DOWNSTREAM CONSEQUENCES OF MEDICAL NEGLIGENCE

1. INTRODUCTION

As much as fingers may be pointed at claimants, attorneys, expert witnesses, advocates, presiding judicial officers and providers of indemnity insurance, and as much as certain of them may be dishonest, unethical and/or unfair, these so-called "enemies of doctors and healthcarers" are not responsible for medical negligence. They only come into the picture after negligent harm has already occurred. Their involvement is "downstream" whereas the real causes of medical negligence occur "upstream".

2. WHY DO PATIENTS INSTITUTE LEGAL PROCEEDINGS?

2.1 The desire for monetary compensation – parents claiming on behalf of injured children; dependents claiming for loss of support from a deceased;

2.2 Touting and advertising by lawyers – touting is illegal but advertising is legal. Touting means "**to solicit custom**".[1] The dangers of touting are threefold: (i) It constitutes **unfair competition** against other members of the profession; (ii) Touts who are paid substantial sums of money may **tend to fabricate claims,** thus harming the administration of justice and the medical healthcare industry; (iii) Members of the **public may be exploited** in the sense that the attorneys involved overcharge them, share in the proceeds of successful claims, pay touts out of the awards made to clients and fail to render a proper professional service.[2] Touts are **often seen in hospital** wards carrying a **briefcase** full of Powers of Attorney authorizing their employing attorney to institute on behalf of a patient, a claim for damages against the hospital or any medical health provider. The **tout normally attends each patient in every bed with a** proposition to sign a Power of Attorney, where after the attorney will institute action for damages free of charge on a contingency fee basis. Hospital staff should be encouraged to enforce more readily the hospitals "Right of Admission is Reserved" notice by removing from the hospital premises persons caught touting for work from patients. On the other hand, advertising is legalized by the Attorneys Act and the Rules and Regulations passed there under.[3] It, therefore, stands to reason that both unlawful touting and lawful advertising have substantially increased the amount of medico-legal litigation.

2.3 Claiming on a contingency fee basis – less risk involved for the claimant, as the attorney is paid nothing if the claim fails but receives the lesser of 25% of any amount successfully recovered or double the normal taxable fees, whichever is the lesser amount. It induces the patient to institute litigation without the fear of losing the court case and having to pay his attorney any legal costs. However, this proposition induces a **false sense of security** because if the case is lost, the patient may have to pay substantial costs to the successful defendant.

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[1] See Simaan v SA Pharmacy Board 1982 (4) SA 62 (AD) at 75H.
[2] See Cirota and Another v Law Society, Transvaal 1979(1) SA 172 (AD) at 175E – F.
[3] See Act 53 of 1979 sections 83 (11) (e) and (f).

2.4 Lack of proper doctor/patient communication undermining "informed consent" – proper explanatory communications with patients are important, both pre- and post treatment.

2.5 Deterioration of service by overburdened and understaffed medical personnel and equipment causes unnecessary adverse outcomes giving rise to claims.

2.6 Criminal conduct – it has been reported that healthcare staff unlawfully sell the hospital records to attorneys leaving the hospital defenseless. Theft is a dismissible offense and staff found guilty at disciplinary hearings of theft should be dismissed immediately. If lawyers are found to be in possession of original hospital records, it should be reported to the police for investigation as well as the relevant Law Society or Bar Council with jurisdiction over the lawyer. Gaining unauthorised access to medical records is a criminal offence.[4]

2.7 Advent of Constitutional protections – section 10 (right to human dignity); section 11 (right to life); section 12(2) (right to bodily and psychological integrity); section 27 (right to health care services, ability to support dependents, right not to be refused emergency medical treatment); section 28 (children rights to basic health care services, protection from maltreatment, neglect, abuse or degradation, entitlement to legal representation in civil proceedings); section 34 (everyone has the right to go to court or other tribunal or forum).

