THE SOUTH AFRICAN MEDICO-LEGAL ASSOCIATION'S COMMENTS AND RECOMMENDATIONS TO THE ENQUIRIES OF THE SOUTH AFRICAN LAW REFORM COMMISSION ON ISSUE PAPER 33

December 2017

INTRODUCTION

The South African Medico-Legal Association as an independent and neutral organization strives to promote excellence in medico-legal practices in both the private as well as public health care sectors in South Africa. For that reason, the organization remains committed to the promotion of justice, sound ethical practices and promotion of constitutional values. Part of our commitment is to find solutions to the devastating crisis that is facing our healthcare industry, with medical malpractice litigation spiraling out of control. Similarly, the Law Reform Commission is investigating the present state of affairs of the Health care crisis in South Africa, as means to find solutions to the issue tabulated by the Reform Commission and the answers sought by the Commission. The issues raised herein below are answered in conformity with the answers sought in the different categories.

A. AD 6.2: THE MAIN REASONS FOR THE INCREASE IN LITIGATION

1. Before the issue of the possible changes in the patient-outlook towards suing health care professionals is addressed, the South African Medico Legal Association through its experienced members in both the practice of medicine as well as law, has identified shortcomings within the health care system. Although there are many skilled, well-motivated and caring health care practitioners within both the private and public sectors, who provide medical care with the highest

professional standards, regrettably this cannot be said about all the members who function within the medical profession. In more recent times, more and more cases of medical misconduct and the deviation of professional standards are being experienced in South Africa. The Association has identified the following factors as possible causes that influence the commission of negligent harm by health care practitioners. They include the lowering of standards from the initial intake of aspirant doctors at medical schools to those who eventually qualify as fully fledged doctors. The same can be said at other medical institutions, responsible for the training of other health care practitioners as well. Another issue that underscores this challenge, is the shortcoming in the excellence in training and the lack of facilities for practical training at medical schools. It is also the Association's view that insufficient emphasis is placed on medical ethics and clinical care while aspirant health care practitioners undergo their initial medical education. What is required Benatar [1] opines is *"……to strive for high-quality teaching conditions of service and an ethos of care in clinical services that would encourage dedication by healthcare professionals to excellence, rather than merely having job security and a salary."*

The influx of foreigners and the overcrowding of hospitals especially in the public health care sector where the infrastructure is shockingly inadequate, is not helping to manage the risk of medical mistakes being made. The morale of the staff is believed to be at an all- time low, which impacts negatively on service delivery. The Association calls for a proper study to be conducted by an independent body as to the extent to which the aforementioned factors have influenced the increase in medical negligence claims, supported by reliable statistical evidence.

[1] Editorial The challenges of health disparities in South Africa The South African Medical Journal Vol. 103, No 3 (2013)

2. Change in patient's outlook

The change in patient's outlook is influenced by and large by the following factors:

- The South African *Constitution* [2] more in particular the following constitutional imperatives found in the Bill of Rights [3] that form part of the *Constitution* inter alia: 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 (access to the courts and other independent and impartial tribunals that resolve disputes, including medical negligence matters. Mediation and arbitrations, but to a lesser extent, are ideal to handle those disputes in most disputes. But, it still leaves room for those disputes that cannot be resolved through the alternative dispute means, to be tried in a court of law.

- The Consumer Protection Act [4] has had and will continue to have a profound influence on the relationships between business enterprises as well as other institutions and consumers, including the relationship between health care service providers and patients.[5] The relevant sections of the Act and regulations, with their significance are briefly mentioned herein after. Their import to healthcare shall still in time make their presence felt. 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

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[2] The Constitution of the Republic of South Africa, 1996.

[3] See Chapter 2: Bill of Rights of the South African Constitution.

[4] See the Consumer Protection Act 68 of 2008 as well as the Regulations published in GG 34180 on 1 April 2011 (GN R 293) which came into operation on 1 April 2011.

[5] See van den Heever "Impact of the Consumer Protection Act in the health care context" DE REBUS (March 2012) 22-25 at 22;Nothling, Slabbert, Maister, Botes and Pepper "The application of the Consumer Protection Act in the South African health care context: concerns and recommendations" XLIV CILSA (2011) 168 at 170.

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(3) 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.[6]

- The role of the South African attorneys, especially with regards to touting; [7]
- The influence of contingency fee agreements; [8]
- Changes in peoples' religious belief that medical mishaps are God's will;
- With a shift in general philosophical outlook, doctors are no longer put on godly pedestals; [9]
- A general lack of proper doctor-patient communication, both pre- treatment and post-treatment, assist in fuelling litigation;[10]
- The overburdening and understaffing of personnel as well as the non-replacement of obsolete and faulty equipment, do not help to minimize the risk of mistakes being made, resulting in further negligence claims against particularly, the public hospitals. [11]

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[6] See also Lerm "A Critical Analysis of Exclusionary Clauses in Medical Contracts" Unpublished LLD Thesis (University of Pretoria) who supports the English approach to those types of clauses.

[7] Evans " Lawyers Targeting Doctors after RAF Shake-up Motsoaledi" 14 February 2016 News 24 http://www.news24.com/SouthAfrica/News/lawyers-targeting-doctors-after-raf-shake-up-motsoaledi

[8] See a discussion on the influence of contingency fee abuse by Lerm "Medical Malpractice Litigation: Do We Need A Paradigm Shift in Our Approach to Handling Medical Negligence Disputes?" Obiter Vol. 38 2 2017

[9] Wasserman "Should you sue your doctor?" fin 24 (March 17 2011) http://www.fin24.com/Money/Money-Clinic/Should –you-sue-your-doctor-201103-17 (Accessed 2013/08/05.

[10] See the very instructive Medical Protective Society of South Africa's publication titled "Challenging The Cost Of Clinical Negligence: The Case For Reform" (Nov. 2015) MedicalProtection.Org; For foreign writings why the lack of communication between the health care practitioners and hospitals drive up litigation see Spiegel & Kavaler "Better Patient Communications Mean Lower Liability Exposure" Managed Care (August 1997) http://www.managedcaremag.com/archives/9708/9708.reducerisk.html (accessed2013/08/05); Gebhardt "From reducing litigation to improve patient care, communication is key" American Academy of Orthopaedic Surgeons (May 2011) http://www.aasos.org/news/aaosnow/may11/managing5.asp (accessed 2013/08/05).

3. **Intervention required**

Because our health care system in South Africa is under siege to such an extent that unless something drastically is done to rescue the situation so as to avoid a major catastrophe, it is suggested that legislative changes be brought about to curb the unbridled litigation process governing the present handling of medical negligence disputes.

Upstream, it is recommended that the following innovations be considered for implementation, namely: a peer review system, designed to accommodate a patient-centered complaints system as well as a health care practitioner-centered conduct approach.

The investigations and results could then be transposed into case studies and used for collaborative learning for medical practitioners in CPD education and training programs and for lawyers in their continuous legal training, provided the principle of anonymity of the identity of those who feature in the case studies, is observed.

Downstream, it is further recommended that legislation be enacted for mandatory mediation to be introduced as a first attempt towards resolving medical malpractice disputes.

Besides the primary recommendations set out hereinbefore, what follows is a discourse on other burning issues that beset both the South African public and private health care sectors. Besides identifying the challenges facing the sectors, the discourse also includes finding solutions to those challenges with accompanying recommendations.

Consequently, the issues contained in sections A-F of the Law Reform Commission's Issue Paper sought to be answered regarding medico-legal negligence and related issues, shall be addressed. With section A having been addressed supra, what remains is to address sections B-F below.

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[11] See Lerm Obiter fn. 6 page 325.

B. CONCERNS ABOUT THE CURRENT SYSTEM

1. Although our common law system has been operative for a few centuries, with the introduction of our *Constitution*, all laws and any conduct are subject to constitutional scrutiny.[12] The *Constitution* also guides the legislature when formulating legislation, and so are the courts when reviewing the aim and purpose of legislation. In this regard Section 39(2) of the *Constitution* (known as the interpretation provision) is instructive.[13] It is thus clear that Section 39(2) enables the development of the common law. And so, our courts have made great strides in developing the rules of customary law in an endeavor to bring especially, the customary law of succession and administration of estates in line with the general laws governing estates in South Africa,[14] just to mention the profound influence of the *Constitution* in one area of law. From experiences after the Constitution came into being, a compelling argument can therefore, be made out that the common law is not necessarily the best system. But then, you cannot throw overboard a system that has made its presence felt over so many centuries and of which, many principles still hold sway. What is required is a mixture of the present common law and the introduction of some legislative

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[12] Section 2 of the Constitution provides: "*This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid and the obligations by it must be fulfilled.*"

[13] Section(2) of the Constitution provides: "*When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.*"

[14] See Zondi v President of the Republic of South Africa 2000(2) SA 49 (N) on the right of illegitimate children to inherit; see also Bhe v Magistrate, Khayelitsha (Commission for Gender Equality as Amicus Curia), Shibe v Sithole; SA Human Rights Commissioner v President of RSA 2005 (1) SA 580 (CC) on the inconsistency of the intestate succession rules on black intestate succession and the effect of sections 9 and 10 of the Constitution on the system.

changes and rules of practice in conformity with the constitutional values, to regulate medico-legal aspects concerning the following:

- ✓ Introducing a better risk management system that enhances professional competence, client satisfaction and avoids taking on too much work;
- ✓ More effective and open communication, including explanations about what could have gone wrong with treatment or surgery and where indicated, tendering an apology;
- ✓ Mediation as a first step towards resolving a dispute;
- ✓ Introducing a practice of certification or certificate of merit issued prior to the institution of litigation and prior to defending the action;
- ✓ Introducing a peer review program;
- ✓ Adapting or amending the Rules of Court to secure more effective pre-trial conferences and trial management proceedings;
- ✓ Introducing Specialist courts in South Africa to deal exclusively with medical malpractice disputes where an attempt to mediate fails.[15]
- ✓ Develop the common law where in medico-legal matters it is indicated.

2. See the above reply in respect of the development of the common law.

3. It is not necessarily so that the adversarial system is the best option for dealing with medical negligence disputes for the adversarial system has the following drawbacks namely, it is:

- ○ too formalistic;
- ○ too time consuming, where rules of evidence govern the process;
- ○ there is very little prospect of an early settlement;
- ○ Open communication between litigants is discouraged;
- ○ The system lends itself to the exploitation of the legal practice to increase legal fees;
- ○ The atmosphere in court is very daunting for the litigants, witnesses, including expert witnesses;

[15] For a discussion on the creation of Specialist courts in medical malpractice litigation see Lerm Obiter op cit. 332.

