

February 2022

MPS submission in response to the South African Law Reform Commission to *Discussion Paper 154 - Project 141: Medico-Legal Claims* (October 2021)

Introduction

Medical Protection Society (MPS) welcomes the South African Law Reform Commission (SALRC) decision to publish a discussion paper on medico-legal reforms for the state sector in South Africa.

Our comments are informed by our direct experience of assisting doctors, dentists and other healthcare professionals with clinical negligence claims not just in South Africa but across many countries. We were pleased to see our previous comments in relation to issue paper 33 included in this discussion paper. We are keen to remain actively involved in the development of further reform around clinical negligence and medico-legal claims and assist the South African Law Reform Commission and Government by sharing our experience and expertise when required.

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals, with more than 300,000 members around the world, including over 30,000 members in South Africa. Our in-house experts assist members with the wide range of legal and ethical problems. Of particular relevance to this discussion paper, membership to MPS provides members with the right to request indemnity for claims arising from professional practice.

Our submission is focused on responding to the proposals from the Commission in the above paper and suggesting any further reforms that we think are needed in some of the areas.

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Background - the rising cost of clinical negligence claims

It is clear from the publication of your discussion paper that there is growing recognition of the need for legal reform in regard to clinical negligence in South Africa. Not only to reduce mounting costs that are becoming a burden for the public purse – doubling from R37bn to R74bn over the past five years – but also to create a system that ensures both reasonable compensation for patients and allows for a fair and robust defence where necessary. The problem has a long history and MPS believes that the time for action is long overdue

For some specialities, the claims experience risks threatening the sustainability of some areas of private practice. If this causes a shift in the workload to the public sector, it could increase pressure on public services and affect important health sector reforms. We believe that legal and procedural reforms are required to begin to tackle some of the factors that have led to this claims experience and ensure a fairer and more efficient system for all parties.

It is important that there is reasonable compensation for patients who are harmed due to clinical negligence, but this must be balanced against society's ability to pay. We have long highlighted that if the cost of claims rises too high then the balance could tip too far, and the cost will become significantly greater for the state sector, for healthcare professionals and for society.

Aside from the financial cost, there is also a very real human cost to litigation. The current clinical negligence system does not facilitate the efficient and fair resolution of disputes. Injured patients face delays in receiving compensation, patients and healthcare professionals go through a long, costly, and stressful process.

This is particularly true for birth injury claims, where the system proves to be neither equitable nor appropriate as it does not provide all families and children who suffer child-birth injuries with appropriate compensation and support, only those who are able to prove fault against a healthcare worker. A failure to be able to do so results in children and families with major challenges getting no compensation while for the few who do succeed the financial gain can be enormous.

Our comments are based on the discussion paper which concentrates on issues in the State sector, but there are problems in the private sector that also need addressing and many would be resolved by changes that apply to both. Conversely, reforms that do not apply equally across public and private healthcare would increase inequalities and negatively impact on the delivery of healthcare

Reforms proposed

Prerequisites

Firstly, in regard to the prerequisites set out from page 5, we do not have substantive comment on prerequisites 16 (1-10), 17, or 19 and in principle agree.

While we recognise that SALRC have to address this issue from a particular perspective and therefore why prerequisite 18 acknowledges that the SALRC can only deal with legal issues, there are of course issues with resources, management and facilities that play a role in clinical negligence claims. Obstetric risk dominates the cost of claims, and this is a perfect example of

where legal reforms alone cannot solve. Resolving these issues in the delivery of care would be a welcome accompaniment to the reforms being considered by SALRC for legal change.

In other words, a parallel process concurrently addressing the ‘supply side’ issues of resources, infrastructure and leadership needs to be implemented alongside reforms to address the ‘demand side’ of litigation.

