Medical Malpractice Workshop: Panel 1 Discussion Framework

Navigating our way around Medical Malpractice Litigation

Mediation vs Litigation – Preventive Measures

PANEL

Panel Chairperson:

Dr H Edeling — Neurosurgeon (Clinical Negligence Director of the South African Medico-Legal Association)
Email: edeling@emlct.com
Tel: (011) 648-0449 / 071-682-9704

Panel Members:

Dr Anthony Behrman — Medico-Legal Adviser - Constantia Insurance Co Ltd
Email: ethel@cpcqualicare.co.za
cpctb@mweb.co.za
Tel: (021) 426-4777 / 083-270-7439

Adv Alan Nelson SC — Advocate of the High Court / Mediator
Email: nelson@law.co.za
Tel: 083-675-2528

Adv Jacques Joubert — Advocate of the High Court / Mediator
Email: jfjoubert@mweb.co.za
Tel: 076-907-1361

Non-Profit Company. Registration Number: 2005/013822/08
Web: www.medicolegal.org.za | **E-mail:** info@samla.org.za

Directors : Claassen, Judge CJ - Neels (National Chairperson); Becker, Prof Jan (National Education Director; Gauteng Branch Chairperson); Bütow-Dûtoit, Dr Lucille; Claassen, Dr Brand; Dutton, Adv Ian (Kwazulu-Natal - Branch Chairperson); Edeling, Dr Hannetjie (Administration- and Communications Director); Edeling, Dr Herman (Clinical Negligence Director; Faculty Course Leader); Enslin, Dr Hans (RAF Director); Fobian, Mr Ulrich; Fredericks, Dr Gavin; Jacobs, Mrs Elzeth; Jordaan, Mr Johan (Free State - Branch Chairperson); Kellerman, Prof Rita; Lamey, Adv Albert; Lautenbach, Prof Charles; Lawrenson, Adv Natalie; Lerm, Dr Henry (National Deputy Chairperson - Legal; Eastern Cape - Branch Chairperson); Ncongwane SC, Adv Thami (Transformation Director); Nelson SC, Adv Alan (Mediation Director); Nkeli, Mr Jerry (Membership Director); Pienaar, Dr Hennie (National Treasurer); Reynolds, Mr Trevor (National Deputy Chairperson - Health Sciences); Saayman, Prof Gert; Snyckers, Dr Frank; Sutherland, Ms Romany; Van Den Bout, Dr & Adv Anton - (Western Cape -Chairperson); Van den Heever, Adv Pat; Wasserman, Dr Marlene

Dr. Paul Dalmeyer Gynaecologist (Representative of the South African Society of Obstetricians and Gynaecologists)
Email: paul@dalmeyer.co.za
Judge Neels Claassen Retired Judge and Chairman of the South African Medico- Legal Association
Email: neelsclaassen15@gmail.com
Tel: 082-468-2854
Prof Kapil Satyapal Medical Doctor – Senior Professor at UKZN
Email: satyapalk@ukzn.ac.za
Tel: 083-777-8780

PROBLEM STATEMENT

The high incidence of malpractice in South Africa, as well as high litigation costs associated with medical malpractice litigation in the current system, have resulted in unaffordable costs of professional indemnity cover for the medical profession as well as an unaffordable financial burden on the State. This is threatening the provision of medical services.

The following questions arise : -

- How can South Africa reduce the incidence of medical malpractice and the serious harm that results?
- How can South Africa make litigation more efficient?
- Is introducing additional alternative dispute resolution mechanism such as mediation a waste of time and money, as the decisions would not be binding on the parties as is the case with litigation?

- How do we make alternative dispute resolution viable and achieve equivalent outcomes as we would with litigation, without infringing on claimants' constitutional rights as embodied in section 34 of the Constitution.
- Can the mediation process be amended to align itself with the Superior Court rules in relation to the exchange of pleadings?
- If so, in the event of mediation being unsuccessful, then and in that event the "pleadings exchanged during the mediation process" can be substituted for those that would have to be exchanged in the event of the litigation process commencing allowing the parties to commence proceedings with the application for a trial date and the discovery process.
- In that event, the additional time incurred in exploring alternative dispute resolution would not be wasted.
- How would we implement such a system? Would it be necessary to amend the Uniform Rules of Court through approaching the Rules Board or can we do so by way of including such a process in the various Courts' practice manuals.

DISCUSSION POINTS

(a) MEDIATION (questions addressed by Adv Nelson)

- What is mediation?
- Does mediation really work?
- How do we implement a system of mediation in respect of both the private and public sector?
- The benefits of introducing mandatory mediation prior to litigation or at an early stage of litigation?