- Judges generally do not get actively involved in the legal process for fear of being accused of being biased;
- There is always a winner and a loser whereas the ideal would be win-win situations;
- Adverse publicity can ruin a successful professional career, even in cases where for example, the claim is completely unmeritorious;
- Not all adverse outcomes constitute negligence, justifying the institution of a claim;
- Most claims are settled at the doors of court, after the parties had suffered much trauma, and incurred substantial legal costs;
- Often the root of the complaint is never disclosed in the proceedings as technical interlocutory points are taken, resulting in applications for postponements, exceptions, pleas in bar etc.;
- Many claims are instituted long after the event that gave rise to the alleged damages, which seriously hamper the proper investigation and ventilation of all relevant facts;
- The presiding officers in courts are judges and magistrates who are not necessarily *au fait* with intricate medical procedures and complications, sometimes resulting in unjust decisions;
- Litigation seldom, if ever, results in reconciliation of the opposing parties; But, there are also critics who believe that the adversarial system can and should be refined and streamlined through the introduction of an efficient and effective case flow management system, aimed at bringing about a fair system of adjudication. What is also recommended is the appointment of expert medical assessors in complex matters.[16] Here the Rules of Court need to be adapted to provide for their appointment and payment of a reasonable stipend. Should that not be possible, the presiding judge could make use of the inherent power bestowed in our Higher courts in terms of Section 173 of Constitution.[17]

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[16] See Lerm "Two Heads Are Better Than One – Assessors in High Court Civil Cases" De Rebus (October 2012) 22-24.; See also Lerm Obiter op cit. 333.

[17] Section 173 provides: The Constitutional Court, Supreme Court of Appeal and High Courts have the inherent power to protect and regulate their own process, and to develop the common law, taking into account the

4. The inquisitorial system in civil cases is the common procedural approach in the civil law system or continental system. It aims to attain justice through a judge being actively involved in the preparation and the gathering of evidence necessary to resolve the dispute. The judge also questions the witnesses in pursuit of the truth. The legal representatives play a less active role. In the adversarial system that we are accustomed to, a premium is placed on the rights of the litigants, with the judge playing a less active role in adjudicating the dispute between the parties before the court.[18] It is recommended that some inquisitorial flavor could be beneficial towards reaching a sound result in preference to the accusatorial or adversarial system that is less focused on achieving fair and just results. Here, the Judge could play a more active role in achieving a just result. At the same time, it is suggested that a way be found, to relax the rules of evidence in the quest to attain justice.[19] The answer contained hereinbefore must be read in conjunction with the answer provided in 3 above. An area that is in need of urgent investigation is the role of expert witnesses in medical negligence cases. It is nothing uncommon that a bevy of experts are called by both sides, most of the time at huge expense. The parties may even call two experts, for example, to give evidence concerning the same matter. What is called for and it is so recommended, that disputes be resolved efficiently, justly and at a

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interests of justice."

[18] Asfords "Differences between an Adversarial and an Inquisitorial Legal System" (Oct. 2015) http://www.ashfords.co.uk/article/differences-between-an-adverarial-and-an-inquisitorial-.... (accessed 2016/6/12

[19] See Murphy *Practical Guide to Evidence* mentioned in Wikipedia "Adversarial system" (Oct. 2016) https://en.wikipedia.org/wiki/Adverarial_system (accessed 2016/06/12 where a barrister, recounting a frustrated Judge in an English (adversarial) court relays the following; the Judge asked counsel after a witness had produced conflicting accounts, "*Am I never to hear the truth*?" "*No, my lord, merely the evidence*", replied counsel; See also the English Civil Procedure Rules ("CPR" which came into force in 1999. Judges adjudicating in civil trials, have wide case management powers which are used to ensure that disputes are resolved efficiently, justly and at a proportionate cost. Here, the Court may even exclude superfluous evidence, managing the parties' costs, using strict timetables to manage both pretrial and trial proceedings under the threat of sanction should legal teams transgress.

proportionate cost through the appointment of joint experts for both parties, sourced from a pool of accredited experts who belong to a recognized medico-legal organization. It is further suggested that the Rules of Court or Rules of Practice, whichever is applicable, absorb the recommendation.

5. With medical malpractice litigation spiraling out of control, draining budgets that could be used more wisely, it is recommended that alternative measures are found to deal with medical negligence claims other than through the courts. Although alternative dispute resolution systems have been used widely in areas, including labour law matters [20], family law related disputes [21] and other matters [22], just to mention a few, the health care profession has been slow to change the way disputes are handled. But the dramatic rise in medical negligence litigation has sparked an interest in how best ADR can be applied to medical negligence disputes.[23] Arbitration is a more formal and binding form of ADR. Lawyers in the arbitration process also argue the case before an arbiter who then makes a decision, giving reasons for his or her decision. The decision then becomes binding on the parties. Mediation on the other hand, is less formal and no evidence is led. All the mediator does is to assist the parties towards a settlement. It is the parties to the mediation who, through their own voluntary efforts, reach a settlement. The mediator, unlike an arbiter makes no decision. The mediation process is also much shorter and less costly than arbitration or litigation. The informal atmosphere induces an environment where the parties can work out more creative remedies *inter alia* the implementation of future safety protocols, undertaking to undergo a training course or be subjected to mentorship and coaching or the expression of sympathy/apology.[24] Because

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[20] The Commission for Conciliation Mediation and Arbitration (the CCMA) is a dispute resolution body established In terms of the Labour Relations Act, number 66 of 1995.

[21] Brownlee v Brownlee (Unreported judgment on 25 August 2009 per Brassey AJ South Gauteng High Court)

[22] Chief Lesapho v North West Agricultural Bank 2000(1) SA 409 (CC).

[23] For a very instructive article on the advantages of mediation in medical malpractice disputes see Claassen "Mediation as an alternative solution to medical malpractice claims" *The South African Journal Of Bioethics & Law* Vol. 9, No 1 (2016)

[24] Sohn & Sonny "Medical Malpractice Reform: The Role of Alternative Dispute Resolution" (May 2012) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3314770/ (accessed 2013/11/11); For a discussion on the need for the introduction of an alternative dispute resolution system in medical malpractice cases see Szmania,

medical negligence disputes involve professional and personal challenges, with accompanying stress and emotional upheavals for both the patient and health care practitioner, the mediation process is the preferred alternative dispute resolution option. It is under the circumstances superior to the arbitration process or negotiations before a referee.

6. South African law is a 'mixed legal system', an amalgam of different legal systems, with their origins from the foundations in Roman-Dutch law and English law. South African law in the main, comprises 'common law' and statutory law ~~as~~ interpreted and applied by judicial precedent.[25] Since the inception of the *Constitution,* our common law as seen earlier, has also been subjected to constitutional scrutiny and so, developed. The South African statutory law, as with our common law, has been augmented by the influence of our *Constitution.* Besides the common law and statutory law, our community is also influenced by customary law provisions, provided they are consonant with the *Constitution.* The South African Constitution has also introduced the constitutional imperative that courts, tribunals or forae when interpreting the Bill of Rights in the *Constitution*, may have regard to comparative law.[26] Given the unique heritage of South African law and the influence of our Constitution, our system of law is sound and needs no overhaul. What is needed is the continuation of our mixed system. A total reform is therefore, not ideal. An area that needs possible exploration is provincial legislation. It may be worthy to investigate whether innovative legal processes aimed at transforming the medico-legal sphere in especially the provincial health care sector should not be incorporated in provincial legislation[27],

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Johnson, Mulligan "Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices" *Conflict Resolution Quarterly*, vol. 26, no.1, 2008.

[25] Department of Justice &Constitutional Development SCA History (May 2015) http://www.justice.gov.za/historysca.htm (accessed 2016/01/12).

[26] See Section 39(1) which provides that: "*When interpreting the Bill of Rights, a court, tribunal or forum*

(a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;

(b) must consider international law; and

(c) may consider foreign law."

[27] See Chapter 6, Section 104 of the Constitution that grants legislative authority to provincial legislatures to pass

provided of course they do not conflict with the *Constitution* or parliamentary legislation. Areas of public interests that may receive the attention of the provincial legislature include but are not restricted to *inter alia* the inclusion of pre-mediation clauses in the admission forms of public hospitals; the implementation of immunity to protect health care providers who wish to provide explanations or even tender apologies after medical mishaps had occurred [28]; declaring case flow management meetings as well as peer review meetings and processes to be privileged from disclosure; promoting periodic payments as a settlement option; incorporating indemnity certificates for future medical care into settlement agreements; promoting an effective patient-centered complaints systems.

7. The answer to this question must be read in conjunction to the answer provided to question 6 herein before and amplified by what follows hereunder. The use of International law and foreign law is specifically sanctioned by the Constitution.[29] Although the Constitution imposes a duty on our courts to consider International law by virtue of the International conventions and treaties South Africa is party to,[30] the consideration of foreign law is also permissive but is not peremptory.[31] The use of foreign law our courts have warned, should be done with a certain amount of caution and circumspection. The correct approach was described as follows by Kentridge AJ in the Constitutional Court judgment of *Du Plessis v De Klerk and Another* [32] when relying on the Canadian dictum in R v Saliture (1992) 8 CRR 2d 173 "*Judges can and should adapt the common law to reflect the changing social, moral and economic fabric of the country. Judges should not be quick to perpetuate rules whose social foundations have long since disappeared. Nonetheless there are significant constraints on the power of the judiciary to*

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legislation in respect of any matter of public interests.

[28] See the suggestions by Lerm Obiter page 336 regarding the introduction of legislative protection to the health care provider after tendering an apology and undertaking to take corrective action. See also the discussion on legislative steps taken in the United States of America and Australia in regulating the immunity process against those health care providers who give explanations and tender apologies after medical mishaps.

[29] See Section 39(1) of the Constitution.

[30] See Section 39(1)(b) where the word 'must' is used.

[31] See Section 39(1) (c) where the word 'may' is used.

[32] 1996 (3) SA 850 (CC); 1996 (5) BCLR 658.

change the law. In a constitutional democracy such as ours it is our legislature and not the courts, which have the major responsibility for law reform. The judiciary should confine to show incremental changes which are necessary to keep the common law in step with the dynamic and evolving fabric of our society." Kriegler J in Bernstein v Bester [33] with whom Didcott J concurred, rendered the following cautionary remarks on the use of foreign law to develop the law in South Africa. *"…I however, wish to discourage the frequent and, I suspect, often facile resort to foreign 'authorities'. Far too often one sees citation by counsel of, for instance, an American judgment in support of a proposition. The prescripts of section 35(1) of the (Interim) Constitution are also clear: where applicable, public international law in the field of human rights must be considered, and regard may be had to comparable foreign case law. But that is a far cry from blithe adoption of alien concepts or inapposite precedents."* There are however, a host of South African cases where foreign law was received to develop our law.[34] It is suggested therefore that any application of foreign law to the South African legal landscape must, properly account for South African realities, especially the prevailing socio-economic and social security. [35]

8. The inherent 'once and for all' rule prevents a multiplicity of actions, based on a single cause of action and ends potential future litigation. But, is this method fair and reasonable, given the fact that the quantum is determined through a lot of guess-work if not much speculation? What may be a better system, is to replace the 'once and for all' rule with a system of periodic payments as opposed to a single amount at judgment stage. (See the recent Constitutional Court judgment

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[33] 1996 4 BCLR 449 (CC), 1996 (2) SA (CC) PAR {133}.