2.8 Consumer Protection Act 68 of 2008 making patients aware of their rights and limiting the protective effect of exculpatory clauses – section 22 (right to information in plain language); section 48 (right to fair, reasonable and just contract terms); section 49 (right to proper notice of certain terms and conditions); section 51 (prohibited terms and conditions); section 54 (right to quality service); section 58 (warning concerning nature of risks); section 61 (faultless liability for damage caused by goods and services). Regulation 44(1) introduced by the Minister responsible for consumer protection matters, provides that a consumer agreement is presumed to be unfair if it has the purpose or effect of *"excluding or limiting the liability of the supplier for death or personal injury caused to the consumer through an act or omission of that supplier."* In Britain the *Unfair Terms Act of 1977,* prohibits the exclusion of liability for negligence including ordinary negligence leading to bodily injuries or death.

2.9 The failure of the Road Accident Fund system of compensation.

2.10 Change in peoples' belief that doctors are infallible and injuries are God's will.

3. MANAGING CLAIMS FOR DAMAGES

3.1 Preservation of records – without records the state and/or private practitioners have no defence. In terms of section 13 of the National Health Act 61 of 2003 the person in charge of a health establishment is obliged to create and maintain such health records containing

[4] See section 17(2)(*h*) of the National Health Act 61 of 2003.

the prescribed information. In cases of childbirth, records are to be kept for at least 22 years because the running of prescription in respect of minors is suspended for 19 (18+1) years and the claims will only become prescribed 3 years thereafter. This requirement poses practical problems in relation to adequate storage space, financial implications for the cost of digital recording and technological obsolescence. Since almost 80% of claims result from birth defects and/or spinal operations, pro-active conduct is required. Continuous contact with neo-natal institutions should be maintained so that as soon as Cerebral Palsy or other brain damage is noticed the hospital where the birth took place should be informed in order to red flag that file.

3.2 Adverse outcomes – They should be followed by timeous Mortality and Morbidity (M&M) meetings while the personnel and documents involved are still readily available and facts are fresh in the mind of those concerned. In order to encourage open, honest and transparent M&M meetings, it should be made privileged from disclosure. This can be achieved either by ensuring the presence of a lawyer or by appropriate provincial legislation declaring such meetings privileged. In certain states of the USA "patient safety work product" such as data, reports, records, memoranda, analyses (such as root cause analyses), written or oral statements (but excluding patients' medical records) produced after an adverse outcome, are privileged from disclosure in any civil or administrative proceedings[5]. Hospitals against whom a multitude of legal claims have been instituted should seriously consider employing a permanent in-house lawyer to attend all M&M meetings thus rendering them privileged from disclosure. What is discussed at M&M meetings should be properly minuted and preserved for future reference.

3.3 Legal Representation – State hospitals are not obliged to utilize the services of the State Attorney if experience shows that the services rendered by that office are inadequate. It is a well-known fact that the State Attorneys' offices are also over burdened and under staffed. One solution is to appoint a permanent in-house lawyer to manage the initial duties in regard to the receipt of letters of demand, summons and other correspondence as a time saving action. Although Provincial Health departments and hospitals may not budget for legal costs and court awards, there could be no objection to include in the hospitals' staff complement, one or two legal officers.

3.4 Legally Privileged Peer Review Meetings –

3.4.1 Because this is a new concept for application to clinical negligence claims, SAMLA will assist and train staff of the department in the conduct of these meetings. Peer Review meetings and M&M meetings are well known in clinical medicine but these are not privileged meetings. When there is a claim of negligence medical health carers are reluctant to speak freely. As a result such meetings do not occur. Peer Review and M&M meetings do occur infrequently when there are no claims of negligence. The purpose of a legally

[5] See "Patient Safety and Quality Improvement Act of 2005" amending Title IX, section 922 of the Public Health Service Act (42 U.S.A. 299 et seq).

privileged meeting is to afford legal protection so that participants can speak freely.