- ➢ Can we introduce mandatory mediation through the relevant Court jurisdictions' practice manuals?
- ➢ Do we need to legislate it? If so, how?

(b) LEGALLY PRIVILEGED PEER REVIEW (questions addressed by Dr Edeling)

- ➢ What is legally privileged peer review?
- ➢ How do we implement a system of legally privileged peer review in respect of both the private and public sector?
- ➢ The benefits of introducing legally privileged peer review prior to litigation or at an early stage of litigation;
- ➢ Can we introduce a legally privileged peer review system through the relevant Court jurisdictions' practice manuals?
- ➢ Do we need to legislate it? If so, how?

(c) SASOG BETTEROBS PROGRAM (questions addressed by Dr Dalmeyer)

- ➢ What is the BetterObs Program?
- ➢ The benefits of introducing discipline specific post-graduate programs, aimed at enhancing patient safety and reducing negligent harm?
- ➢ How do we implement such programs in respect of both the private and public sectors?
- ➢ Do we need to legislate for such programs? If so, how?

FINAL RECOMMENDATIONS OF PANEL – DESIRED OUTCOMES

As soon as practicably possible the public and private sectors including hospitals and practitioners should take steps to ensure that mediation becomes the first option that is used for the resolution of health related claims and disputes.

To that end it is proposed that the following clause be inserted in all hospital admission forms and in agreements that all medical practitioners conclude with their patients:

1. DRAFT PRE-MEDIATION CLAUSE FOR DEPARTMENT OF HEALTH, PRIVATE HOSPITALS AND MEDICAL PRACTITIONERS

> "It is in everyone's interest for health related claims and disputes to be resolved expeditiously in a fair and cost effective way. In the event of any such claim or dispute arising from treatment at this hospital, the doctor, the patient and the hospital representative hereby agree to attend an *entirely free* pre-mediation meeting before any legal action is taken.
>
> A qualified and independent medical negligence mediator duly appointed by a Judge or retired Judge of the High Court of South Africa (or his or her nominee) will chair the aforesaid pre-mediation meeting. The purpose of the confidential and *without prejudice* meeting will be to inform all interested parties about mediation so that they can take informed decisions whether or not to make use of mediation before any other legal action.
>
> It is acknowledged that this agreement does in no way violate the parties' constitutional rights in terms of section 34 of the Constitution."

2. MEDICAL ACCOUNTABILITY AND GOVERNENCE

Medical practitioners should take charge of their own affairs. If this can be achieved through co-operation, goodwill and professional integrity, the role of lawyers in the affairs of doctors will become progressively excluded. Implementation. HPCSA. DoH. Specialist Societies. SAMA.

3. PEER REVIEW

In all appropriate cases, conduct will be referred to a legally privileged peer review meeting at an early stage (see detailed proposal below). Implementation. Pre-mediation meeting. MEC instructions to public sector legal representatives. Protection Society or Indemnity Insurer instructions to private sector legal representatives.

4. MEDIATION

The outcome of the peer review meeting, will guide Defendants at the mediation and promote fair outcomes. Implementation. MEC instructions. Protection Society or Indemnity Insurer instructions to private sector legal representatives.

Should the parties reach an agreement in mediation, that agreement will be signed by each and will be legally binding. Implementation. Mediators. Plaintiffs, Defendants and their legal representatives.

Should the parties fail to reach an agreement during mediation, the parties will proceed to litigation in court. Implementation. Plaintiffs, Defendants and their legal representatives.

In the latter case, the discoverable records and expert reports that were used in mediation will be carried over into the litigation process without any need for duplication. Implementation. Mediators, Plaintiffs, Defendants and their legal representatives.

5. EDUCATION / TRAINING

South Africa implements a co-ordinated system of post-graduate educational- and other programs, in each relevant discipline, aimed at enhancing patient safety and reducing negligent harm. Implementation. HPCSA. DoH. Specialist Societies. SAMA.

To promote the value of such programs, the DoH, Protection Societies and Indemnity Insurers will provide relevant statistics and anonymized case summaries, with pertinent facts and outcomes, to the specialist societies and SAMA. Implementation. DoH. Protection Societies. Indemnity Insurers.

The public sector and private sector should join hands in developing post-graduate specialist training programs in all disciplines. Implementation. HPCSA. DoH. Specialist Societies. SAMA.

FURTHER COMMENTS AND RECOMMENDATIONS OF INDIVIDUAL PANELLISTS

A. THE ROLE OF MEDICAL PRACTITIONERS – (Proposal of Prof Satyapal)

Mandatory introduction of suitably-qualified medical practitioners with appropriate mediation certification to be the chairperson/mediator in all matters relating to medical mediation.

