of South African children with cerebral palsy" *SAMJ* S Afr Med J 2021;111(6):591-594 https://doi.org/10.7196/SAMJ.2021.v111i6.15272.

[161] Whittaker 49 refers to James, Maduna and Norton "Knowledge levels of midwives regarding the interpretation of cardiotocographs at labour units in KwaZulu-Natal public hospitals." *Curationis* 42(1), a2007 at http://doi.org/10.4102/curationis.v42i1.2007.

[162] Whittaker 75.

[163] *Idem.*

[164] Also see Bhorat, E Buchmann, P Soma-Pillay, E Nicolaou, L Pistorius, I Smuts "Cerebral Palsy and Criteria Implicating Intrapartum Hypoxia in Neonatal Encephalopathy – An Obstetric Perspective for the South African Setting" *South African Medical Journal* 2021;111(3b):280-288. DOI:10.7196/SAMJ.2021.v111i3b.15399

[165] Whittaker 111.

[166] 2018/19 EC Department of Health Annual Report 13: "The department continued to be confronted by the increasing medico legal claims which seeks to undermine its concerted efforts to manage the scourge. In the year under review, R797,434 million was paid in settlements of medico legal claims which is an 88% increase from the previous year."

- Anti-corruption and Fraud Multi Group (AFMG) on Medico Legal claims Double Dipping Prevention Task Team (DDPT).[167]

The 2019 report contains no clear evidence of disciplinary consequence management regarding non-professional conduct resulting in medico legal claims. The 2019/2020 annual report is available to determine if there is progress with curtailing negligent adverse events or implementation of other measures. However, a recent report suggests that there is regression and no improvement.

Free State

Reducing the department's exposure to litigation through improved clinical governance and efficient management of medico-legal cases is stated as one of its health department priorities.[168] It also has implementation of mediation as one of its strategies to deal with medico legal claims but reports that mediation is limited because the state attorney's office is reluctant to implement mediation. It raises concern in the increase of medico legal claims. [169]

The 2020 annual report reflects a slight increase in mediation. Liability for medico legal claims was R1,8 billion at 2019 and steps are proposed to limit increasing incidence. Claims against the department is shown as R3,4 billion increasing by 30% from the preceding year. [170] No consequence management disciplinary steps were taken against professionals.[171]

Gauteng

In reply to the request for responses on house resolutions emanating from SCOPA report on the auditor-general's report on the financial statements and performance information of the department of health for the year ended 31 March 2018, the Gauteng Department of Health has drafted a litigation strategy and adopted other measures aimed at improving the management of and limiting medico-legal claims.

The strategy and measures are:

- Prevention of harm and promotion of patient safety with the support of internal audit processes against a risk register with quarterly reports.
- Staff-related risk management, including in areas of performance agreements, absenteeism, supervision, and disciplinary action for negligence.
- Appointment of an external independent expert team on patient safety and a medico-legal team.
- Establishing a Medico-litigation Centre as a data management and intelligence centre for patient safety, mediation coordination and litigation management.
- Implementation and coordination of mediation and legally privileged peer review processes.
- e-Health system that ensures interoperability and validity of data.
- The litigation system will not only enable tracking of claims but monitoring of disciplinary cases instituted because of employee negligence and civil cases instituted by the Department to recover costs incurred because of employee negligence.
- Cases must be thoroughly researched to examine pathogenesis to exclude non-clinical causes to avoid exorbitant costs against the Department.
- There is a need for a body of legal research to inform investigative approaches to medical litigation
- Appropriate monitoring of labour by skilled birth attendants; correct and consistent use of the partogram for all patients in labour

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[167] 2018/19 Eastern Cape Health Department Annual Report 36 at *http://www.echealth.gov.za › document-library › annua...*

[168] 2019 Free State Health Department Annual Report 36 at https://provincialgovernment.co.za/units/financial/20/free-state/health.

[169] 2019 Report 38, 139.

[170] 2020 Report 144, 390 at https://provincialgovernment.co.za/units/financial/20/free-state/health.

[171] See p 202 of the 2020 report.

- Where there is a potential case of cerebral palsy, investigations must be carried out immediately after birth to determine gas levels and possible anaemic condition of the pregnant woman.
- Establishment of a partnership with the Nelson Mandela Children's Hospital to treat children born with cerebral palsy to ensure that they receive quality health care and that research into this condition is carried on a continuous basis.
- Long-term solutions intended to deal with incidences of medical negligence:
    - Case management team staffed by well qualified legal officers.
    - Clinical review team providing medical experts' opinions.
    - Consortium of attorneys to deal with cases.
    - Partnership with the Specialized Investigating Unit (SIU) focusing mainly on data analysis and physical files verification to identify possible fraudulent and duplicate claims, theft of medical records, and prosecutions of these cases.
- Consequence management in respect of employees found to have been negligent and who did not follow the Patients' Rights Charter and guidelines for the treatment of patients.
- As well as the above strategies, the Office of the Premier has established a Specialized Litigation Unit (SLU) to deal with all medico-legal matters[172]

The policy identifies key areas of risk and is a laudable attempt to deal with the pressing problem of negligent adverse events. It also introduces consequence management for employees guilty of substandard service into the equation. The 2020 Human Resources report shows that 10% of disciplinary hearings involved negligence. No details are given, and the data does reflect a clear indication of the outcomes of disciplinary hearings involving negligence.[173] The outlined strategy appears to be what it says it is – a strategy. Reports indicate that there was a 13% increase in the number of serious adverse events in 2019/2020 in Gauteng hospitals.[174]