3.4.2 Immediately upon receipt of a letter of demand, summons or other claim oriented correspondence, a peer review meeting should be held to determine whether or not the claim has merits or not. Not all mistakes or adverse outcomes constitute negligence.[6] These meetings should also be privileged from disclosure by ensuring the attendance of a lawyer or in-house lawyer. The purpose is not only to determine early indications of liability, but also as an educational tool to prevent future similar circumstances. The presence of peers of equal standing and/or more experience will reduce unnecessary litigation by advising an early settlement.

3.4.3 In the public sector the Health MECs may instruct their legal representatives to conduct a peer review process, and require their health care employees to participate in the process. In the private sector the indemnity insurers may instruct their legal representatives to conduct a peer review process, and require their insured practitioners to participate in the process.

3.4.4 The purpose of these recommendations is not to enquire into any confidential evidence or findings in the peer review process, but importantly to encourage the accused healthcare practitioner and his or her legal representative to engage in a peer-review process in view of the major benefits that such process is likely to confer on the further conduct of the dispute, whether by mediation or litigation, and more particularly in view of the major benefits that such process is likely to confer on the upstream issues of patient safety and prevention of future negligent harm to patients.

3.4.5 If the Department is interested, SAMLA is willing to provide training in the manner of conducting such Legally Privileged Peer Review meetings.

3.5 Mediation – The national Minister of Health has already determined that mediation should be the first choice of resolving any medical negligence claim. What are the benefits of mediation?

3.5.1 Mediation is far **less costly** than litigation or arbitration.

3.5.2 Mediation is far **less time consuming** than litigation or arbitration. It has been estimated that the largest portion of mediations are completed in less than a day. Mediating parties are also not subject to waiting time for trial dates as in the courts. It is only the mediator and the parties who have to coordinate their diaries for a suitable date.

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[6] In *Buthelezi v Ndaba* 2013 SA 437 (SCA) the Supreme Court of Appeal in Bloemfontein decided that the mere admission that "*something went wrong*", does not amount to negligence as "*even with the best will in the world things sometimes go amiss in surgical operations or medical treatment*." Liability for negligence is only established where the healthcare professional's conduct fell below the standard of a reasonable competent practitioner in that particular field under the prevailing circumstances.

3.5.3 Mediation is a **voluntary** and not a compulsory process and under no circumstances does it deny a party's right to withdraw and enforce his right to litigate in court. If any party feels aggrieved by the mediation process, withdrawal at any stage therefrom is permissible. In such event, the mediator would usually ask for a private session with the aggrieved party to enquire the reason for his/her dissatisfaction in order to have an opportunity to remove any misunderstanding, hopefully to convince that party to continue with the process. If one of the parties unreasonably obstructs the completion of a mediation the other party may seek an appropriate costs order from the court. Although it is generally not a compulsory process, certain legislation obliges disputing parties to submit their disputes to mediation first before instituting litigation.

3.5.4 Mediation is an **informal process.** The formal laws of evidence and the rules of court do not bind the parties. Knowledge of court procedures is, therefore, not a prerequisite for parties to engage in mediation successfully.

3.5.5 Mediation is **without prejudice** to either party's rights. This allows parties to speak freely without fear of their rights being adversely affected. Such freedom often leads to the parties getting to grips with the real problem. If, however, the mediation fails, then neither party is allowed to refer to anything said or admitted during the mediation during any later court proceedings.

3.5.6 Mediation is a **private and confidential affair** where no adverse publicity will influence the parties to withhold the truth. It is a safe place to speak the unadulterated truth! It is also permissible to have your own attorney present throughout the mediation process. Experience has shown that it is always beneficial to have the parties' attorneys present in clinical negligence claims. It makes their clients feel safe and comfortable and undermines any fear they may have that they will be prejudiced.