B. THE BETTER OBS PROGRAM AS EXAMPLE – (Summary prepared by Dr, Paul Dalmeyer, PhD, obo SASOG – MiM – SAMLA)

Containing Spiralling Indemnity Cost – Reduce Litigation – Protect the Demise of the Obsteric Discipline - A Template for all Medical Disciplines and Sectors

Remedial proposal – "BETTEROBS" PROGRAM

Role players:

The Hospitals.

- ✓ role out of EBM guidelines, protocols, programs,
- ✓ continuous education CME of staff EOMOS, MM/PN meetings, meticulous record keeping,
- ✓ inclusion of options to resolve disputes in admission documentation
- ✓ Refrain from incentivizing / Acceptance of Peer review EOMC

The Obstetrician.

- ✓ Adhere to the SASOG guidelines and protocols (introduced into all labour wards in RSA).
- ✓ CME – CPD to attend at least 50% of the MM and PM and meetings
- ✓ Complete a delivery report on each delivery medico legal document)
- ✓ Comply with the SASOG peer review, need to be draconian - delivery rights etc.
- ✓ sharing responsibility – lead obstetrician

The Paediatrician.

- ✓ Proper and shared documentation
- ✓ Part of CME - MM and PM
- ✓ Maintain contact

The Patient.

- ✓ informed of the complaint channels leaflets etc.
- ✓ Made aware of 1st port of call - ? mediation
- ✓ Ring fencing the future of expectations of the “perfect baby”

The Indemnifiers

- ✓ Absolute transparency on products, Need verifiable historical d – financial and claims data. Development of future data base – goal indemnify on individual risk, incentivizes good practice
- ✓ Historical indemnifier to make a bold paradigm shift towards becoming more doctors friendly. Encourage local indemnifiers – different players well underway
- ✓ Skin in the game – “Unrestricted Grants” – SASOG – data collection, for educational projects, incentivize good practice – OUTsurance

- ✓ Indemnify – not only for financial loss, but fear reputation and professional standing, duration of legal process, loss of professional integrity
- ✓ Financial regulators (FSB) "Claims based" products legality by NPO Mutuals
- ✓ Collective decision of indemnity fee structure with SASOG – determined by data
- ✓ Documentation of indemnifiers regarding Mediation **-** informs doctors first port of call is Mediation – not unconstitutional
- ✓ Report "bad apples" for peer review to SASOG

The Funders

- ✓ Funding – unrestricted grant of BetterObs program -education
- ✓ Documentation that first port of call in dispute – mediation
- ✓ Report of "Bad Apples" of claim data for peer review

Education

- ✓ Reduce the Obstetric Brain Drain – fear of practice
- ✓ Quality and quantity of specialist education - staff and clinicians
- ✓ Potential of PPP training ventures – use private intellectual capital
- ✓ Continuous CME – staff and clinicians

B. BetterObs Recommendations

- ✓ Aim is to get the "Obstetric House in order" – deliver a safer obstetric service to both public and private sector under the stewardship of SASOG
- ✓ Establish the EOMC (Expert Opinion and Mediation Committee will need to be renamed). Peer Review and Mediation – to be standardized throughout the healthcare system to help resolve disputes in a just and equitable way.

- ✓ Indemnifiers need to make substantial paradigm shift regarding their products to help reduce spiralling cost and they need to make financial and historical litigation data available.
- ✓ Need for local indemnifiers – help develop transparent reliable data. Allow SASOG and doctors to have “skin in the Game” for CME of staff and clinicians that will encourage and recognize excellence with the aim to bring about individual indemnity cost.
- ✓ To de-stigmatizing Obstetrics as the litigious discipline and encourage its practice to re-establish quality and quantity training. Allow PPP and tap into private intellectual capital and technology for the good of both public and private sectors.
- ✓ Need role out initiatives into the both public and private sectors and focus on the public backlog.
- ✓ Encourage Mediation as the medico-legal tool of choice by all stakeholders as the first port of call to resolve disputes This will lead to legal cost containment, protect professional reputation and integrity, reduce personal fears, duration of legal process and expedite resolutions.
- ✓ Is the program transferable to all medical disciplines – YES but with discipline specific modifications
- ✓ Focus of the remedial approach to obstetrics is to support both the public and private sector.

C. LEGALLY PRIVILEGED PEER REVIEW – (Proposal of Dr Edeling)

1. In every case in respect of which a claim is lodged, for alleged clinical negligence by a medical practitioner, professional nurse or other healthcare professional (as opposed to non-clinical claims and claims lodged against the conduct of other employees), a legally privileged peer review meeting should be held. The purpose is threefold (a) for the benefit of the defending lawyer and potential payer, (b) for the benefit of the implicated healthcare professional/s, and (c) for the benefit of his or her peers and other healthcare professionals.