[34] See the seminal cases of S v Makwanyane 1995 (3) SA 391 (CC) para {9} (abolition of the death penalty); Soobramoney v Minister of Health, Kwazulu-Natal 1997 (12) BCLR 1606 (CC) (duty to provide access to Healthcare); Carmichell v Minister of Safety and Security and Another (Centre for Applied Legal Studies Intervening) 2001 (4) SA 938 (CC) at 952-953, 2001 (10) BCLR 955 (CC) (development of the common law concerning delictual liability by extending the general duty of care in accordance with the spirit, purport and objects of the Bill of Rights); more recently in the *Minister of Justice and Correctional Services and Others v Estate Stransham-Ford* (531/2015) 2016 ZASCA 197 (6 December 2016) paras {58} to {61} (the legitimacy or not of the practice of euthanasia).

[35] See Claassen's previous submission to the South African Legal Reform Commission.

of MEC, Health and Social Development, Gauteng v DZ [2017] ZA CC 37 Delivered 31 October 2017). Although the Court did not decide the issue for want that the issue was not pleaded and determined by the trial court, it does however, appear that the indications are omni-present that the Constitutional Court will ultimately veer in the direction of recognizing periodic payments. It also appears that the court concludes that compensation in a form other than money was not incompatible with the basis of awarding delictual damages. It is recommended that the once and for all rule should be relaxed in relation to specific cases (e.g. cerebral palsy) where such relaxation is warranted.

9. The doctrine of avoidable consequences also known as mitigating damages is well known in the South African law. It is a rule whereby a Plaintiff is required to take all reasonable steps to mitigate the loss caused to the plaintiff by the defendant's wrongful act. Here the plaintiff cannot recover damages for losses which he or she could have avoided by taking steps that are reasonable in the circumstances of the case. Where the plaintiff fails to reduce his losses, the defendant is liable for his side less the damages caused by plaintiff himself or herself.[36] It is suggested that this principle be retained. From a medico-legal perspective, the doctrine can be of use to prevent hospitals being held liable for patients who refuse medication or fail to attend at scheduled examinations. The mitigation of damages doctrine does also have a place in regulating the conduct of lawyers engaged in doing medico-legal work. It is recommended further that specific provision for such a duty in the code of conduct of legal practitioners under the new Practice Act [37] be created. Any legal practitioner who advises a client not to undergo any medical treatment for the purpose of increasing the quantum of damages, should be subject to sanction.

[36] See Joubert The Law of South Africa 2 Ed vol. 7 2005.
[37] See the Legal Practice Act No. 28 of 2014.

10. Prescription as a legal concept is a means of acquiring or losing rights, or freeing oneself from obligations, by the passage of time under conditions prescribed by law.[38] The effect of prescription on litigation amounts to this: if a claim is not instituted within the time limitation set by the *Prescription Act,* the claimant loses that right to claim damages. Section 34 of the *Constitution* however, grants everyone a right to access the courts as long as there is a right to approach a court of competent jurisdiction.[39] *The Constitution* itself does not provide any hard and fast rule whereby that right, can be tested for as long as the limitation, raised by a party, is still compatible with Section 34 of the *Constitution*. The courts have at times interfered where a time restriction placed on legal proceedings has been too short.[40] Generally, the current prescription periods currently applied in the field of medical malpractice legislation in South Africa, especially with regard to adults who have the required locus standi, appear to be fair and just.[41] An area of concern includes minors who become victims of medical malpractice mishaps, but the true impact of the injuries would not be known until he or she is 20 years of age. As the claim in terms of the Prescription Act prescribes within a year after the injured party attains the age of majority [42] this could cause a serious dilemma

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[38] See the definition used by the South African Law Reform Commission Discussion Paper 126 Project 125 Prescription Periods July 2011.

[39] Dormehl v Minister of Justice 2000 (2) SA 987 (CC) para {4}.

[40] See Mohlomi v Minister of Defence 1997 (1) SA 124 (CC) 129 (section 113(1) of the Defence Act of 44 of 1957 Infringes on the right to have access to the court.) But see Barkhuizen v Napier 2007 (5) SA 323 (CC) (the court found that a time –bar clause of 90 days to institute action after the repudiation of an insurance claim, did not offend public policy.

[41] The prescriptive period by when claims for compensation in respect of general damages for bodily injuries and special damages, including hospital expenses, medical expenses, loss of earnings, past and future, both in respect of delictual or contractual or any other liability is to be instituted is governed by the Prescription Act 68 of 1969. Section 11 (d) of the Act provides for a period of three years from when the debt (claim) arises. But, note in terms of section 13 of the Prescription Act, prescription is delayed in instances where *inter alia* a minor is involved, until the minor attains the age of majority which is eighteen years of age and a year thereafter lapses in which the legal proceedings should have started by the issue of a summons. For case law see Truter and Another v Deysel 2006 (4) SA 168 SCA. In this case the court held that prescription starts running in cases involving adults from the time the claimant gains knowledge of the facts and not when expert opinion is first obtained. Knowledge in this regard is tested subjectively, taking into consideration the claimant's physical and mental condition, the pain he or she was suffering, his or her memory function and the environment in which he or she found himself or herself. See Brand v Williams 1988 (3) SA 908 (C).

[42] See Malcolm v Premier, Western Cape (207/2013) {2014} ZASCA 9 (14 March 2014). In this case the court after considering the term 'minor' in section 13(1)(a) of the Prescription Act in relation to the changed age of majority from 21 years to 18 as provided for in terms of the Children's Act 38 of 2005, considered the special protection afforded minors under the age of 18 (section 28(1)(g)(i) in conjunction with international trends where the age

in that the defence of prescription will be invoked. What now? The Prescription Act does not provide for condonation for the late filing of a claim. Generally, it appears that our courts have no inherent power to condone a failure to comply with limitations placed on claimants in terms of the law. Non-compliance with the Prescription Act has the effect that the claim is extinguished notwithstanding the fact that the claim may be meritorious in nature. The Institution of Legal Proceedings against Certain Organs of State Act 40 of 2002, among others, provides for a notice period, namely six months that needs to be given to the State department involved, of the intended action before legal proceedings are instituted. Where no notice is given in time, no legal proceedings may be instituted against the organ of state, unless consented to by the organ of state.[43] But, the Act provides for an application for condonation provided certain "jurisdictional facts" are present before a court may grant an order for condonation. [44] What must be shown to the court's satisfaction include inter alia that there is a cause of action; a good cause exists why notice was not timeously given; there is no prejudice to the organ of state.[45] Consequently, SAMLA after giving consideration to prescription in South Africa in relation to damages claims, including medical malpractice claims, support the Law Reform Commission Paper 126 in the following recommendations, which will bring about greater fairness:

(i)That the prescription period set out in section 11(d) of the Prescription Act 68 of 1969 be extended from three to five years from the period the creditor has knowledge of the debt or could have taken necessary steps to acquire such knowledge.[46]

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of majority has also being lowered from 21 to 18, and concluded that a fair interpretation allows the law to develop to the effect that claims in respect of minors prescribe one year after they attain the age of majority.

[43] See Section 3(1) of Act 40 of 2002.
[44] See Section 3(4) (a) of Act 40 of 2002.
[45] See Section 3(4) of Act 40 of 2002.
[46] See the options for reform identified by the South African Law Reform Commission Discussion Paper 126 Project 125 July 2011.

(ii)That the prescription period set out in section 13(1) (a) and (i) of the Prescription Act 68 of 1969 involving minors, be extended to two years from the period the minor reaches the age of 18 and has knowledge of the debt or could have taken necessary steps to acquire such knowledge.

Despite the dawn of our democracy in 1994, South Africa still remains a country where inequality is the order of the day. Poverty, illiteracy, language barriers and other socio-economic circumstances present many challenges. One of those is that a large percentage of of our people are still very poorly informed about their legal rights. In many instances, legal assistance escape them. That, may impact heavily on their children's rights. Because their parents are ignorant about rights issues, including legal rights, there may be many minors who are injured in personal injury incidents, who never get to claim compensation for the hurt they suffered. Or, there are those, when they do find out that they do have a remedy, it may be too late as any potential claims that they might have had, may have become prescribed. By extending the period from 1 year to 2 or even 3 years, will allow those who may have missed out on bringing action but for their parents ignorance, to successfully pursue their legal remedies, themselves.

(iii)That the notice requirement of the intention to institute legal proceedings against organs of state before issuing of summons be abolished. [47]

(iv)That courts should be granted the power to condone, on good cause shown, the late institution of a claim, where the claim has prescribed in terms of section 11(d) of the Prescription Act. It is suggested that the legislature identifies the factors caused to be relied on when such an application is made.[48]

(v)That regulations be passed to secure the preservation of records for all cases of adverse incidents.

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[47] This is an option identified by the South African Law Reform Commission ibid

[48] See the recommendations of the South African Law Reform Commission Discussion Paper 126 Project July 2011 iv-v.

11. The Contingency Fees Act 66 of 1997 provides for agreements to be entered into between a legal practitioner and his or her client wherein the lawyer agrees to charge the client no fee if the litigation is unsuccessful. Where however, the claim is successfully prosecuted, the agreement provides for the lawyer to recover a fee from the client in excess of his or her normal fee. [49] The percentage of fees recovered should generally not exceed 25% of the total amount awarded, excluding costs.[50] Contingency fee arrangements are crucial to providing access to justice for large numbers of the South African population that can ill afford to pay their lawyers and need some kind of assistance. But, the application of fee arrangements have left many traces of concern in that the process has been exploited so that some horrific narratives have emerged. [51] So great are the concerns from so many quarters that it has been mooted that ways must be found to curb the abuse by unscrupulous lawyers, just as clinical negligence litigation is exploited by some legal practitioners. (Something is missing in this last sentence). It is however, uncertain whether this requires legislative intervention, or merely more proactive oversight and sanction. The Contingency Fees Act *per se*, does not pose a problem. The abuse of the Act seems to be the big problem. The State has also become vulnerable to contingency fee claims, particularly where certain claims warrant resistance but the defence put up by the lawyers and experts witnesses appointed, appear to be inadequate. Although it may create an additional administrative burden to the courts, it is suggested that the courts should play a greater oversight role, post the litigation stage. A process has already been introduced in some of the High Courts in the Eastern Cape division where cases are recalled months after finalization in an endeavor to investigate what fees were appropriated by the lawyers. It also appears that the current percentage of 25% is on the high side and calls for a reduction to a percentage of say, 12.5%.