3.5.7 Mediation is **client based**, i.e. the **interest or needs** and not the rights of each party are paramount. It is not rights based, as is the case in litigation or arbitration. The skilled mediator guides the parties to a mutual solution satisfactory to them irrespective of their legal rights. Thus, they arrive at a solution designed by their own needs leaving two winners instead of a loser and a winner. In arriving at a solution, the parties are not limited to their legal remedies. Often, a mere apology, suffices to bring healing to broken relationships. It would be wise to remember, "having your **day** in court" does not always result in "having your **say** in court".

3.5.8 Mediation called for at the **earliest moment possible**, allows the parties to face one another after the event sooner than in litigation. At such early stage, attitudes have not yet hardened and the relevant documentation and personnel that can shed light on the causes of the problem are usually still available. No

waiting time for trial dates is required and the problem can be resolved while everything is still fresh in the memory of the respective parties.

3.5.9 The mediator facilitates any **lack of understanding** or any **miscommunication** existing between the parties in language devoid of legal formalism or scientific technicalities. Where the problem is, however, **technical or scientific** in nature, the mediator will be in a position to guide the parties to appoint a single independent expert to look at the problem and give a neutral view or explanation. Usually this procedure will resolve the problem resulting in a far more cost effective resolution of the dispute than a procedure where each party employs his/her own expert.

3.5.10 Another benefit of mediation is that it engenders **equality** between the parties and removes any imbalance in power between the "stronger" professional and the "weaker" lay patient. This balance occurs during private sessions that the mediator conducts with each party in the absence of the other where the weaker party is free to speak without reservation. This freedom usually discloses the real nature of the dispute and the real needs of the party.

3.5.11 Mediation allows the parties **greater control** over the process in comparison to litigation where their legal representatives are in control. The process of mediation removes the disadvantages of the adversarial nature of litigation. The adversarial process produces surprises that are often devastating to the parties. Cases are often decided on legal principles far removed from the parties interests, e.g. a case may be decided on who the onus of proof rests upon, a concept far removed from the parties' interests and real needs.

3.5.12 A mediator does not supply the parties with a **verdict**. Nor does the mediator judge the **credibility** of the parties and/or their witnesses. A mediator does not cross-examine any one as is done in court or arbitration proceedings. The bona fides of each party or person are accepted at face value and this removes the threatening atmosphere that is so often prevalent in court proceedings. It is a safer place to protect one's dignity and reputation.

3.5.13 In medical negligence mediation, it is advisable to allow the parties to have their own **legal representatives** present at their own cost. Legal representatives are necessary in order to advise parties, inter alia in relation to the selection of mediators and experts, appropriate reality checks, risk assessments of BATNA (best alternative to a negotiated agreement) and WATNA (worst alternative to a negotiated agreement), evaluation of expert reports and evidence, questioning of experts, and reducing settlement agreements between the parties to writing. The reality is that mediation of these disputes will occur "**in the shadow of litigation"**, i.e. if the mediation does not succeed the matter will probably proceed to court. The risk of this occurring is often a strong persuasive

consideration to settle rather than suffer the trauma of litigation over an extended period of time.

3.6 Classification of medical mediations -- It is necessary to appreciate that there are two fundamentally different types of medical/clinical mediation, and that the second type has two subtypes:

3.6.1 The first type of mediation that arises in the health sector may be called "Health Sector Commercial Mediation"(HSCM). This type of mediation concerns disputes that are unrelated to scientific knowledge and expertise, but more related to conflicting interpersonal relationships between health carers, hospital staff and/or management or any financial improprieties allegedly committed. Although disputes of this type may arise in a medical setting, such as at a hospital or between a health carer and a patient, they do not require particular scientific knowledge and expertise to reach resolution through mediation. A single mediator can usually deal with this type of mediation. The qualifications for this category are a suitable professional in good standing who (a) is an accredited mediator AND (b) has certified that he or she abides by the DISAC Code of Professional Conduct for Mediators or other similar codes of conduct, AND (c) commits to contributing his or her professional services to the mediation of medical disputes.