Proposals [20.1 – 24]

As to the proposals set out in point 20 [20.1 – 20.35], we broadly agree with these, with some exceptions. We have no concerns or comments with the proposals set out in points 20.1 to 20.23. Similarly, we are not particularly concerned with the proposals set out in points 20.26 to 20.35; although in regard to periodic payments our experience is that patients prefer the lump sum up front and that when we offered PPOs in the past our experience was that there was limited take up of them.

Similarly, we have no issue with the ‘other proposals’ set out on points 22 and 23. Indeed, we fully endorse the proposal of a “Good Samaritan” law, exempting a medical practitioner acting in an emergency situation from negligence claims as long as certain conditions are complied with. We have no comment on point 24.

However, we are concerned by the proposals set out in points 20.24 and 20.25 which we will explore in our further comments.

In regard to point 21, which states that the Commission does not support the creation of trusts for administering large lump sum compensation payments, MPS does not necessarily oppose the creation of trusts. However, we acknowledge there may be administrative charges incurred. We would welcome more the rationale behind the opposition.

Further comments

1. Learn from events to improve patient safety

Preventing negligent harm in the first place is obviously the right thing to do. MPS as the leading defence organisation in South Africa has an important role to play. Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We draw on our experience and expertise to raise awareness of the causes of claims, the conditions behind these, and how errors can be prevented. We also aim to reduce the prospect of claims, by offering education programs and advice to our members.

We fully support moves towards creating a culture of openness and learning in the healthcare sector where clinicians feel empowered and confident to admit errors, and learn from mistakes, without fear of incrimination. There needs to be explicit support from leaders who need to be equally committed to the principles of open disclosure, in order for clinicians not to fear being blamed when admitting a mistake.

In our experience more often than not, apologising, admitting a mistake and communicating effectively will help to mitigate litigation. However, this is only plausible if there is a change in the

current mentality which allows for healthcare professionals to be open about mistakes without the fear of being blamed and subsequently faced with regulatory, civil, or criminal proceedings. We therefore support the proposals by the commission that health care workers should be protected by the introduction of legislation that prevents information given by healthcare workers to be discovered for the purposes of court or disciplinary proceedings.

Recommendations:

MPS agrees with proposals from the Commission that to ensure openness and honesty legislation to protect information provided by a health co-worker from being discovered should be introduced. We also suggest the below reforms to improve patient safety:

- encourage incident reporting and learning from events
- promote a culture of speaking up
- encourage a culture that prioritises safety, quality, learning and improvement
- manage behaviour that undermines a culture of patient safety
- move away from a 'blame and shame' culture to one that promotes openness, transparency, candour, and fairness.

The above needs to be achieved through a positive culture rather than law and criminalisation – which creates a negative culture.

Record Keeping

Point 20.2 and 20.3 are incredibly important and ones that MPS wholeheartedly endorse. We carry out risk prevention and provide educational resources to our members on good record keeping, and these are a popular tool. We are pleased to see the SALRC highlight the importance of proper record keeping systems and the role they play both in terms of patient care as well as evidence in legal processes. We also would be happy to see record keeping guidelines be developed that address the NHA provisions and related regulations.

2. Comprehensive and consistent complaints process

MPS agrees with the statement in the discussion paper which expresses that taking a matter to court should be avoided as far as possible. While there are claims where the patient understandably pursues financial compensation, in many cases patients are simply seeking answers, an apology, and reassurance that necessary changes have been made by the healthcare professional involved.

The priority must therefore be to develop a robust, efficient and, above all, patient-centred complaints system to address patient concerns as an alternative to litigation. Such a system should also allow for effective, local resolution in the first instance.

A good complaint handling service can give patients an opportunity to be heard, an acknowledgement when things go wrong, to receive an explanation and lessons to be learned, in a much less adversarial forum than litigation. Investing in such a system is in everyone's best interests.

MPS would like to see the development of a complaints system that allows for local resolution in the first instance as the ‘tier one’ for complaints. That way a strengthened ‘tier two’ complaints system at the level of the Office of Health Standards Compliance, its Ombud and the HPCSA would ensure that patients and their families have an effective alternative to litigation.