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[49] See Druker The Law of contingency fees in South Africa

[50] See section 2(2) of the Contingency Fees Act of 1997.

[51] See the most recent judgment of Plasket J in Mfengwana v Road Accident Fund 2017 (5) SA 445 (ECG) paras [12], [19], [27] – [29] in which the Judge decried the 'a manifestation of possibly endemic corruption embedded in the attorneys' profession', calling on the Law Societies as custodians of ethical standards of the profession and in public interest, to find ways to stop this rot.

C EXISTING MEASURES OR SHORT TERM SOLUTIONS

Save where otherwise indicated, the comments that will follow in response to the statements contained in this section, will be responded to in very brief form.

6.4.1 The keeping and preservation of proper records, including electronic records, making copies of records and making back-ups will assist in:

- Improving the risk management system;
- Adhering to ethics and ethical codes;
- It will make litigation more reliable;
- It serves to comply with the Health Professions Council of South Africa regulations. In addition, it also serves to comply with legislation, including the Access to Information Act of 2002 and the Consumer Protection Act, 68 of 2008.

6.4.2 Improving communication is critical for the practice of medicine not only to obtain accurate patient histories, determining the correct diagnosis and explaining treatment plans for the patient, but it can also keep the health care practitioner out of the court if he or she can tender an early explanation of what went wrong. Communication also assists with effective decision-making where potential risks are present. The advantages of proper communication will result in:

- Improving the patient/doctor relationship;
- Compliance with the basic consumer right that the public should enjoy;
- Managing more effectively, client's expectation;
- Ensuring effective informed consent is reached;
- Improving the risk management system.

6.4.3 Yes it is necessary to review current consent forms in that it is essential to comply with the plain language requirement as provided for by Section 49 of the Consumer Protection Act. The content and style of consent forms in

general are not reader friendly in their current form. It is recommended that consent forms should be available in all languages spoken in any particular area and if the patient is a foreigner, an appropriate interpreter should be obtained, where feasible.

6.4.4 The implementation of a consistent, efficient and patient-centered complaints process needs to be supported for it would form part of the future risk management system. [52] It will also assist to educate potential plaintiffs that no proper grounds for a civil claim exists, especially when an exculpatory explanation is given as to what caused the adverse outcome. The introduction of a patient-centered complaints process will also be covered in the section dealing with Proposals for Legislation.

6.4.5 The investigation of adverse events without delay needs to be supported, for it brings about certainty and confidence in our health care system. It is a very essential component of the future risk management system.

6.4.6 Peer review in a medico-legal set-up is the process by which a committee of health care practitioners, including doctors, physicians or nurses, examines the work of a peer and determines whether the conduct of the peer under review fell below the standard of care when rendering the medical services. The peer review process could serve as a useful tool where a complaint has been lodged by a patient, a peer or the medical protection society or insurer.[53] Some of the advantages of the peer review process include:

- Where negligence is established, an offer of settlement can follow;
- If no negligence can be established, the matter can be put behind them (vindication) and the party under investigation can get on with his or her life with or without an appropriate apology;

[52] See the MPS Paper referred to in fn. 10.

[53] See the American Medical Association "Medical Peer Review" AMA discussed by Wikipedia https://en.wikipedia.org/wiki/Clinical_peer_review (accessed 2017/12/21); Lerm Obiter 330-331.

- The process serves as learning curve to the practitioner whose conduct is assessed;
- Corrective action can be taken.

6.4.7 Protocols, standard operating procedures and check lists are important measures for they are usually a set of detailed instructions that define and standardize procedures, with check lists serving as a measurement tool to determine if standards have been met. They may all form part of the nucleus in a broader quality risk management system, aimed at improving health standards and minimizing risks.

6.4.8 Accountability in a medical set-up is essential. Holding staff accountable if protocols, standard operating procedures and check lists are not complied with or updated are as essential as creating them. Since the ancient times, certain duties and responsibilities have been cast upon those who enter the noble profession of medicine. Those who work within the health care sectors, both in the public as well as the private sector, are ethically obliged to practice medicine not only to adhere to professional standards, but also to act with honesty and in good faith. One way of demonstrating that, is to take responsibility for one's own actions. Where therefore, a health care practitioner makes a mistake, he or she should be encouraged to own up and help to resolve the issue instead of concealing the mistake.[54] The advantages to accountability include:

- It accords with taking responsibility;
- It reduces the risk of future mistakes;
- It encourages values of good practice;
- Accountability also involves measures of censure to prevent re-occurrences.

[54] See the Free Dictionary by Farlex who defines accountability as "responsibility for one's own actions; this is a principle of professional practice that is obligatory for health care providers" https://medical-dictionary.thefreedictionary.com/accountability (accessed 2017/12/21). See the HPCSA Guidelines under the heading: 5.1 Disclosures Which Benefit Patients Indirectly.

- It accords with Kant's famous invocation: "*Do your duty, even if heavens fall ill*".

6.4.9 It is essential to keep a healthy staff/patient ratio so as it minimizes the risk of mistakes being made by an overburdened few, having to carry the work load. Being short staffed, and the failure to fill vacancies, do add to the risk of medical malpractice mistakes being made, followed by an increase in litigation and other challenges that beset the health care industry.

6.4.10 Adequate supervision of junior staff is essential and prudent as it ensures that junior staff develop their skills under the watchful eyes of the senior practitioners. Appropriate supervision of junior staff especially doctors, aims to develop competent junior doctors who are skilled at communicating and working as effective members of a team. As training and education are central to the development of junior staff, effective supervision introduces an element of mentorship and coaching which enhance their role in delivering patient care. Educational supervision will also boost the confidence of the junior staff. At the same time, supervision will help to develop qualified competent doctors and so reduces the risk of mistakes being made.

6.4.11 The genesis of improving the quality of health care services in both public as well as private health care sectors, involve patient safety and the setting of quality health assurance standards against which health care practitioners' conduct are measured and judged. Improved quality of health services have many advantages, *inter alia* it improves patient and staff satisfaction, enhances the efficiency and effectiveness of health services in the said sectors and instills trust in the health system.[55] A compelling argument can also be made out that an improved health care system will reduce litigation and so minimize the risk of non-compliance with an effective risk management system.

[55] See Whittaker Shaw Spieker and Linegar "Quality Standards For Healthcare Establishments In South Africa" SAHR 2011 59, 60.

6.4.12 Taking disciplinary action in terms of transgressions such as theft of files or information or violating a patient's right to privacy, needs to be supported for such conduct violates ethical standards and existing legislation.[56] It may also impact adversely subsequent civil trials where hospital or medical records may present important evidence for the court to reach a just decision. But, it is suggested that the labour laws will have to be amended to streamline disciplinary processes.

6.4.13. Health records as a source document, is described by the eminent writers Van Den Heever & Lawrenson[57] as 'the lifeblood of the case'. That signifies that disappearance of health records has frequently become a serious problem in South Africa so much so that the courts have frequently expressed their concern at 'it not serving the interests of justice', often drawing 'adverse inferences' where parties were unable to furnish reasonable explanations for not being able to produce the records.[58] In the light thereof the recommendation to prosecute the transgressors who willfully or negligently make records disappear, needs to be endorsed for it will be fair towards the litigants and the general administration of justice. These transgressors include hospital staff who unlawfully sell or distribute medical records to attorneys or their touts; attorneys found in possession of the originals of medical records; and hospital staff who destroy or hide or unlawfully amend medical records.

6.4.14 It is suggested that litigation costs and compensation should not be paid from the operational budgets of hospitals Such payments run counter to public interests as such practice impacts adversely on medical care. Funds allocated for resources are intended to be spent on the acquisition of new or the maintenance of obsolete or broken equipment. A compelling argument

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[56] See the "National Health Act 61 of 2003", sections 13,14 and 17.

[57] *Expert Evidence in Clinical Negligence A Practitioner's Guide* (2015) 3.

[58] See Khoza v MEC for Health and Social Development 2015 (3) SA 266 (GJ); Ntsele v MEC for Health, Gauteng Provincial Government [2013] 2 ALL SA 356 (GSJ); Goliath v Member of the Executive Council for Health, Eastern Cape 2015 (2) SA 97 (SCA).

can be made out to rather use that money to replace obsolete equipment to improve health care, instead of funding legal costs. [59]

6.4.15 This is an area of great concern in that the offices of the State Attorney seems to be in a state of disarray and is not functioning efficiently. Perhaps, this can be ascribed to the number of cases their offices are carrying. It is suggested that their system needs to be overhauled, proper systems be put in place and their staff compliment be increased by the appointment of lawyers experienced in the conduct of medico-legal cases where warranted. A further suggestion to be considered is for the State Attorneys' offices to embrace mandatory mediation to reduce the volume of cases they carry.

6.4.16 The appointment of specialized and suitably qualified legal staff with experience in medico-legal litigation in the provincial departments of health to specifically deal with this type of work needs to be supported. Although there already exists such legal departments in certain provincial health departments, they still function ineffectively. It is a question of competence. The idea of appointing suitably qualified skilled personnel who specialize in this field is a noble idea for it fits in with the demands of this century to appoint the right people to deal with specialized work. The educational and experience levels of employees by quantifying their quality and skill should serve as a barometer for recruiting staff. What is also called for is for a so-called Medico-Legal Unit, headed by a suitable person, possessed with leadership skills, managerial talent and specialized knowledge. The traditional bureaucratic style of operating should form no part in establishing these specialized units. Instead, what is needed is to establish Units that specialize in this type of work, with cross-functional teams feeding into them. The latter teams could serve special functions in research and development; compiling case reports data base; training and continuous education. The latter may even champion partnership with the medical schools at university and law

[59] Lerm Obiter 325

schools for the future benefit of society. While SAMLA embraces affirmative action to correct the wrongs of the past, it is however, submitted that where appointments to the proposed Units are made, suitability of candidates should be paramount irrespective of their disadvantaged backgrounds. Opportunities should be created for integrating those who show potential to pursue a career in this field of expertise.