Kwazulu-Natal

One of the 2015-2019 strategic objectives of the Kwazulu-Natal Provincial Health department is to "strengthen health system effectiveness".[175] One of the issues raised in the 2019/2020 report under this heading is medico legal claims. Apart from reporting 450 new claims and that R427 418 595.22 was paid in damages for the 2018/19-year, medico legal damages claims are apparently not a sufficiently serious problem which deserves dedicated measures to curb its incidence.[176] The 2019/20 annual report merely registers the medico-legal liability.[177] No further mention of medico legal claims liability is made apart from its effect on operations and no evidence of consequence management involving disciplinary steps against professionals could be traced..[178]

Limpopo

The 2019 Annual report contains no proposals to curb medico legal liability. The 2020 report states that plans "addressing the reduction of accruals and medico legal cases" were being developed.

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[172] 2018/19 Gauteng Health Department Annual Report 108 at *https://provincialgovernment.co.za › 2019-gauteng-...*PDF.

[173] *Idem* 146. Also see IOL 30 Oct 2018 "Serious adverse events in Gauteng hospitals killed 3 832 patients in 2018" at https://www.iol.co.za/the-star/news/serious-adverse-events-in-gauteng-hospitals-killed-3-832-patients-in-2018-36291826. It is reported that there were 10 000 SAEs in Gauteng for the 2018/19 year. Only 77 disciplinary referrals were made.

[174] There were 4 701 SAE's during this period, See "Serious Adverse Events on the rise in Gauteng's worst hospitals" in Medical brief of 17 March 2021 at https://www.medicalbrief.co.za/archives/serious-adverse-events-on-the-rise-in-gautengs-worst-hospitals/. Also see "The incidence of serious adverse events at Gauteng's public hospitals is shocking" City Press 3 June 2021 at https://www.medicalbrief.co.za/archives/serious-adverse-events-on-the-rise-in-gautengs-worst-hospitals/.

[175] 2018/2019 Kwazulu-Natal Department of Health Services Annual Report 31 at *http://www.kznhealth.gov.za/reports.htm*.

[176] Despite registering 450 new claims for this year of reporting of which 188 were obstetric. See Annual report (fn 158).

[177] R20 110 314 000,00. See p 384.

[178] 2019/20 Kwazulu-Natal Department of Health Services Annual Report at *http://www.kznhealth.gov.za/reports.htm*.

The liability for negligent adverse events increased from 2019 by 19% and amounted to R11 billion in 2020.[179] No evidence of consequence management involving disciplinary steps against professionals could be found in the 2020 annual report.

Mpumalanga

The 2019 Annual Report states that empowerment of legal officers should be prioritised as there is a need for the establishment of a special units dealing with medico claims. Furthermore, training of health professionals in high-risk targeted areas for litigation should be adequately funded as the focus should be on monitoring and implementation of policies to avoid errors and curb claims.[180] Further steps are:

- A developed and implemented litigation management strategy where cases are mediated between the parties thus improving turnaround time on finalizing cases which reduces legal costs.
- The expenditure incurred is journalized against the relevant institutions for management to take disciplinary actions where applicable and improve clinical care.
- Conduct workshops in all districts on causes of litigation to create awareness on the financial implication that litigation claims have on service delivery programs and to improve accountability from facility management.
- 15 medico claims to the value of R 116 296 000.00 have been selected for a pilot project on mediation in 2018/19 to test the turnaround time on finalizing cases within 3-5 months. This project will test the Amendment of the state Liability Act, which will allow periodic payments on claims against the state.[181]
- Utilization of service level agreements with private hospitals, to reduce future medical expenses which are paid as lump sum. This will ensure that patients are not paid upfront future medical expenses.
- Continuous engagement with other stakeholders such as SAPS on reporting theft of records and an MOU with Department of Home Affairs to access Hannes system for birth & death verification to improve turnaround time of investigations.[182]
- A Medical specialist has been appointed to investigate improving obstetric clinical management and assess current claims to determine validity of such claims.
- A post for Director: Legal services will be advertised on the 10th of March 2019 and recruitment will be prioritised for 2019/20.[183]

The plan contains an attempt to curtail the root causes of claims and promote consequence management. Its attempt to introduce structured payments by the back door is problematic. A positive aspect is that the medico legal liability of the province increased by only about 2% from 2019 to 2020.[184] On the other hand no details of disciplinary steps against health professionals for causing medico legal claims are to be found in the 2020 annual report.