3.6.2 The second type of mediation may be called "Technical Medico-Legal Mediation"(TMLM). This type of mediation concerns medical- and other issues where scientific knowledge and expertise are required to enlighten the parties and should preferably be dealt with by two co-mediators, one being a medical specialist and the other a seasoned lawyer in medical negligence disputes. Experience has shown that the specialist medical co-mediator should be of a different medical specialty to that of the defendant's specialty. This prevents the plaintiff from any perception that the medical co-mediator specialist and the defendant will team up against the layman plaintiff. This type of Technical medico-legal mediations include two distinct subtypes:

3.6.2.1 Subtype A may be called "Technical Medico-Legal Mediation – Clinical Negligence" (TMLM-CN). These relate to disputes, which include allegations of clinical negligence and damages brought about by the alleged negligence. They require appropriate expertise to enlighten aspects of negligence, outcome, causation, apportionment and/or quantum of damages. The qualifications for this category are all of the above mentioned in 3.6.1 plus (d) a senior health care practitioner with considerable medico-legal experience which includes experience in litigation of medical/clinical negligence disputes, OR (e) a senior legal practitioner with considerable medico-legal experience which includes experience in litigation of medical/clinical negligence disputes OR (f) a senior mediator with extensive experience in various types of mediation, whether medical or non-medical. Health care- and legal co-mediators

should have an adequate understanding of the medico-legal concepts of negligence, outcome, causation, apportionment, quantum of damages and legally privileged peer review meetings.

3.6.2.2 Subtype B may be called “Technical Medico-Legal Mediation – Personal Injury”(TMLM-PI). These are less complex in that they do not require considerations of negligence, and in that the “merits” of these claims are typically resolved without any need for expert evidence. Claims of this nature do, however, require appropriate expertise to enlighten aspects of outcome, causation, apportionment and/or quantum of damages..

3.6.3 Co-mediators or single mediator? – Technical Medico-Legal – Clinical Negligence mediations should only be done by single mediators who have attained the necessary self-confidence; extensive experience and peer recognition to mediate technical medical negligence disputes on their own. The qualifications for this category are all of the above plus (g) sufficient experience in co-mediation of Technical Medico-Legal Mediation – Clinical Negligence (see above) matters to achieve sufficient peer recognition. Such Sole Mediators should also have an advanced understanding of the medico-legal concepts of negligence, outcome, causation, attribution, apportionment, quantum of damages and legally privileged peer review meetings.

3.6.4 Pre-mediation meetings – It is advisable that all hospital admission forms should contain a clause dealing with an agreed method of dispute resolution. This clause should state that in case of any dispute the parties would submit to attend a pre-mediation meeting chaired by an accredited mediator. It is recommended that the chairing of pre-mediation meetings be offered free of charge as a public service by accredited mediators. The purpose of the pre-mediation meeting will include the purpose of obtaining properly informed consent to mediate the dispute, to be confirmed in an agreement to mediate, as well as the determination of the issues in dispute and the participants in the mediation. The first task to secure a successful medico-legal mediation is for all participants to understand the nature of the dispute required to be resolved.

3.6.5 The mediation agreement should include an indemnity clause that provides that the mediator/s shall not be liable for any loss that the parties may suffer (whether such loss is recoverable by a claim based on contract, delict or any other basis) as a result of any act or omission directly or indirectly connected to the mediation.

3.6.6 In medical mediations the role of an insurer of the defendant can become very important. This applies to the private sector because employees of the state are not insured, as the state is its own insurer. This situation may have to change in view of the financial crisis in the medical negligence industry as far as claims against the state are concerned.

3.7 Merits experts in mediations – Experts appointed to address issues of negligence; outcome, causation, and/or apportionment should consult independently with each disputant, i.e. both the patient and the health care provider. Expert/s appointed only to address issues of causation should be guided by the legal representatives and mediators in relation to whether it is necessary to consult with the patient and/or the health care provider.