6.4.17 The development of a standardized modus operandi for dealing with medico-legal claims in the legal divisions of the provincial departments of health and various offices of the state attorney needs to be welcomed and supported. Developing standardized systems to deal with medico-legal cases have the following distinct advantages:

- It sets uniform standards on how to deal with medical malpractice claims from the investigative stage to the litigation stage, including preparation for trial;

- It sets a uniform standard with respect to assessing the legal outcomes of medical negligence disputes, including criteria that will determine when to settle matters, alternatively when to litigate;

- Protocols may also be designed regarding a complaints system, aided by peer reviews, the practice of certification of merit and mediation, designed to efficiently handle medical malpractice cases;

- Developing uniform medico-legal policies and practices, designed for the legal staff and support staff to deal with this type of work;

- Design uniform training and developmental courses to accommodate the needs of staff for them to deliver efficient and effective services.

6.4.18 The use of the so-called 'in-house medical experts' is a very broad and ambiguous term. It is not understood who would qualify to be included in the pool of experts? The term 'in-house' in the context of expert witnesses, somewhat awake some concern of bias since objectivity, a hallmark of being an expert, may be compromised. Instead, what is suggested is a pool of independent expert witnesses, accredited to an organization from where those experts may be sourced for the purpose indicated. But, it must be acknowledged that setting-up such accredited organizations, do have potential pitfalls in that the accreditation of experts may be abused, if left to be unchecked. It is suggested that those organizations tasked with accreditation, need to be regulated and pass the high-standard muster.

6.4.19 Although the practice of appointing joint expert witnesses is still very much an alien concept in South Africa, with the escalation of legal costs and the depletion of budgets, especially in the public health sector, it is a practice worth investigation in South Africa. Single joint experts may be appointed either through being court-appointed[60], alternatively by both sets of lawyers. [61] The use of joint expert witnesses may be optimally used in complex cases involving issues such as quantum. [62] It is suggested that this practice is worthy of investigated, provided the experts are accredited as afore stated bearing in mind the potential pitfalls that the abuses of inappropriate "accreditation" of experts brings. But, it has the potential to eliminate the duplication of evidence and of securing a saving of costs.

6.4.20 The idea needs to be supported, provided a reliable and trustworthy accredited scheme of expert witnesses is created by the professional health professions associations. What is also recommended is that litigants and their legal representatives need to consider making use of accredited expert

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[60] See the Civil Procedure Rules in the United Kingdom.

[61] See Reynald, Malcolm "Role of expert witnesses in litigation and arbitration" (March 2011) Financier Worldwide https://www.financierworldwide.com/role-of-expert-witnesses-in-litigation-and-arbitration/#.Wkld2

[62] ibid

witnesses listed by the South African Medico-Legal Association on its website, representing expert witnesses from all disciplines and resident in all provinces.

6.4.21 Exercising proper case management is a very important step in the litigation process and calls to be supported. It is a process recognized by policy makers, including the Chief Justice [63] and the Judge Presidents. [64] Case management involving the judiciary and legal representatives of both parties to the litigation process is essential to curb the duration of trials and the saving of litigation costs. It aims to enhance the efficiency of the judicial system. Although in many provinces in our country, case flow management processes have been put in place, it is however, suggested that judges take up a firmer oversight role, with cost penalties as a measure to bring about compliance by lawyers taking part in the process. [65]

6.4.22 Collecting information and developing databases for information sharing is a very important step in the right direction. Databases are foundational to the collection, storage, accessibility and retrieval of healthcare information. Databases, besides its advantage in allowing the sharing of crucial healthcare information, have many other positive features. Another important advantage is the retention of hospital and other medical records crucial to litigation. The capture and retention of the said information will assist in minimizing the risk of records being mislaid or wrongfully obtained by lawyers, previously eluded to. It also enables those engaged in this type of work to rely on precedents, which in turn, create uniformity and stability.

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[63] See the Norms and Standards issued under the hand of the Chief Justice of the Republic of South Africa in terms of Section 8 of the Superior Court Act 10 of 2013 read with Section 165 (6) of the Constitution and published in the GG 37390 on 28 February 2014.

[64] See the Practice Notes of the various divisions of the High Courts in the Western Cape, North Gauteng and South Gauteng.

[65] See the MPS "Challenging The Cost Of Clinical Negligence: The Case For Reform 2015; Lerm Obiter 2017.

6.4.23 The idea of providing training to health care professionals needs to be endorsed. Offering expert medico-legal training to both health care professionals as well as those lawyers who engage in this type of work is key. Training, focused on the important medico-legal practice discipline, empowers those individuals who undergo the training, with sounder knowledge, from a practical angle, to provide a more effective and efficient service, both in the medical and legal landscapes. Such training will enhance the general administration of justice. Both court and mediation proceedings will benefit from their expertise. That in turn, will instill public confidence in such proceedings. SAMLA, as an organization, is committed to medico-legal education and the transfer of skills. That, it achieves through the roll out of seminars, mock trials, expert training symposiums and other educational facilitation, around the country. It is from this oasis of learning that health care professionals and lawyers should make use of for the betterment of their skills and reduction of their shortcomings and inadequacies. The training Faculty of SAMLA will commence an outstanding course in Medico-Legal Practice from 2018. Included in the curriculum are subjects such as the law applicable to personal injury litigation, ethical conduct in medico-legal practice, psychology and communications in medico-legal practice, logical reasoning, medical science applicable to medico-legal practice, and other sciences applicable to medico-legal practice. [66]

6.4.24 Providing training and assistance to state attorneys is equally essential to improving services to deal with medico-legal claims. The contents in the paragraph herein before (para 6.4.23), apply *mutatis mutandis* to the needs of the state attorneys. It is recommended that they too need to be encouraged to attend the training courses offered by SAMLA.

D AMENDMENT TO STATE LIABILITY ACT 20 OF 1957

[66] For details of the SAMLA Faculty course, see http://www.lawatwork.uct.ac.za/foundations-medico-legal-practice

The proposed amendment of the State Liability Act 20 of 1957 calls to be supported unless otherwise indicated. The following factors serve as motivating factors:

Ad paragraph 6.5:

The payouts of substantive amounts for awards as compensation and costs, have in the last 5-7 years, depleted the healthcare budgets in all the provinces in South Africa. This has caused devastating crises in both our public as well as private healthcare sectors, with medical malpractice litigation spiraling out of control. Large amounts are being spent from the public purse to fund cases. Payments are frequently made from funds, designated for medical equipment and other purposes. Faulty equipment that cannot be renewed or upgraded, often results in even further litigation arising from the use of such faulty equipment.[67]

If the situation is allowed to continue, it would have catastrophic consequences for our health care system in South Africa, for those who benefit from public health care. It also poses a real threat to the constitutional protection afforded in terms of the right to access health care services. Consequently, individual rights are also violated.[68]

The proposed amendment to the State Liability Act heralds in a shift towards a 'social democratic model' and follows a trend adopted in countries like Canada, the United Kingdom, New Zealand, Sweden, other Scandinavian countries, Australia, Germany, etc.[69] What the amendment seeks to achieve is to do away with a lump sum payment where damages are awarded to a litigant and replace this method of award, with a structured form of settlement, including settlements and awards in the form of periodic payments. [70]

Some of the advantages of lump sum payments over structured periodic payments include the following:

- It concludes the dispute between the parties with a degree of certainty;

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[67] Refer Lerm Obiter page 325.
[68] Refer Lerm Obiter page 341.
[69] See the South African Law Reform Commission's Issue Paper 33, Project 141; Medico-Legal Claims, 20 May 2017 reference to the countries where changes had been affected and the applicable legislation.
[70] See the proposed sections 1, 2A of the State Liability Amendment Bill.

- From a plaintiff's perspective, he or she has full control over the award given to him or her, and if the money is invested wisely, the awardee may amass a substantial amount, over time.

But the down side of lump sum awards may bring the following realization:

- The once and for all rule that governs lump sum payments, brings about uncertainty inherent in the calculation of lump sum payments, especially with regard to future patrimonial damages. Here reference can be made to future loss of earnings or future medical and/or hospital expenses. Factors that influence the uncertainly in the calculation of accurate amounts payable, include:
  - The life expectancy of the plaintiff or person in respect of whom the payment is affected;
  - The uncertainly of the costs of future medical care, corrective surgery and treatment, as well as, future loss of earnings;
  - It is especially those who are in need of long-term care or permanent incapacity that run the risk of being under compensated, where, a lump sum is awarded;
  - Where huge lump sum awards are given and the party sustaining damages, dies before the money received, are expended, the estate of the plaintiff could be unduly enriched to the detriment of the State, responsible for paying the awards. Similarly, if the patient outlives the estimated life expectancy, the lump sum award may prove to be inadequate resulting in "double dipping", i.e. the already compensated patient returns to the state institutions for free medical care.

The South African Medico-Legal Association recommends that a system of periodic payments be put in place as this will result in curbing over compensation or under compensation.

Ad paragraph 6.6:

The rationale for the strategic shift in the payment of compensation from the appropriate provincial department budget instead of the health establishment, i.e. public hospitals

needs, is welcomed. The operating costs of a hospital should be utilized for that purpose namely, the delivery of health services and not for litigation purposes that impact adversely on service delivery. [71]

Ad paragraph 6.7:

Save for the comments that follow in respect of the calculation of lump sum payments, no issue can really be taken with the considerations enumerated in subparagraphs 6.7.1 to 6.7.8, and cause to be supported.

The only issue that raises concern with regard to lump sum payments as general damages and the suggested maximum amount payable is this: what amount would be regarded as a reasonable 'maximum' amount and who determines that amount? That is an issue that calls for a full investigation. It is recommended that a task team be appointed comprising of a Judge, lawyers from both the Bar and Side-bar, as well as a panel of medical experts in the different fields of discipline as a means to tabulate a fair and reasonable amount of general damages.

It is also recommended that the Commission should have regard to the proposals of the Association for the Protection of Road Accident Victims (APRAV) with regard to lump sum payments of general damages and the method of calculation introduced by its Medical Committee. It is also suggested that cognizance be taken from the Judges' Bench Book on awards for general and other damages.[72] The Judges Bench Book used in the United Kingdom differentiates between and categorizes most forms of injuries and their sequelae, for purposes of awarding general damages. Consideration should be given to adopt a similar solution in South African, provided of course, the process be adapted to suit local conditions and circumstances. What can be deduced from the foregoing is that the South African Medico-Legal Association is not in favour of the capping of awards for general damages.

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[71] See Lerm Obiter 325.

[72] See the Courts And Tribunals Judiciary "Civil justice in England and Wales" https://www.judiciary.gov.uk/about-the-judiciary/the-justice-system/jurisdictions/civil-jurisdiction/ (accessed 2017/12/29), For a very instructive article on how the Bench Book is used in civil trials in Australia, with reference to Luntz Assessment of Damages for Personal Injury and Death 4th Ed Butterworths, Sydney, 2002, see "Civil Trials Bench Book – Damages" (Nov. 2015) https://www.judcom.nsw.gov.au/publications/benchbks/civil/damages.html (accessed 2017/12/29).