1.1. In the public sector such meetings should be called by the lawyer appointed by the MEC, and should be attended by the implicated healthcare professional/s, by a peer (expert) or peers of equivalent or higher standing as appointed by the defending lawyer, and by as many members of the clinical staff as possible.

1.2. In the private sector such meetings should be called by the lawyer appointed by the protection society or indemnity insurer, and should be attended by the implicated healthcare professional/s, by a peer (expert) or peers of equivalent or higher standing as appointed by the defending lawyer, and by many members of the relevant specialist society as possible.

1.3. The minutes of case specific peer review meetings should be kept and retained by the defending lawyer, and should be protected by legal privilege as they would form a legitimate and necessary part of discussions between attorney and client in preparation of the case.

2. Benefits of such case specific peer review meetings would be, inter alia : -

2.1. A strong motivational tool in encouraging healthcare professionals to avoid negligent harm to patients.

2.2. An effective educational tool to : -

2.2.1. equip attending healthcare professionals with relevant knowledge and understanding with which to avoid negligent harm to patients;

2.2.2. promote understanding of the difference between complications arising from non-negligent clinical errors (not compensable) and complications arising from negligent practice (compensable);

2.2.3. promote understanding of ineffective and wasteful “defensive medicine” practices as opposed to ethical and effective “defensive medicine” practices;

2.2.4. provide relevant educational material to specialist societies for use in seminars, conferences and CPD programs; and

2.2.5. provide relevant educational material to universities for undergraduate and specialist training programs.

2.3. An effective mechanism for the defending lawyer and MEC, protection society or indemnity insurer, to

2.3.1.1.1. establish relevant facts at an early stage;

2.3.1.1.2. identify and preserve relevant records; and

2.3.1.1.3. develop an early informed view on the defensibility or otherwise of the matter.

3. In order to achieve these very powerful outcomes, it is essential for all participating in such peer review meetings to have the freedom to report facts and express their opinions openly and truthfully. This would only be possible if all can be assured that what they say will remain confidential, and will not be used in any court of law.

4. If the law does not protect the confidentiality of what is said in such meetings, the meetings will need to be confined to the defending lawyer, the implicated healthcare professional/s and the appointed peer (expert).

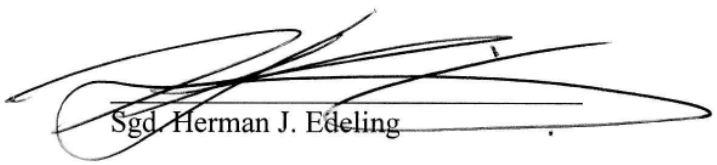
4.1. In this case the benefits will still be substantial, but will be confined to those that apply to the implicated healthcare professional/s and those that applied to the defending lawyer and MEC, protection society or indemnity insurer (see above).

4.2. The very powerful motivational and educational benefits, that would otherwise accrue to large numbers of non-implicated healthcare professionals, and which, if employed regularly and consistently, would have the capacity to reduce the national incidence of negligent harm to patients, would not be achieved.

5. In this case, a less satisfactory but alternative option, to achieve the motivational and educational objectives to reduce the national incidence of negligent harm to patients, would be for the defending lawyer and peer (expert) participating in such peer review meetings to prepare an anonymized summary of essential facts, expert opinions and legal opinions in relation to the case.

5.1. Such case specific summaries should be provided to professional bodies that engage in continuing professional development programs, such as SAMLA, SAMA, medical specialist societies, other professional healthcare societies, the College of Medicine and the medical faculties at universities.

5.2. These professional bodies should use the facts, expert opinions and legal opinions in such summaries in their continuing professional development programs. In presenting such programs they should invite lawyers and experts who are experienced in medico-legal practice to present the educational material and answer questions.

6. If the law does not protect the confidentiality of what is said in peer review meetings, the law should be amended to apply a specific legal privilege to peer-review meetings, in order to protect the confidentiality and permit the safe and valuable inclusion of large numbers of non-implicated healthcare professionals in the national interest of reducing negligent harm to citizens.

7. If the law does protect the confidentiality, i.e. the best case scenario in which legally privileged peer review meetings can be held with the inclusion of large numbers of non-implicated healthcare professionals, it would obviously be of immense additional benefit if the steps referred to above in paragraphs 5, 5.1 and 5.2 were to be implemented by all involved professionals and organisations.