Recommendation: MPS agrees with the commission that there is a need for a new system to deal with clinical negligence claims. As SALRC, we advocate for the development of a consistent, efficient, aligned and patient-centred complaints process that allows for local resolution.

3. Alternative Dispute Resolution and Mediation

MPS, as SALRC, believes that when an adverse incident occurs early resolution should be a priority. We note that the discussion paper proposes that mediation be introduced as a first step to deal with disputes, with mediation being voluntary but that parties must attempt mediation before instituting court proceedings. We support alternative dispute resolution such as mediation. We understand that not every case is suitable for conciliation or mediation, however, we believe that with judicial case management the parties should at every stage be encouraged to consider alternative dispute resolution as an alternative to formal proceedings.

We believe that SADA have a very effective mediation process for the resolution of disputes between dentists and their patients. Access to mediation can reduce litigation intent, particularly in cases where the treatment is non negligent.

The paper also proposes a dedicated alternative dispute resolution team in each province. In a legal system that can at times be unduly complex and potentially inaccessible, MPS can see the value of exploring alternative dispute resolution. The South African legal system already uses alternative dispute resolution fruitfully in the fields of family and labour law.

MPS welcomes any mechanism that will facilitate the early resolution of meritorious claims. This is in the best interests of patients, their families and healthcare professionals. This will also help to alleviate the pressure on the present court system and save money for the public purse, as well as to potentially provide a more time and cost-effective means of resolving a matter to the benefit of both plaintiff and defendant.

Recommendation: MPS agrees with SALRC that Alternative Dispute Resolution systems should be established; and mediation should be introduced as voluntary, attempting at mediation compulsory before instituting court proceedings.

4. Certificate of Merit

We support the proposal in the discussion paper that suggests the introduction of a certificate of merit affidavit by an accredited and suitably qualified medical practitioner form part of the papers when action is instituted for damages based on medical negligence to avoid frivolous, meritless, fraudulent, or abandoned claims.

In order to reduce the number of claims, some Australian and US states have introduced a Certificate of Merit. This certificate requires the patient's lawyer to confirm, before the start of the case, that it has merit. If, once the case has concluded, the judge decides that this is not the case, the existence of the certificate permits a party to claim the costs of proceedings from the other side's lawyer if it is established that there was no basis for the issue of proceedings or service of a defence.

We believe that this could be an effective measure to reduce the number of unmeritorious claims in South Africa and we will support the introduction of financial penalties to discourage the prolonged pursuit of unmeritorious claims and the continued defence of meritorious claims. We suggest that such financial penalties could be awarded against the attorneys who bring the claim, rather than the patient.

Recommendation: MPS supports the Commission's proposal that a Certificate of Merit should be introduced.

5. Pre-Action protocols

We welcome the proposal that a pre-action protocol be introduced which is similar to the United Kingdom's protocol for clinical disputes for larger medical negligence claims.

Such a system would provide a mechanism for parties to obtain sufficient information and understanding of their respective cases early. This allows them to investigate claims efficiently and, where appropriate, resolve them before a case becomes a litigated claim.

The United Kingdom's Pre-Action Protocol for the Resolution of Clinical Disputes¹= regulates the conduct of the parties by providing a reasonable timetable for the exchange of information, an acceptable standard for the content and quality of the correspondence exchanged, as well as guidance on what is acceptable conduct between the parties in pre-action negotiations.

We believe the introduction of pre-action protocols would reduce the delays that injured patients face before receiving compensation, reduce the stress that patients and healthcare professionals endure, and also reduce legal costs for all parties.

Recommendation: MPS agrees with the Commission's proposals to introduce Pre-Action protocol similar to those established in the UK.