Northern Cape

There is a comparatively low incidence of negligent adverse events in the Northern Cape.[185] Nonetheless the authorities are aware of the risk posed by medico legal claims and trained 180 health professionals to raise awareness of the increasing risk posed by these claims. The training also included development of prevention strategies. Seven units from Clinical Support Services are actively involved with the medico legal department in managing children with Cerebral Palsy. A

[179] 2019 and 2020 Limpopo Health Deprtment5 Annual Report at https://provincialgovernment.co.za/units/financial/63/limpopo/health. For plans and claims see 2020 Annual Report 150, 419.
[180] 2019 and 2020 Mpumalanga Department of Health Annual report 29 at https://provincialgovernment.co.za/units/financial/79/mpumalanga/health.
[181] Bill referred to central government Department of Health. See par 7.2.5 above.
[182] 2019 Annual Report 85.
[183] 2020 Annual Report 115.
[184] 2020 Annual Report 290 – from R 9,616,069 000.00 to R 9,636,156 000,00.
[185] See par 4.1 above.

medico legal unit was established to identify adverse events experienced at the province's facilities. No 2020 report was available to judge the impact of measures proposed and/or introduced.[186]

Northwest
No 2018/19 annual report is available. No mention is made of medico legal claims in the 2020 report, but the latter reflects claims against the department as R5,5 billion.[187] No consequence management involving medico legal claims could be found.

Western Cape
Western Cape is a province with low medico legal claims liability.[188] Apart from an 30% increase of provisions for claims, this province's health department annual reports do not contain any measures to deal with the incidence of negligent adverse events.[189]

National Department of Health and National Treasury
After the Medico-legal Summit held on 9 and 10 March 2015, the Minister of Health appointed a Ministerial Task Team to consolidate all the recommendations of the various Commissions, and to compile a Declaration that will pave the way forward in resolving the medico-legal claims problem. The Minister approved the conversion of the Ministerial Task Team to a Ministerial Advisory Committee on 20 June 2016.[190] The committee devised an implementation plan of the recommendations made to the Minister. This plan encompassed patient safety, management and legal. The plan was approved and sanctioned by the Minister of Health on 15 March 2016. Unfortunately there was a change in Minister of Health on 30 May 2019 and the plan has not been implemented.

During 2020 the National Department of Health introduced a claims management strategy by contracting law firms with medico-legal expertise to manage medico-legal claims.[191] According to National Treasury medico-legal claims is a multifaceted problem caused by inadequate quality of care, weak capacity in provincial medico-legal teams, poor administration of medical records, and high profitability for law firms specialising in this area. It was reported that six of the provincial health departments had not implemented the management plan. One of the measures considered to reduce liability was the State Liability Bill (discussed above). The effect of these interventions on state contingent liabilities will be evaluated. Long-term solutions may require wider legal reform, which the South African Law Reform Commission is exploring. The government has recently mooted the establishing of a dedicated no-fault compensation fund to finance damages claims resulting from negligent adverse events in the public sector. This measure is aimed to curb cost and expenditure. One of the problems identified as a cause of claims was the loss of records and medical professionals' mobility.[192] Apart from the preceding a special fund to cater for medical negligence has been mooted.[193]

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[186] See 2019 Northern Cape Health Department Annual Report at 99, 331 at http://premier.ncpg.gov.za/index.php/resource/more-info/app. No report for 2020 available. Its liability for medico legal claims in the 2019 financial year is R2,1 billion - an increase of 30% from the previous year.

[187] 2020 Northwest Health Department Annual Report 293 at https://provincialgovernment.co.za/units/financial/101/north-west/health

[188] See 4.1, fig 2 above.

[189] 2019 and 2020 Western Cape Health Department Annual Report at https://www.westerncape.gov.za/dept/health/documents/annual_reports/. See 2020 annual report 243.

[190] Consisting of Judge N Claassen – Retired Judge, Prof G Lindeque – UP, Prof K Bolton – WITS, Prof A Dhai – WITS, Adv R van Zyl – SALRC, Dr M K Phalane – SAMA, Ms O Phahlane – State Attorney – Justice, Adv M Mantsho – Health and Dr T Carter – Health.

[191] This is contrary to the previously approved implementation plan of March 2016.

[192] *SA News.gov.za* (26 February 2020) "Plans to curb medico-legal claims". Also *IOL* (2 May 2021) "Health considers fund to deal with medical claims".

[193] See Mayibongwe Maqhina "Health considers fund to deal with medical claims" IOL 2 May 2021 at https://www.iol.co.za/news/politics/health-considers-fund-to-deal-with-medical-claims-65307d07-c941-465b-b8f9-6688d0240683.

7.4 Record keeping

Good clinical records are a prerequisite to delivering high quality health care and ensuring continuity when several clinicians are contributing simultaneously to patient care. More importantly, they can also be interpreted by others as a marker of competence. Maintaining complete contemporaneous records also enables a doctor to provide evidence of the care given and is invaluable in complaints of professional misconduct or a claim of clinical negligence. Poor record keeping can contribute to an adverse outcome such as a delayed diagnosis or treatment and medico legal liability.[194] Adequate and accurate record keeping[195] in healthcare is a statutory and professional duty.[196] Medical records serve a dual function:

- Supporting direct patient care.
- A medico legal record and a source of information for:
    - Clinical audit and research
    - Resource allocation.
    - Epidemiology.
    - Service planning.
    - Performance monitoring.[197]

Viewed from a patient's perspective, medical records may either sustain or non-suit a claim for medical negligence.[198] Clearly, the maintaining of proper medical records is an imperative existing duty and requirement of healthcare practice. However, the lack of records or shoddy record keeping is one of the causative factors in negligent adverse events in the public health sector, occurring in about 17% of claims against provincial health departments.[199] The cause for imperfect record keeping may be ascribed to the work environment and attitude of the health professional.

An analysis based on a survey of doctors ascribe imperfect record keeping to:

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[194] Medical Brief 19 February 2020 "Take note: Doctors want more guidance on record keeping" at https://www.medicalbrief.co.za/take-note-doctors-want-more-guidance-on-record-keeping/.