E PROPOSALS FOR LEGISLATION

Ad paragraphs 6.8 – 6.8.2:

The recommendations are supported and the reasons therefor, are set out in 6.6 above.

Ad sub-paragraph 6.8.3:

The Health Professions Act, adopted regulations in regard to Compulsory Professional Indemnity Insurance in 2010 for doctors, specialists, dentists and psychologists practicing for their own account. Apparently the regulations have been dormant and in a state of moratorium, ever since. [73] But the regulations do not extend to health care practitioners employed, for example, by the State at public hospitals etc. A reason for that can perhaps be found in the fact that the State is vicariously liable for the negligent conduct of those professionals in its employ and the State having the financial resources to satisfy judgments.

Increased medical malpractice litigation has placed a huge strain on the State's liability to finance awards arising from litigation as well as, the accompanying legal costs. The tax payer is the one who is really saddled in footing the bill for malpractice claims against the State. Although there is no perceived prohibition against the introduction of compulsory professional indemnity insurance in respect of medical practitioners in the public sector, the challenges in introducing such scheme are fraught with difficulty. Some of those could include:

- Who would be responsible for insuring the healthcare practitioners? If the responsibility rests with the MEC for Health of each province, would the State be responsible for the payment of the insurance cover? Another question that may arise is this: To what extent would the health care practitioners, whose activities

[73] Lovells "Is there operating room for compulsory PI insurance?" (January 30, 2017) https://www.lexology.com/library/detail.aspx?g=08bb0656-ac2f-44dd-aa2-4d2efd4ec990 (accessed 2017/12/04)

are the subject of liability, be expected to contribute towards the professional indemnity insurance premiums?

- The answer to the above questions will provide the answer to firstly, the extent of the State's financial commitment for the insurance premiums. Payments of claims are usually accompanied by excess payments. The second aspect that needs to be considered is who would be responsible for those excess payments?
- If the idea is intended that the health care practitioner would be responsible to insure themselves against professional negligence, this could be catastrophic. The exorbitant increases in insurance premiums have resulted in a huge number of high-risk specialists leaving the medical profession from the private sector. Making doctors/specialists/nurses pay for their own professional negligence cover while employed by the State, could very well have a similar affect, with disastrous consequences for health care in South Africa.

Ad sub-paragraph 6.8.4

Providing services for direct access to plaintiffs without a legal practitioner as an intermediary, has the effect that the services of the lawyer would be excluded, whereas, the lawyers' services in any country, fulfill an essential public need. If that is ignored, we may very well revert back to the ancient times when the professional role of an attorney was considered as "*infamissima vilitas*" servile, of no value, and contemptible ….."[74].

The suggestion also has serious constitutional implications. Unless a no-fault system is introduced in South Africa (which should not be supported), legal representation in medical malpractice cases is an absolute necessity, for claimants will be faced with the complexities of medicine as a discipline, as well as, the formalistic nature of litigation in our adversarial system of adjudication. It will therefore, be unwise for a claimant to bring and conduct the case himself or herself. Having legal representation in criminal

[74] See Van Zyl *The Judicial Practice of South Africa* (4ed) Vol. 1, at P31 quoted in *Steyn v Ronald Bobroff & Partners* (025/12) [2012] ZA SCA 184 (28 November 2012).

litigation, as well as, civil litigation, is very much part of the rule of law. A denial thereof will lead to a great injustice being done.

Ad sub-paragraph 6.8.5:

One of the means available to assist with reform in bringing about a paradigm shift in handling medical negligence cases is through the introduction of alternative dispute resolution mechanisms, especially mediation. Generally, it will assist with the timely disposing of cases at a cost, affordable by the parties in the dispute. A move towards such a paradigm shift needs to find favour with lawyers in general. Some of the benefits that mediation brings, [75] include:

To the patient:-

- Often quick settlements;
- Avoids exposure to huge financial risks in the event of the plaintiff losing the case;
- The elimination of anger, frustration and hurt;
- Encourages openness of the process with a possibility of an apology;
- Mediation is **without prejudice** to either party's rights. This allows parties to speak freely without fear of their rights being adversely affected. In the event of the mediation failing to arrive at a settlement, each party is free to resort to litigation to resolve the dispute.
- Mediation is a **confidential** process which prevents the disclosure of any admissions or concessions made to the outside world. This protects the dignity of the patient if the claim proves to be without merit and the reputation of the health-carer whether the claim is with or without merit.
- The strength of mediation is that it engenders **equality** between the parties and removes any imbalance in power between the "stronger" professional and the

[75] Lerm Obiter 336-340.

"weaker" lay patient. This balance occurs during private sessions that the mediator conducts with each party in the absence of the other.

- A mediator does not supply the parties with a **verdict**. Nor does the mediator judge the **credibility** of the parties and/or their witnesses. The bona fides of each are accepted without question.

To the health care provider:-

- Avoids trial by media;
- Maintains privacy;
- Minimizes reputational risk;
- Fair hearing, less formalistic and open process of resolving disputes.

To the lawyer:-

- ✓ Early completion of the case;
- ✓ Reduces case-loads;
- ✓ Cash flow advantages.

To the Protection Society:-

- Expeditious payment of compensation at less costs to the Society;
- Better planning.

To the Government:-

- ○ Quicker disposing of cases;
- ○ Reduction of case-loads;
- ○ Increase in staff morale;
- ○ Bettering service delivery standards.

Ad sub-paragraph 6.8.6

How and when mediation is to take place is very important for the success or failure of the mediation.

Because mediation is a voluntary process and the success thereof, depends very much on the co-operation of both parties to the dispute, the mediation process, provided there is a will present from both the parties, could be used at a very early stage after the dispute arises.

Because the patient or his/her family lacks medical knowledge, and where the doctor or hospital fails to give an explanation about what had possibly gone wrong, suspicion and anger on the part of the patient often results. It is through such conduct, that a dispute often arises. It is at this early stage that the parties need to be encouraged to communicate with each other, preferably with the aid of a mediator. Van Den Heever & Lawrenson [76] seem to suggest that 'it is at this stage that the parties are more receptive to settling their differences.' All the patient or the family sometime wants, is an explanation. That, together with an apology, might in some instances, even influence the patient not to sue. [77]

Because mediation is a voluntary practice in which the parties to the dispute acts freely, compulsory mediation, runs counter to the essence of the mediation process.

In direct opposite to compulsory mediation, is a mediation process that is completely voluntary. Although this model would serve as an ideal, this model is very much dependent on all parties to the process, exercising discipline and they take responsibility as means to assist in averting the crises we are all in. Unless that is achieved, the situation will continue to worsen. Given the reluctance shown by lawyers thus far to advise their clients to solve their disputes by way of mediation, the complete voluntary model may also run counter to what is presently in public interests namely, to stop the abuse of litigation.

Given the complexity of clinical negligence disputes and medicine not being an exact science, it may happen that the mediation process will not necessarily bring successful results. That being the case, the process may be superseded by litigation. It is therefore

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[76] Expert evidence in clinical negligence A Practitioner's Guide (2015) at 102

[77] For the advantages that disclosure and an apology can bring, see Lerm *Medical Malpractice Litigation: Do we need a paradigm shift in our approach to handling medical negligence disputes?* Obiter Vol. 38 2 2017 334-336.

suggested that legislation be created that there be a bona fide attempt at mediation before litigation is pursued. In other words, mandatory mediation in this way, is indicated. This would not conflict with the rights entrenched in Section 34 of the Constitution since such mandatory attempts at mediation will only constitute a postponement (and not a denial) of a party's right to exercise the Constitutional right entrenched in section 34.

Ad sub-paragraph 6.8.7

The Consumer Protection Act 68 of 2008 provides for tribunals to deal *inter alia* with medico-legal claims, either to screen and evaluate claims and to adjudicate claims. But, the question may be begged, are those officers tasked with those functions, sufficiently trained in medical law and ethics or medico-legal practices and procedures? Because they in all likelihood lack the expertise, technical and scientific knowledge to match medical experts called to testify, this form of adjudication may not be desirable and should not be supported. What may be more desirable would be to create specialist medical courts. [78]

Where the establishing of specialist courts is not possible, it is then suggested that our policy makers urgently pay attention to the introduction of a practice where skilled assessors can be appointed to assist judges and magistrates in complex medical negligence matters. Here the Rules of Court need to provide for the implementation of such a process.

Ad sub-paragraph 6.8.8

Although there are a number of countries around the world, including New Zealand; Australia, Quebec Canada, a number of Scandinavian counties notably, Sweden and Finland as well as a number of states in the United States of America, including Florida and Virginia,[79] the South African Medico-Legal Association is opposed to the introduction of a no-fault system

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[78] See Lerm Obiter 332; see also the MPS paper page 25 that that a pilot project be created of specialist clinical negligence courts to assess their viability."

[79] Health, Nutrition and Population : "Medical Malpractice Systems around the Globe: Examples from the US-tort liability system and the Sweden-no fault system (2012) 4.

Our common law relies on a "fault" system that relies on negligence determinations to prove claims. In our fault- based system, for the claimant to succeed with a claim, he or she needs to prove:

- The existence of a duty of care;
- Negligence in the performance of that duty;
- Damages caused by the negligent or intentional act.

In a no-fault model, the requirement of proving negligence or intent, falls away. As the term 'no-fault' signifies, fault is not a requirement.

The common law right to sue for damages for personal injury, was abolished in New Zealand in 1974 and replaced with a no-fault compensation scheme, administered by the State. The Woodhouse Royal Commission 1967 relied upon the following five principles to adopt the new system:

- ❖ Community responsibility (the community as collective bore a basic responsibility for costs of accidents);
- ❖ Comprehensive entitlements (equity dictates that all those disabled should benefit irrespective of cause, time, or location);
- ❖ Complete rehabilitation (full recovery in shortest possible time) is very essential;
- ❖ Real compensation (only real loss should be compensated);
- ❖ Administrative efficiency (payments need to be made in an efficient way). [80]

It is the submission of SAMLA that these principles cannot be applied to the socio-economic circumstances currently prevailing in South Africa. In particular, it would be foolhardy to contend that the entire South African population as a collective should bear responsibility for the adverse results of medical negligence.

[80] See the OLR research report "Medical Malpractice No-fault System" December 8, 2003. https://www.cga.ct.gov/2003/olrdata/ins/rpt/2003-R-0885.htm (accessed 2017/12/04).

THE PRESENT SYSTEM OF LIABILITY AND COMPENSATION BASED ON FAULT

It has been stated over and over that our current system is burdensome.