6. Improve pre-trial procedures

We welcome proposals in the discussion paper to improve pre-trial procedures. In our experience, the more open the parties can be early in proceedings, the greater the chance that the claim can be resolved early to the benefit of both the patient and defendant.

¹ *The Protocol is a procedural framework which aims to maintain/restore the patient/doctor relationship as well as resolve disputes without the need for litigation. Further information on the UK protocol can be found here: <https://www.justice.gov.uk/courts/procedure-rules/civil/protocol>*

Medical negligence cases are often complex and are heavily reliant on expert evidence so there is a need for robust case management to ensure efficient and cost-effective progression of the case by both parties. That is why we agree with the proposals for improving pre-trial procedures including the early exchange of expert notices and summaries, as well as factual witness statements and mandatory experts' meetings as a way of ensuring a more constructive engagement from the beginning of a claim process.

The benefit of early exchange of expert evidence is that the parties then know the strengths and weaknesses of their respective cases, thereby facilitating early settlement negotiations or withdrawal of the action. If the parties still believe that the case needs adjudication, it assists in limiting the issues in dispute.

The other benefit is that where a party has been unable to secure expert evidence, they cannot continue with the case to the doors of court in the hope of securing some form of settlement. For these reasons, early exchange of such notices and summaries improves transparency and can allow for cases to be settled earlier to everyone's benefit.

Expert witnesses would then be able to provide expert opinions based on all the facts, ensuring an objective view which will assist with the resolution of merits claims. However, we must be aware of the over reliance

Lastly, early experts' meetings will allow parties to assess whether the expert evidence is objective and balanced and will determine if the experts tasked to comment on the facts have the relevant expertise. This will ensure that the correct experts are retained which will save time and cost.

Point 20.25 While we understand the concept of single joint expert has attractions in terms of resolving liability issues in a less adversarial environment and in limiting costs, particularly in low value claims, we also wish to highlight some concerns with the approach.

In clinical negligence claims, where an individual clinician's reputation may be at stake, the use of a single joint expert should be balanced with the clinician's wish to seek independent expert evidence in their own defence, in appropriate cases. Internally, we never allow an expert opinion to go unreviewed: as a matter of course, we will always review an expert opinion prior to use. An argument's robustness is only improved by scrutiny.

We also suggest that the choice of a single joint expert should not become a point of delay in the management of the case, as the parties seek to agree the choice of expert, and the format and content of the instructions. This may be addressed through the use of approved registers of experts.

We do however see circumstances where a single expert would be appropriate, by agreement between the parties, for example to establishing condition and prognosis, and for straightforward breach-of-duty and causation issues.

Recommendations: MPS supports the commission's proposals to improve pre-trial procedures and court case flow and management including the early exchange of expert notices and summaries, an exchange of factual witness statements as well as mandatory experts' meetings.

However, use of a single expert should not be the default approach, in order that appropriate scrutiny is provided.

7. Future loss of income

In representing its members, MPS recognises the importance to society for fair compensation following clinical negligence. However, this must be balanced against society's ability to meet the level of compensation required.

In recent years MPS has seen an increase in the amount of special damages claimed by plaintiffs particularly high value catastrophic injury claims. While it is important that plaintiffs receive an award that provides them with the care they need, there can be an enormous differential between costings proposed by care experts for the plaintiff and those for the defendant. Whilst it is right that plaintiffs should be free to utilise their awards in any way which best meets their needs, there is unfairness if in fact they are over-compensated for the costs incurred in care.

MPS notes that the Commission propose that calculations of future loss of income be premised on a structured format or guideline based on the average national income, or the average income of the area where the claimant lives. We welcome this proposal; however, we would also support placing a limit on future earnings and earning capacity as an important tool in lowering costs. We believe there is an issue of fairness as in many cases, the costs associated with an expensive clinical negligence system are felt by society. Yet some plaintiffs receive significantly higher special damages awards than others – purely because they are very high earners, or because they are able to persuade a judge that they might have been a high earner in the future.