[195] See the Medical Protection Organisation's Guide to Record Keeping available at *https://www.medicalprotection.org › sa-booklets* PDF

[196] See par 4.2.1 and See ss 13 and 17 of the National Health Act 61 of 2003 and Health Professions Council's Guidelines on the keeping of patient records Booklet 9 accessible at *https://www.hpcsa.co.za › Uploads › Ethics Booklet.* Also *Khoza v MEC for Health and Social Development, Gauteng* 2015 (3) SA 266 (GJ). Also see rule 31 of the *Rules of the South African Nursing Council issued under the Nursing Act 50 of 1978* accessible at *https://www.sanc.co.za/r386/*.

[197] Robin Mann and John Williams "Standards in medical record keeping" *Clin Med* 2003;3:329–32 at *https://www.rcpjournals.org › 329.full-text.pdf*.

[198] See e.g. See eg *Madida obo M v Mec for Health for the Province of Kwa-Zulu Natal* (14275/2014) [2016] ZAKZPHC 27 (14 March 2016); *PS obo AH v MEC for Health for the Province of KwaZulu-Natal* (14197/2014) [2017] ZAKZPHC 37 (24 August 2017); *Sifuba v MEC for Health, Eastern Cape* (2314/13) [2015] ZAECMHC 62 (7 August 2015).

[198] *M obo M v Member of the executive Council for Health of the Gauteng Government* 2014/32504 [2018] ZAGPGJHC 77 (20 April 2018); *Mbola obo M v Member of the Executive Council for Health, Eastern Cape* (4521/18) [2018] ZAECMHC 67 (6 December 2018). Also see *The Member of the Executive Council for Health, Eastern Cape v DL obo AL* (Case no 117/2020) [2021] ZASCA 68 (03 June 2021) where adequate records substantially contributed to a successful obstetric negligence claim defence. Also *Luyanda v Member of the Executive Council for Health, Eastern Cape* (114/2014) [2019] ZAECBHC 7 (15 March 2019): " [13] The absence of the hospital records was a most unfortunate situation and is becoming an all too regular feature of similar actions against the defendant in this court, leaving much to conjecture and speculation to the great disadvantage of the plaintiff litigant in my view. Mr. Brown who together with Ms. Mduba appeared for the plaintiff urged upon me to make an adverse costs order to indicate the disapproval of this court and to put a halt to the common refrain by the responsible custodians of records of the provincial departments of health that these have been destroyed despite a statutory prohibition on such destruction of these records, but the adverse costs order which I issued when I refused the defendant's application for a postponement on the first day of trial was in part to ameliorate this anomaly already." It also leads to several PAIA applications. See *Paul v MEC for Health, Eastern Cape Provincial Government and Others ; M obo B v MEC for Health ,Eastern Cape Provincial Government and Others; Ncumani v MEC for Health, Eastern Cape Province and Others* (5031/2018; 5108/2018; 5689/2018) [2019] ZAECMHC 18; [2019] 3 All SA 879 (ECM) (29 March 2019).

[199] See par 4.1, Table 2.

- Too time consuming (76%).
- Too busy (52%).
- Habit of keeping records in a certain manner (46%).
- Lack of training (33%).
- Lack of computer skills (18%).
- Unlikely to get a complaint/claim (8%).

Given the working conditions health professionals in the public health sector experience, the time factor and understaffing seem to suggest reasons for imperfect record keeping in this sector. In addition the need to keep paper records may be adding to the problem. Moreover, evidence-based standardisation of record keeping[200] using structured pro forma reporting contributes to positive outcomes with improvement of quality of records, better patient information, improved patient outcomes, improved data validity for secondary outcomes (possible medico legal liability), and more efficient health services [201] It follows that standardised records should be digitised doing away with space consuming physical records which are either often stolen or lost.[202] The advantages of digitisation are:

- Compared to paper records, a digital patient-record (EHR) system can add information management tools to help providers provide better care by more efficiently organizing, interpreting, and reacting to data.
- EHR software can provide clinical reminder alerts, connect experts for health care decision support, and analyse aggregate data for both care management and research.
- The more interactive an EHR system is, the more it will prompt the user for additional information. This not only helps collect more data but also enhances their completeness.
- EHRs are the future of healthcare because they provide critical data that informs clinical decisions, and they help coordinate care between all providers in the healthcare ecosystem.
- EHR systems focus on the total health of the patient. EHR software is designed to reach out beyond the health organization that originally collects and compiles the information. They are built to share information with other health care providers, such as laboratories and specialists, so they contain information from all the clinicians involved in the patient's care.
- The information moves with the patient—to the specialist, the hospital, the nursing home, the next state or even across the country. EHR systems are designed to be accessed by all people involved in the patient's care—including the patient.[203]
- EHR may prevent liability actions by:
    - Demonstrating adherence to the best evidence-based practices.
    - Producing complete, legible records readily available for the defence (reconstructing what happened during the point of care).