- Claimants will not succeed unless they show the presence of fault or negligence;
- The process is complex, with court proceedings, often a very unpleasant experience to the public, including health care practitioners;
- Malpractice litigation takes years to conclude;
- In an adversarial system designed to resolve disputes between the parties, the latter are discouraged to talk to each other. Saying sorry, is taboo, resulting in litigation being encouraged;
- Relationships between the parties are frequently destroyed forever.

The no-fault option:-

Some of the main arguments promoting the no-fault system include:

- It brings with it considerations of fairness;
- The dispute is resolved much speedier;
- Lower administrative and legal costs;
- Consistency in compensating claimants;
- Reduced tension between health care practitioner and patients;
- Willingness by health care practitioners to report errors and adverse events. [81]

But, critics of the no-fault system have also voiced their skepticism against the introduction of the no-fault option in as much as:

- The costs of resolving disputes can be higher than under the tort (delictual claims) system. More people will be encouraged to claim;
- A compensation culture will be promoted;
- The no-fault system does not necessary encourage explanations and apologies;

[81] See the discussion on no-fault option by Howarth & Carstens "Can private obstetric care be saved in South Africa? *The South African Journal Bioethics & Law* Vol. 7, No 2 (2014) Pages 5-6.

- Failure to place fault on the responsible individuals, may influence the quality of medical care in the long run. Whereas in a malpractice fault base system, challenges are brought to bear on professional performance, reputation and identity of a doctor, nurse or specialist, with the no-fault system it is not. [82]

It is suggested that while the present system is not flawless, a no-fault medical liability system may not be the right answer. [83]

There is doubt whether the introduction of the no-fault option, will pass constitutional muster. Access to courts and other tribunals in terms of Section 34 of the Constitution, seems to hold sway. It is the very essence of the Rule of law that we embrace with such passion. That, possibly answers why, despite the RAF Commission under the Chairmanship of Judge Satchwell recommending a no-fault system to be introduced in motor vehicle accident claims, government has not acted on the commission's report.

Ad sub-paragraphs 6.8.9

The suggestion made that a certificate of merit process be implemented, needs to be supported. It is a practice founded in the United States of America in 2003. The rationale behind the idea was to decrease frivolous claims in medical malpractice cases. [84] But, it is respectfully submitted that the acceptance thereof, should not only be aimed at the plaintiff's lawyers certifying before the start of the case that the plaintiff has a cause of action; certification should also apply to the defendant's lawyers as well in that they need to certify that the defendant has a reasonable defence before filing a plea. Here, they need to produce a certificate of merit that will serve as a screening

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[82] See Scubert & Laurie "Is "no-fault" the cure for the medical liability crises? AMA Journal of Ethics April 2007, Vol. 9, Number 4: 315-321 at 320.

[83] See Howarth & Carstens *op cit* who opine that "*to date there is insufficient evidence to assess whether the steps taken in jurisdictions where no-fault systems were introduced, (e.g. New Zealand and the Scandinavian countries) have been effective, specifically with regard to the promotion of patient safety"*. The MPS in its paper at page 26 also suggests that "*further research into the complexities of no fault compensation is required*"

[84] See Mello and Kachalia "Evaluation of Options for Medical Malpractice System Reform 2010 Report prepared by the Harvard School for Public Health for the Medicare Payment Advisory Commission (Med PAC) 10 quoted as authority in Lerm Obiter 329.

mechanism so that health care practitioners cannot raise defences that are without merit.

Should any of the lawyers representing the parties, abuse the process by certifying that their clients have a meritorious cause or defence, whereas their clients' cases have no merit, adverse cost orders de boniis propriis should be granted by the courts against the transgressing lawyer. [85]

What is further called for is for specialist medico-legal attorneys to deal with these type of matters. Not only should they have undergone some specialist training, they should, as with expert witnesses, also be accredited by an organization recognized in the medico-legal field.

Ad sub-paragraph 6.8.10

The early exchange of information, expert notices, summaries and witness statements and the holding of early expert meetings calls for further investigation. At the heart of the possible reform called for, is the encouragement of resolutions as early as practically possible. Although the Rules of Court for both the Provincial and Local Divisions make provision for the exchange of information by way of discovery, inspection and production of documents, [86] the Rules, save for the exchange of expert notices and summaries of their evidence, [87] do not ordain the exchange of lay witness statements. The exchange of factual witness statements is an alien idea in South Africa. Litigators generally, like playing poker, tend to hold their cards close to their chests and will only reveal their hand when it becomes absolutely necessary.

Lawyers have for many centuries been renowned for exploiting the adversarial system, often for self-gain. Instead of working towards a speedier end to litigation, both the pre-litigation stage, as well as, the litigation stage, offer very little to resolve disputes. What the adversarial system does is to expose the parties to a formalistic and time-

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[85] For a glimpse of how it could possibly work in practice see Lerm Obiter 2017, pages 329-330; Support for the introduction of a certification process see the MPS Paper 19.

[86] See section 35 of the Rules of Court.

[87] See section 36 (9) (a) & (b) of the Rules of Court.

consuming process, with very little prospect of early settlements. Where settlements do ultimately take place, they are at huge expense. What is also amiss is an effective pre-litigation stage in which parties are encouraged to communicate with each other in a meaningful way. This may include the early exchange of information. [88] The early exchange of information place the parties in a position to effectively investigate the strength of one's own case as well as one's opponents. That may allow the parties to resolve the dispute between them before the process of litigation is embarked on.

Here, the MPS's proposal for the adoption of a formal pre-litigation resolution framework similar to other jurisdictions falls to be supported. [89] To this end, two areas are worth investigating. The first goes hand in hand with the early exchange of information, namely the introduction of a complaints process.

Here, the parties may be encouraged to discuss in a meaningful way what may possibly have gone wrong. The doctor/specialist may in response tender an explanation. This may lead to the end of any potential dispute. If the patient or the family accepts the explanation, it can lead to the end of the enquiry. The enquiry should be as informal as possible.

Where it is at all possible, an early apology and remedial action where it is found necessary, should be encouraged. Studies in the United States of America have shown that there are many advantages to early apologies and remedial action, where it has been indicated. [90]

It is however, uncertain at this stage who would oversee the complaints process. Because complaints may arise from the public health care sector and others from the private health care sector, two distinct structures may have to be established for the health care sectors. The "patient-centered complaints system" otherwise known as a "medical errors reporting system" could be fused with the so-called system of peer

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[88] See the MPS Working Document on Case Reform page 20, with reference to the protocol used in the United Kingdom to handle clinical negligence matters under the Pre-Action Protocol for Resolution of Clinical Disputes. The whole idea is to resolve the dispute through the early exchange of information at the earliest opportunity in order to avoid litigation; See also Lerm Obiter 325.

[89] Ibid.

[90] See Lerm Obiter 334-335 and the authorities.

review and should ideally be held at the health care establishment where the incident arose that gave rise to the complaint. In the public health care sector, the said system should be overseen by the Department of Health's Medic-Legal Unit, duly assisted by an independent lawyer and medical expert from the medical discipline wherein the complaint originates. [91] The Medical Protection Society in its paper for reform, [92] is not specific on where, and by whom the first stage of the complaints process will be conducted, but the Society does introduce the involvement of the Ombud or Office of Health Standards Compliance and the HPCSA at what it perceives to be 'tier two' stage. [93] It is suggested that it will make sense if the 'first stage' or 'tier' as with the public health care sector also takes place at the health care institution where the incident occurred. What also falls to be supported is the Medical Protection Society's recommendation that cost penalties be imposed where the conduct of lawyers obstructs an efficient pre-litigation process.[94]

Where however, it is not possible to resolve the dispute at the early stage, it is recommended that the dispute be referred for mediation. The parties need to be encouraged to consider alternative dispute resolution, especially mediation. It is a legal process that has many benefits. Besides the early resolution of disputes, it will also serve to be a cost saver especially with regard to public funding. But, it could also bring much relief to the private health care sector, as well. [95]

But, even if litigation has to be resorted to, there are key ingredients wanting in our present process. The following are some of the procedural changes that need to be encouraged. The South African Medico-Legal Association supports the MPS's call for procedural changes in the following areas, namely, the exchange of factual witness statements; the early exchange of expert notices and summaries and mandatory early experts' meetings as soon as litigation commences. [96]

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[91] See Lerm Obiter 330-331 and the authorities relied on.
[92] See the MPS Discussion Paper on The Case For Reform.
[93] MPS op cit 19
[94] MPS op cit 13
[95] For the advantages that mediation can bring to both the public and private sectors see Lerm Obiter 336-340; Claassen "Mediation as an alternative solution to medical malpractice claims" The South African Journal of Bioethics & Law Vol. 9, No 1 (2016); MPS Paper on the Case for Reform 20.

The process of the exchange of factual witness statements is an alien concept in South Africa, partly due to our adversarial system of litigating. The current system as stated earlier is shrouded in much secrecy and lacks openness as a means to encourage early resolution of disputes. Our rules pertaining to the giving of evidence, is also very formalistic. Save for the Rules of Court that provide for the summaries of expert evidence in the form of such experts' opinions and their reasons therefore be exchanged [97] provided prior notice is given, [98] the Rules do not prescribe for the exchange of factual witness statements. The first time the opposing parties hear what a factual witness is going to say, is during his or her evidence in chief. The opposing party cannot, therefore, assess the potential impact or veracity of the evidence that will be presented. Nor are the respective parties able to identify what is common cause between them alternatively, what are the salient issues that cannot be agreed to and need to be adjudicated upon. A further compellable argument in support of the exchange of factual witness statements presented by the MPS amount to this: expert witnesses engaged by the opposing party knowing all the facts, will be in a better position to express a more objective opinion when formulating the summary of his or her evidence. [99] But, besides the afore stated benefits, one of the major benefits that this innovative idea can bring is that the parties can decide very early whether they have or do not have a meritorious cause or defence. That, could result in a decision whether to continue to pursue the cause or abandon the action. The same holds for the defence to an action. If we were to follow any jurisdiction that have introduced this process we need to look no further than the United Kingdom where rules were tabled in their Rules and Practice Direction 32 – Evidence. [100] The practice simply stated, amount to this: in terms of the Rules a witness statement must be in concise but comprehensive form by way of an affidavit, [101] served on the opponents in the time period provided by the Rules.

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[96] See the MPS Paper on The Case For Reform 21.
[97] See section 36 (9) (b).
[98] See section 36 (9) (a).
[99] See the MPS Paper on The Case For Reform 21.
[100] See Practice Direction 32 – Evidence Ministry of Justice https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part32/pd_part32
[101] Rule 32.8.