Recommendations:

MPS supports the Commission's proposals to base calculations of future loss of income based on the average national income or the income of the area.

We also propose a limit on claims for loss on future earnings.

8. Capping damages awards

As we have explained in previous submissions, the quantification of general damages remains difficult to determine with a degree of consistency in spite of case law and textbooks on the subject. It is this unpredictability that can be problematic when it comes to settling cases quickly. It also increases the chances of over-settlement, which in the long-term drives up costs. It is not just the awards in high value catastrophic injury cases where this is a concern, but also the increasing number of cases that should attract a more modest award and the cumulative impact of these.

The note that the Commission propose to cap any damages other than special damages – such as constitutional damages and general damages (non-pecuniary damages). MPS welcomes this proposal and there is international precedent for this. In Australia, six states have adopted a threshold for general damages awards where no general damages are payable unless the injury

is equivalent to 15% of a most extreme case and are assessed as a percentage of the capped maximum award². Research suggests such limits contributed to a reduction in the number of claims, the value of awards and insurance costs.

Recommendation: MPS agrees with the Commission's proposal that a cap is placed on general damages.

9. Support scheme for birth injury claims

We note that the discussion paper concludes that a no-fault compensation system would not be a viable solution to South Africa's medico-legal claims crisis as it would lead to an enormous increase in the number of claims. We broadly agree, although we believe consideration should be given to developing a support scheme which would provide fair and equal levels of compensation for parents and children suffering from childbirth injuries regardless of fault being proven.

As discussed above in our submission, the current clinical negligence system is an adversarial one in which patients have to identify and prove "fault". This is particularly challenging for families dealing with a childbirth injury as the current system does not provide equitable access to money for families to support their children. Only those who are able to prove fault will have access to compensation while the ones who are not able to, will not get any support at all. Birth injury claims tend to be very high value as they often concern providing children with lifelong care.

According to our data, in South Africa, the average cost of claims for the past ten years is just over R 12,590,000, while the average cost of an obstetrics and gynaecology claim is over R 18,884,000. This represents 153.52% of the average cost of a medical claim.

The huge cost of claims impacts on viability of healthcare services as individual doctors have to incur the increasing costs of protecting themselves from claims. These costs also create real challenges around recruitment and retention of obstetricians. We believe the current regime could prove unsustainable. After taking account of inflation, technology advances and improving care regimes which prolong life expectancy, the cost of these claims will only increase with the resultant impact upon compensation costs. We believe a different approach is needed that is just and equitable allowing families and children to receive compensation and support.

We advocate for a new scheme restricted to childbirth injuries – so there is equity in support for all children with severe neurological impairment. The way in which society currently compensates children and families with severe neurological injuries is neither fair nor equitable in a civilised society as only families who are able to prove fault will receive financial compensation.

The reason why we advocate for this type of scheme for childbirth injuries and not all claims is that we believe in the principle that children with severe neurological impairment and their families should not have to prove fault in order to access compensation – as this may exclude a lot of families - and the concern that if a no-fault type of scheme is introduced for all claims then it may create expectations on patients that any adverse event will lead to a financial redress.

² Annex A and B Challenging the Cost of clinical negligence report MPS

Recommendation:

We support efforts to create a non-adversarial, open system which fosters learning to promote patient safety and reduce the number of childbirth injuries. We recommend the introduction of a type of support scheme which would provide fair and equal levels of compensation for parents and children suffering from childbirth injuries – regardless of fault being proven.

About MPS

MPS is the world's leading protection organisation for doctors, dentists, and healthcare professionals with more than 300,000 members around the world.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

MPS is not an insurance company. We are a mutual non-for-profit organisation and the benefits of membership of MPS are discretionary as set out in the Memorandum of Articles of Association.

Contact

Should you require further information about any aspects of our response to this discussion paper, please do not hesitate to contact us.

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