[200] For standards see *www.rcplondon.ac.uk/college/hiu/recordstandards*.
[201] Mann and Williams 331.
[202] For the advantages of electronic health records see Schopf, T.R., Nedrebø, B., Hufthammer, K.O. *et al.* "How well is the electronic health record supporting the clinical tasks of hospital physicians? A survey of physicians at three Norwegian hospitals." *BMC Health Serv Res* 19, 934 (2019). *https://doi.org/10.1186/s12913-019-4763-0*; Cowie MR, Blomster JI, Curtis LH, et al. "Electronic health records to facilitate clinical research." *Clin Res Cardiol*. 2017;106(1):1-9. *https://doi.org/10.1007/s00392-016-1025-6*; PS Net "Electronic Health Records" *https://psnet.ahrq.gov/primer/electronic-health-records*.
[203] Practice Fusion 21 May 2021 "EHR (electronic health record) vs. EMR (electronic medical record)" at *https://www.practicefusion.com/blog/ehr-vs-emr/*.

- Disclosing evidence that suggest informed consent.[204]

7.5 Protocols

A medical protocol can be described as an agreed framework outlining the care that will be provided to patients in a designated area of practice. They do not describe how a procedure is performed, but why, where, when and by whom the care is given.[205] Protocols improve the quality of clinical decisions. They offer explicit recommendations for clinicians who are uncertain about how to proceed, overturn the beliefs of doctors accustomed to outdated practices, improve the consistency of care, and provide authoritative recommendations that reassure practitioners about the appropriateness of their treatment policies. Protocols are normative standards used as explicit standards of care at the time of the index clinical event and are consulted to assess the degree to which a questionable practice was in line with accepted standards. [206]

It is quite astonishing that, given the advantages of protocol compliance, the analysis of cases in the public health sector, ignoring of protocols is a factor in about 83% obstetric negligent adverse events.[207] Research indicates that reasons for non-compliance with protocols are lack of:

- Awareness: A physician may not be aware of the existence of protocols.
- Familiarity: Although aware the physician is not familiar with a protocol.
- Agreement: Physicians may not agree with a specific guideline or the concept of guidelines in general.
- Self-efficacy: Self-efficacy is the belief that one can perform a behaviour. Low self-efficacy due to a lack of confidence in ability or a lack of preparation may lead to poor adherence.
- Outcome expectancy: If a physician believes that a recommendation will not lead to an improved outcome, the physician will be less likely to adhere, and
- Inertia of previous practice: Physicians may not be able to overcome the inertia of previous practice, or they may not have the motivation to change.
- External barriers: Time limitations, lack of a reminder system.
- Environmental barriers: For example, unavailability of an anaesthesiologist 24 hours a day may interfere with physician ability to adhere to guidelines aimed at decreasing the rate of elective caesarean deliveries or the unavailability equipment or a theatre for an emergency Caesarean. [208]

The analysis of case law[209] where disregard of obstetric delivery protocol was apparent, suggests that two main factors may be the cause of disregard in the public health sector. They are mainly time limitations and environmental barriers. Both these reasons can be linked to a severely constrained public health system which is unaware of this factor as a cause of negligent adverse events.[210]

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[204] HealthITgov "Improved Diagnostics and Patient Outcomes at *https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/improved-diagnostics-patient-outcomes*

[205] Such as the Guidelines for Maternity Care in South Africa 2016 issued by the Department of Health.

[206] Woolf, S. H., Grol, R., Hutchinson, A., Eccles, M., & Grimshaw, J. (1999). "Clinical guidelines: potential benefits, limitations, and harms of clinical guidelines." *BMJ (Clinical research ed.)*, *318*(7182), 527–530. *https://doi.org/10.1136/bmj.318.7182.527* ; Oyebode F. "Clinical Errors and Medical Negligence" *Medical Principles and Practice* 2013, Vol.22, No. 4 at *https://www.karger.com/Article/Fulltext/346296#* .

[207] See par 4.2.2 above.

[208] Cabana, Débora & Rand, Cynthia & Powe, Neil & Wu, Albert & Wilson, Modena & Abboud, PAC & Rubin, Haya. (1999). "Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement." *Pediatric Research.* 45. 121A-121A. 10.1203/00006450-199904020-00719 at *https://www.researchgate.net/publication/279792345_Why_Don't_Physicians_Follow_Clinical_Practice_Guidelines_A_Framework_for_Improvement/citation/download* .

[209] See fn 75.

[210] Mgobozi, P. & Mahomed, O.H., 2021, 'Epidemiology of patient safety incidents in a long-term rehabilitative hospital in KwaZulu-Natal, South Africa (April 2011 to March 2016)', *Curationis* 44(1), a2151. https://doi.org/10.4102/curationis.v44i1.2151state that: "The main reasons for staff factors contributing to PSI included inadequate allocation of staff, inexperienced staff, inadequate communication and suboptimal adherence

It follows that remedial steps should be taken to ensure that protocols are strictly adhered to and to remove barriers which inhibit compliance by revisiting administrative and other procedures and determining the exact environmental barriers inhibiting strict compliance in each and very public health care facility. This is a fruitful area for further research. Compliance and service delivery can be enhanced by the integration of protocols into CHR.[211]

7.6 Consequence management

7.6.1 Introduction

Patient safety incident reporting, management, and training

The main obstacle in the way of consequence management is the lack of information. The study by the SA Law Commission, Whittaker and this study, was reliant on press reports and reported cases to gather information to analyse and discuss the fundamental problem of negligent adverse events in the South African public health care system. Despite the publication of The National Guideline for Patient Safety Incident Reporting 2017, South Africa does not have a national operational patient safety information system which could gather the information needed to implement a consequence management regime.[212] Apart from Kwazulu-Natal[213] and Gauteng no evidence of an operational provincial patient safety incident system could be found, and no Patient Safety Incident (PSI) reporting could be traced in annual reports.[214] Based on press reports, Gauteng seemingly has a PSI reporting system.[215] Allied to the gathering of patient safety information, is the training of all relevant participants in the PSI system not to repeat mistakes uncovered. The outcome postulated for the introduction of an effective PSI, is an improved safe health system and decreased damages liability for negligent adverse events.