3.8 Quantum experts in mediations – In the event of the parties' mediated agreement requires quantification of damages, provision for future treatment and care, or some financial- or other benefit, the parties will jointly appoint one or more quantum experts. Quantum experts may be required in one or more of the fields of medicine, surgery, nursing, occupational therapy, physiotherapy, clinical psychology, neuropsychology, educational psychology, industrial psychology, or any such field as may be deemed appropriate to the facts of the dispute/s, to investigate the dispute/s and render independent and impartial expert reports in accordance with the above recommendations. Once the necessary quantum expert reports are available, it may be necessary to appoint an actuary.

3.9 Payment of mediations costs –

3.9.1 Professional fees for legal representatives will be agreed between each party and his/her legal representative, who will also agree whether these fee agreements are to remain confidential. This type of agreement should preferably be concluded prior to the pre-mediation meeting. The chairperson of the pre-mediation meeting will not inquire into the nature or details of the fee agreements, but may enquire into the existence of such agreements and whether they are satisfactory to the parties.

3.9.2 Costs for the venue, catering, transport, accommodation, translation services and any other necessary services or facilities will need to be agreed with the provider/s thereof.

3.9.3 Professional fees for the mediator/s and expert/s will need to be agreed with the individual professionals. The standard principle is that the parties share the costs of mediation equally. In particular cases it may be in the interests of both parties that the costs are shared on a different basis, or even that the costs are fully paid by one party. In other cases it may be possible to obtain funding from an outside benevolent source.

3.9.4 In cases where agreement is reached between the parties and their legal representatives that the costs will not be shared equally, this agreement should be kept confidential and should not be disclosed to the mediator/s or expert/s. This is to guard against the risk of subconscious bias.

3.9.5 An undertaking to pay the mediator, mediators and experts for their professional services must, however, be signed by the person who has agreed to make the payments, without disclosure of the source or sources of funds.

4. LEGISLATIVE INTERVENTIONS

At provincial level legislative amendments may include innovations provided they do not conflict with the Constitution, common law or other parliamentary legislation. Provinces may e.g. legislate that every state hospital should include pre-mediation clauses in their admission forms; apologies by health carers are protected from negative inferences; M&M and Peer Review meetings are privileged from disclosure to enhance transparency of the real causes of adverse outcomes; certificates similar to section 17 of the RAF Act may be issued for future medical care; effective patient centered complaints systems be introduced.

5. LITIGATION

5.1 The management of claims for damages in court litigation is an entirely different subject. In view of the Honourable Minister's directive that mediation is preferable to court litigation, this lecture cannot traverse the pitfalls for state hospitals in the varied aspects of court litigation.

5.2 It should however be noted that it is never too late to opt for mediation instead of a litigation process which has already reached an advance stage. Agreeing to transform litigation into a mediation process still retains the benefit of a quicker result, cost savings and the possibility of restoring relationships.

6 CONCLUSION

6.1 In conclusion it may be mentioned that all health carers are encouraged to engage in further education, particularly in the field of medico-legal practice and mediation.

6.2 Conflict Dynamics and Mediation in Motion are organisations that train mediators for commercial disputes as well as for medical negligence and malpractice disputes.

6.3 Between January and June 2018 SAMLA, in conjunction with the University of Cape Town and Function Venues, presented a highly successful and transformative multidisciplinary certificate course on Foundations of Medico-Legal Practice, focusing on competent- and ethical practice. The course, with lectures by experts from across the country, was presented simultaneously at 5 venues in Bloemfontein, Cape Town, Durban, Johannesburg and Port Elizabeth, via interactive high grade video-conferencing facilities. The course was presented on 11 Saturdays, followed by an online examination.

6.4 For all medical-, legal- and other practitioners who are interested, but did not attend the course, the SAMLA Faculty is in the process of preparing an online e-learning course from full video recordings of the course lectures and discussions.

6.5 A second, more practically oriented course on Medico-Legal Practice, focusing on pre-trial-, mediation- and trial procedures, is planned for 2019.

August 2018 Judge Neels Claassen and Dr Herman Edeling