Accountability

The breach of medical standards has the following important consequences in that it may:

- Give rise to delictual liability.
- Be a breach of an ethical code.
- Result in internal disciplinary steps.[216]

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to protocols for patient safety. System factors and inadequate equipment were minor contributing factors." See e.g. *Luyanda v Member of the Executive Council for Health, Eastern* Cape 114/2014) [2019] ZAECBHC 7 (15 March 2019) (time constraints); *M T obo M M v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government* (20454/2014) [2018] ZAGPJHC 540 (27 September 2018) (theatre unavailable); *Member of the Executive Council for Health, Eastern Cape Province v YN obo EN* (3651/15) [2020] ZAECMHC 46 (23 July 2020) (no CTG equipment). Non-compliance with protocols largely overlaps with no response to clinical indications. Clinical indications call for implementation of protocols.

[211] See e,g, D2i "Monitoring Adherence to Protocols" at *https://www.d2ihc.com/monitoring-protocol-adherence-important-in-health-care/* ; João Rafael Almeida, José Luís Oliveira "A Software Solution for Clinical Protocol Management" medRxiv 2021.03.10.21253055; doi: *https://doi.org/10.1101/2021.03.10.21253055*

[212] See "National Guideline for Patient Safety Incident Reporting and Learning in the Public Health Sector of South Africa" 2017 at *https://www.idealhealthfacility.org.za › Download* PDF. The guideline has not been fully implemented and is due for review in 2022.

[213] See Kwazulu-Natal Provincial Department of Health: Adverse Events Monitoring and Reporting Guidelines compiled by Dr Ozayr Mahomed under the auspices of the Nelson Mandela and University of Kwazulu-Natal at *http://www.kznhealth.gov.za › family › Adverse-e..*PDF.. Also see the studies referred to in fn 208.

[214] No PSI statistics are reported in provincial health department annual reports. The reason for this may that it is not required and/or unfavourable nature of PSI reports. Cf the press reports in this regard referred to in fn 207.

[215] Gauteng reported 4170 SAEs in 2019 and 4701 in 2020. Only 77 cases were referred for disciplinary action. See IOL 30 October 2020 "Serious adverse events in Gauteng hospitals killed 3 832 patients in 2018" at *https://www.iol.co.za/the-star/news/serious-adverse-events-in-gauteng-hospitals-killed-3-832-patients-in-2018-36291826* and Medical Brief 17 March 2021 "Serious Adverse Events on the rise in Gauteng's worst hospitals" at *https://www.medicalbrief.co.za/serious-adverse-events-on-the-rise-in-gautengs-worst-hospitals/.*

[216] See Oosthuizen "An Analysis of Healthcare and Malpracitice Reform: Aligning Proposals to Improve Quality of Care and Patient Safety" LLM University of Pretoria (2014) 16 at *https://repository.up.ac.za › bitstream › handle › Oo...*PDF

Ensuring professional accountability is a factor that will inhibit the occurrence of PSIs and limit negligent serious adverse event litigation.

7.6.2 Patient safety incident reporting and management

The merit of proper and effective patient safety reporting is underscored by local research.[217] Gqaleni *et al* [218]conclude that occurrence of PSIs in CCUs in hospitals in Durban is still high and is of a serious nature, affecting quality patient care and patient safety.[219] The reporting system for PSIs was not effectively utilised, mainly because of fear of litigation and disciplinary action. They state that implementing a uniform national PSI reporting system is crucial to improve quality patient care in CCUs. Mgobozi *et al* [220] found that over a 5 year-period, 13% of patients admitted to a Kwazulu-Natal hospital suffered a PSI. They conclude that: "There is a need for active change management to establish a blame-free culture and learning environment to improve reporting of PSI. A comprehensive quality improvement intervention addressing patients, their families and staff is essential to minimise PSI and its consequences." They recommend that management adopt a blame-free culture and learning environment to improve reporting of PSI. A comprehensive quality improvement intervention addressing patients, their families and staff is essential to minimise PSI and its consequences must take place. [221]

7.6.3 Training

Medical courses at tertiary level do not cover medico legal liability.[222] At an operational level, training to prevent recurrence PSIs can presently not be done because of the lack of an effective and operational national PSI system. The introduction of such training is crucial in a quest to reduce PSIs, improve health care delivery and prevent negligent adverse events.

7.6.4 Accountability

7.6.4.1 Introduction

Essentially accountability means to be obliged to be answerable for actions and decisions made. It has two facets: Informing and explanations, provision of reasons and justification. A further dimension of accountability is sanctioning uncovered illegal or inappropriate actions by overseers using legal, professional codes of conduct and incentives without legal enforcement to deter bad and reward good behaviour. Lack of enforcement and/or selective enforcement undermine accountability and responsiveness, and contribute to the creation of a culture of impunity that can lead to public officials engaging in unwanted practices. Enforcement mechanisms from broad legal and regulatory frameworks to internal monitoring systems are critical. Accountability also requires sufficient and suitable information.[223]

Sections 81-85 of the Public Finance Management Act 1 of 1999 contain detailed disciplinary directives regarding wasteful and fruitless expenditure and steps that must be taken to hold transgressing officials responsible. From a survey of the various provincial departments' of health annual reports, disciplinary steps are routinely taken against officials who are in breach of the PFMA and where millions of Rand are involved. Judging by provincial health departments' annual reports, very few health departments have operating disciplinary codes dealing with substandard healthcare by employees, resulting in contingent liability for damages of billions of Rand. Gauteng

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[217] See Mgobozi, P. & Mahomed, O.H., 2021, 'Epidemiology of patient safety incidents in a long-term rehabilitative hospital in KwaZulu-Natal, South Africa (April 2011 to March 2016)', *Curationis* 44(1), a2151. https://doi.org/10.4102/curationis.v44i1.2151; Gqaleni, T.M. & Bhengu, B.R., 2020, 'Analysis of Patient Safety Incident reporting system as an indicator of quality nursing in critical care units in KwaZulu-Natal, South Africa', *Health SA Gesondheid* 25(0), a1263. *https://doi.org/ 10.4102/hsag.v25i0.1263* and KwaZulu-Natal Department of Health (KZN DoH) has formulated guidelines on the reporting of types, frequencies and severities of PSIs

[218] Fn 206

[219] *Idem.* 1017 PSIs in 10 hospitals of predominantly serious occurred (47% were moderate, major and catastrophic) were a cause for concern.

[220] Fn 207.

[221] *Idem.*

[222] The South African Medico Legal Association offers a course on medico legal practice. See https://medicolegal.org.za/.

[223] Brinkerhoff, Derick. January 2003. *Accountability and Health Systems: Overview, Framework, and Strategies.* Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc. at

is the only province reporting disciplinary steps based on negligence.[224] Considering the magnitude of the consequences of substandard healthcare, accountability for negligent adverse events require thought and steps to prevent recurrence of negligent adverse events and its serious financial consequences.

7.4.3.2 Legal sanction

Delictual and vicarious liability

In the public health system, negligent adverse events give rise to vicarious liability of the Member of the Executive Council for Health of the province concerned. In all cases action is instituted against the MEC. The health care professional is never sued despite being liable for his negligent adverse event damage causing conduct. Even though his employer is vicariously liable this does not absolve the negligent health care professional from liability. [225] The negligent health care professional is in these circumstances a joint wrongdoer in terms of the Apportionment of Damages Act 34 of 1956 and is legally liable.[226]

There is the legal option for plaintiffs to sue both the MEC and the wrongdoing health professional(s) as joint wrongdoers and if this is not done a MEC can join the negligent health care professional by delivering a third-party notice before *litis contestatio.* If the MEC then pays, he has a right of recourse against the wrongdoer employee[227] for that portion of the damages caused by the health professional's negligence.

Vicarious liability in the public health care sector and the non-use of legal provisions governing joint wrongdoers in delictual actions against the MEC for health has the unwanted consequence of removing direct legal sanction for damages resulting from negligent professional behaviour from health professionals employed by it.

Professional sanction.

The Health Professions Council of South Africa established by the Health Professions Act 56 of 1974 is the professional body with the power to frame, police and enforce ethical rules and standard of conduct within the health professions and to protect the public.[228] It is also solely responsible for regulating quality health standards and aims to protect the public[229] and can take disciplinary steps should there be a breach of its codes of conduct. Should a health practitioner after investigation by a committee be found guilty of a breach it can impose a penalty of suspension, striking from the register of health professionals, a fine, a period of professional service and order the payment of costs of the disciplinary proceedings. [230] A finding of guilt and a penalty by the HPCSA is published in the *Government Gazette.[231]* During 2020 the HPCSA dealt with 58 complaints. There were 10 findings of guilt where either a fine, penalty, caution and reprimand was imposed.[232]

Employment disciplinary measures

Conditions of employment and disciplinary measures must be framed, adopted and enforced to facilitate a suitable approach to and ensure accountability.

7.4.3.3 Importance of accountability

Accountability is a factor which modifies behaviour if fair, equitable and consistent enforcement of standards is employed. From the analysis made of the causes of medical negligence claims in the

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[224] See par 7.3.5 above.

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

[226] Neethling Potgieter Visser 393; *Botes v Van Deventer* 1966 3 SA 182 (A) 205–206.

[227] See s 2(1) – 2(8) of the Apportionment of Damages Act 34 of 1956.

[228] See Oosthuizen "An Analysis of Healthcare and Malpracitice Reform: Aligning Proposals to Improve Quality of Care and Patient Safety" LLM University of Pretoria (2014) 16 at https://repository.up.ac.za › bitstream › handle › Oo...PDF

[229] *Idem 17*

[230] *Idem.*

[231] *Idem* 33

[232] See 2020 HPCSA Annual Report at https://www.hpcsa.co.za › Uploads › HPCSA_ANN...PDF

public health sector in this article, failure to comply with the set health care standards embodied in professional medical protocols is a leading cause of negligent adverse events. This has devastating consequences for patient safety and the financial sustainability of the public health care sector. It is imperative that a culture of accountability within this sector is established and nurtured. To promote a culture of accountability, a carrot and stick approach must be adopted to encourage participants to report adverse incidents to enable remedial action. Legal and professional sanction must be reserved for dealing with recalcitrant repeat transgressors.

8. Conclusion

Negligence in the public health sector has been thrust in the limelight by the resulting astronomical financial consequences. The reaction to this phenomenon has largely been a knee jerk and are essentially attempts at damage control. In all this (apart from Oosthuizen[233]) very few voices have articulated the case of the real victims – the patients of the public health system who are largely the voiceless poor. The analysis undertaken by Whittaker and in this article shows that up to sixty percent of the victims of the public health care sector are cerebral palsied minors who suffer debilitating consequences and indignity of the worst imaginable kind. Approaching the crisis purely from a financial perspective creates the subliminal message that public health care is operating optimally, and the patient safety incidents are mere unavoidable tolerable collateral damage incidents. This is far from the truth considering that the cerebral palsy births of our public health system are five times higher than the international average. During the analysis of public health care medical negligence judgments an argument propagating a different standard for judging medical negligence of public hospitals surfaced. The standard of health care in the public sector is predicated by the Constitution as is the relationship between the public health sector. A further disturbing phenomenon was indications that litigation was being abused to manage the cash flow crisis created by medical negligence claims where the public health sector spent approximately R148 million in the 2018/19 financial year on litigation.

An approach that proceeds from the thesis that if the cause of damages in the public health system is eliminated, the currently prejudiced patient's interests will be served and the financial consequences of negligent adverse events will disappear or at least or be contained, is faced with the difficulty of paucity of patient safety incident information. This lacuna prompted Whittaker and the author to analyse reported medical negligence cases in the public sector. These analyses indicate that all is not well with the public health sector system and that the leading cause of patient safety incidents in obstetrics (which make up 60% of claims) and which are all high value claims (ranging from R4 million to R25) are non-response to clinical indications and failure to consistently follow protocols. An adjunct to these professional lapses is the phenomenon of poor record keeping and retention of patient records which impacts on the ability of a claimant to frame his case and the public health system to mount and effective defence against claims for negligent adverse events.

The primary solutions of structured payments and payment of damages *in specie* which are currently actively being propagated (the so-called public health defence) and which have been sympathetically entertained by our courts are effectively solutions that manage the financial aftermath of devastating personal consequences of negligent adverse events in the public health care sector. The duty to deliver adequate and quality healthcare to those who cannot afford to pay is created by the Constitution. Not doing so is a breach of such constitutional duty. Any measure aiding the government and/or the use of the government of its Constitutional legislative power to manage the consequences of the serial breach of its constitutional duty to render adequate and proper healthcare is in effect a constructive condonation of such breach – especially where the measures are at the sole expense of the victims of substandard healthcare. Other solutions

[233] See Oosthuizen "An Analysis of Healthcare and Malpractice Reform: Aligning Proposals to Improve Quality of Care and Patient Safety" LLM University of Pretoria (2014) at *https://repository.up.ac.za › bitstream › handle › Oo...*PDF

proposed deal mostly deal with consequences and not cause, may assist in ameliorating the consequences but do not offer lasting solutions.

Framing a solution to this vexing problem is eminently difficult and complicated. Not only the problem of the high frequency of negligent adverse events, but also the environment and circumstances in which these events occur, create difficulty. The public health system is beset with a variety of operational environment problems such as ageing infrastructure, inadequate funding, over-utilisation, poor working conditions, understaffing, ineffective management, and lack of accountability. Without minimising or excusing lapses of medical professionalism in the public health sector, any proposals for and remedial action undertaken should be viewed against this backdrop. One of the primary immediate and most important steps to be implemented, is the introduction of a standardised Electronic Health Record system (EHR) which integrates both patient safety incident reporting and clinical protocol management. A framework for patient incident reporting does exist. Implementing an Electronic Health Record system will to a large extent remove the contributory factors of medical negligence claims and manage causative risks such as non-adherence to protocols. Not only will it assist in managing risk, but it has substantial benefits for patients and the quality of health care. To ensure compliance, accountability must be ensured in a way which recognises the challenges faced by medical professionals in the public health system but nonetheless ensures that negligent adverse events have behaviour-changing consequences. Furthermore, research into CP indicating that current knowledge of the causes of CP is defective should be heeded and recommendations in this regard considered.

Finally, the focus on and apparent obsession with the financial consequences of negligent adverse events in the public health sector completely ignores the oft devastating and far-reaching personal consequences of an ailing public health system for patients unable to pay for health care. In all deliberations over and measures proposed and implemented to remedy the public health care malady, the interests of the public health care patient should be paramount – it is a Constitutional imperative.[234]

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18 October 2021

[234] 60% of claimants are minors and s 28 of the Constitution applies. Furthermore, the provision of standard adequate public healthcare is predicated by the Constitution. In a Public Protector Investigation, it was found that government regularly breaches the constitutional rights of patients in the manner in which public health is delivered. See Julia Evans "Public Protector investigation finds that hospitals violate South Africans' rights" Daily Maverick 3 October 2021 at *https://www.dailymaverick.co.za/article/2021-10-03-public-protector-investigation-finds-that-hospitals-violate-south-africans-rights/*. Also see par 6.