[102] Where there is a failure to comply with the Rules in form or in terms of service, the court shall not allow that evidence to be given. [103]

The early exchange of expert notices and summaries of the expert witness opinions also needs to be supported. This will allow the parties to ascertain how strong their respective cases are. Early exchange of those witness opinions improve transparency and create a climate for settling matters much earlier. The early exchange will also help the parties to limit the issues between them. [104]

Currently, the Rules of Court do not mandate experts' meetings and the drafting of experts' joint minutes. The meetings of experts and the drafting of joint minutes are now controlled by a judge in charge of the case management process in terms of the Case Flow Management Practice program under the auspices of the Judge President of all the Divisions of the High Courts where a case management program has been introduced. The whole idea for holding these meetings is to endeavor to limit the issues that are of an expert nature. [105] But, it is often found in practice that these meetings take place far too late, often just before the trial is about to start. Meeting at such a late stage and after exchanging views may result in late amendments, increasing the cost of litigation. That is not advantageous to any of the parties. [106]

It is recommended that the Rules of Court should be amended to make provision for mandatory early experts' meetings. It is during those meetings that the experts talk to each other about the evidence they intend giving as a means to find common ground on what they agree on and those issues they cannot agree on. Should they end up in court, those are the only issue they will need to testify on. The benefits of such practice include savings in court time and costs. It may also lead to early settlements. [107]

Ad sub-paragraph 6.8.11

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[102] Rule 32.4.
[103] Rule 32.12
[104] See the MPS's Paper on Case Reform 21.
[105] See Van Den Heever & Lawrenson Expert Evidence in Clinical Negligence 2015 58-59.
[106] See the MPS's Paper on Case Reform 15.
[107] MPS op cit 21

The creation of a Pre-trial Conference system, aided by a Judicial Case Management system are two essential components of the litigation process. Both systems aim to ensure that those who access the courts, experience 'effective, efficient and expeditious adjudication and resolution of all disputes.[108] The whole idea behind those initiatives in South Africa is to define the triable issues so as to curtail proceedings in an endeavour to curb litigation costs.

But, the success of both systems depends very much on the earnestness and seriousness at which lawyers and other role players, including judges approach and commit themselves to the process. To make the systems work, this is where lawyers in particular, need to make a paradigm shift in mindset. Instead of treating both processes as mere tick boxes, lawyers need to look at both processes as a means to further the interests of their clients and the administration of justice, as a whole.

Judges too, have a very important role to fulfill. Through diligence and the will to improve the pre-trial phase, they are able to make the process work. What is also required of the judge taking control of the pre-trial proceedings, and the case flow management processes, is to keep the parties to time limits and minimize postponements of proceedings. The Medical Protection Society's [109] call for sanctions to be imposed on non-compliant parties, needs to be supported.

It is during the case flow management phase that judges could also steer the parties in the right direction. With expert witnesses meeting early and compiling joint minutes, the issues in dispute can be identified very early. The parties may then work together in an endeavor to put an end to the dispute without protracted litigation.

What is also called for is to tailor-make pre-trial procedures for clinical negligence matters. (Question: What specific requirements for clinical negligence cases are necessary?)

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[108] See the Norms and Standards issued by the Chief Justice of South Africa in terms of the Superior Court Act 10 of 2013 read with Section 165(6) of the Constitution; See also Rule 37 (8) regarding the holding of pre-trial conferences to be attended by both sets of lawyers in terms of the Rules of Court.

[109] See the MPS's Paper on the Case for Reform 14.

What is envisaged here is the convening of a pre-trial conference before a judge in terms of Rule 37(8) of the Uniform Rules of Court. This is an institution that has been well established in most of the divisions of the High Court in South Africa. Some of the items that could form part of a standard Agenda include:

- The nature of the dispute and the relief sought;
- What attempts have been made to settle the matter including the use of mediation?
- The duration of the trial, including how many witnesses, lay and expert witnesses will be called;
- What are the major issues in dispute?
- Ascertaining whether expert summaries in terms of Rule 36(9) (b) had been exchanges, if not, by when would that take place?
- An enquiry into whether the experts have met and if the joint minutes can be filed?

Ad sub-paragraph 6.8.12

Engaging in a brief introductory discussion on why the introduction of the capping of claims in medical malpractice claims should be investigated, will give us a better understanding of whether to support the idea of implementing the idea or not. There can be no denial that the sharp increase in both the number of claims as well as the financial value of the claims instituted and eventually paid out through settlements or awards, has had a profound impact on the resources from where the funds are utilized. It is no longer uncommon that those claims for damages, arising from medical negligence, amount to millions of Rands. Reports have shown, that in both the public as well as the private sectors, claims are settled from resources, often not budgeted for. Sometimes payments are being made, especially in the public health care sector from funds designated for medical equipment and other purposes. [110] Although in the private health care sector, payments are being made by the medical protection societies, nonetheless, the medical profession is no better off. Here, physicians, especially

[110] See Lerm Obiter 325

gynaecologists who believe they are being targeted by lawyers, feel particularly vulnerable. Exorbitant increases in insurance premiums are encouraging defensive medicine being practiced and are resulting in many high-risk specialists leaving South Africa or abandoning their practices for fear of being sued. Because of this threat, junior doctors are discouraged from entering specialized fields. There is a danger, albeit remote at this stage that unless there is a paradigm shift to our whole approach in handling medical negligence disputes, that the medical profession can become exstinct, posing a threat to heath care in South Africa. [111]

On the other side of the scale, there is the interests of the consumer, the patient, who suffers damages, physically and/or psychologically, where the health care practitioner or a health care provider exercises care which fall below the standard expected of a reasonable practitioner in that field or class and under the circumstances prevailing at the location where the event occurred. Where harm is caused as a result of someone's action, the law is set in motion in terms of our common law to compensate the party suffering damages. The law of delict sets out the rules for the wrongdoer to compensate the aggrieved party.[112]

The rationale for compensation originates from the Roman law. Both the Actio Legis Aquiliae (means of claiming damages for patrimonial loss) and the Actio Iniuriarum (means of claiming for reputational harm) have always been used to claim for damages suffered. The third action takes the form of general damages, including pain and suffering, loss of amenities of life and disfigurement. The damages are claimed under the 'once and for all' rule. It has been part of our common law that the amount of damages to be awarded must be in relation to the damages suffered.

Any limitations placed on the damages to be awarded by the capping of damages will therefor first have to undergo constitutional scrutiny. This takes place by virtue of the fact that any law or conduct is today, tested against the Constitution. Any statutory limitations involving financial compensation, will have to withstand constitutional muster. Limitations in this regard, are not alien to the South African legal landscape. That, we

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[111] See Lerm Obiter and the sources mentioned therein 324-341.

[112] Van der Walt and Midgley Principles of Delict (2005) 31.

witnessed since 1946, with the passing of the 1942 Motor Vehicle Insurance Act which only came into operation in 1946. The Act was promulgated due to a disturbing increase in road accident, which could not be curtailed by the common law. The Act has since repeatedly been amended. The Road Accident Fund Act 56 of 1996 came into being and was also amended thereafter. The Road Accident Fund Amendment Act 19 of 2005 in particular brought about far reaching changes, including limiting the eligibility for non-pecuniary loss in which one can now only claim for a serious injury, payable in a lump sum. [113] A further limitation placed by the amendments to the Act, also included a cap to the payout of future care costs for accommodation in 'a hospital or nursing home' or the 'treatment of or the rendering of a service' in the said institutions or a claim for 'future loss of income or support'. Loss of care costs, income and support is capped at R182 047 per year, periodically adjustable for inflation.[114] Although the amendments were challenged by the Law Society of South Africa on behalf of its members, the Constitutional Court [115] ruled that the amendments were necessary and passed constitutional muster. The Court in response to the Law Society's main contention that the scheme proposed by the Minister of Transport was irrational, especially the abolition of the common law claim, found that the Minister and the Fund had 'made out a compelling case for the urgent reduction of the Fund's unfunded and ballooning liability' and that 'urgent steps be taken to make the Fund sustainable so that it could fulfil its constitutional obligations to provide social security and access to health services'. [116] The Court found that given the long history of legislation that regulated third party insurance since 1942 in an attempt to find a fair, effective and financially viable scheme of compensation, it still remains elusive, today. [117] The Court also found that the Minister's contention that the proposed scheme was 'transitional and served as an interim measure', was a step 'in the journey to reform the compensation regime to motor

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[113] Subsection 1A read with section 17 of the Act provides that one now has to prove a 30% whole person impairment or serious injury before one could qualify for non-pecuniary damages that will be paid by way of a lump sum.

[114] See section 17(4A) (a) of the RAF Act 19 of 2005 as amended quoted in Law Society of South Africa and others v The Minister of Transport and another 2011 (1) SA 400 (CC) para [24].

[115] ibid

[116] Paragraph [52] of the judgment.

[117] Paragraph [53] of the judgment.

accident victims' and needs to be supported.[118] The lawmaker should therefore, be given 'reasonable room or leeway to advance the reform'. [119] To this end, the Court found, 'the abolition of the common law claim was necessary and a rational part of an interim scheme whose primary thrust was to achieve financial viability and a more effective and equitable platform for delivery of social security services'. [120]

Turning to the issue whether the abolition of the common law delictual remedy is not inconsistent with the Constitution, the court stated the general position, namely, the lawgiver has the authority or power to change or adapt the common law provided that the change is not inconsistent with the Constitution. [121]

The Court then considered whether it would be reasonable and justifiable, given the limitation clause of the Constitution, to cap the character and the extent of the compensation each victim is entitled to in terms the proposed scheme? The Court found that the Minister and the Fund had advanced with a certain degree of cogency and adequate justification for this limitation. To this end, the Court again emphasized 'the need for making the Fund financially viable and sustainable, and to make its compensation regime more inclusive, predictable and equitable'. [122] Consequently, the Court found that given the rationale behind the need as set out herein before, the reduction of compensation recoverable for loss of income or support, does not arbitrarily deprive the claimant of property, which is the threshold requirement for a limitation of Section 25(1). [123]

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[118] Paragraph [51] of the judgment. The Court relied on the Canadian Supreme Court judgments of Thompson Newspapers Co v Canada (Attorney General) [1998] 1 SCR at 53; Egan v Canada [1995] 2 SCR 513 at 573 and McKinney v University of Guelph [1990] 3 SCR 299 (SCC) at 317 at para [52] in which it was decided that when a government brings about reform, it may do so by implementing incremental measures 'one step at a time'.

[119] Paragraph [53] of the judgment.

[120] See para [54] of the judgment.

[121] See paragraph [70] with reference to 39(2) of the Constitution which enjoins the courts to develop the common law. The court also found that it was open to parliament to adapt the common law provided the Constitution is not breached. See paragraph [71].

[122] See paragraphs [77] and [78] of the judgment.

[123] See paragraph [86]. The Appellant in this case sought to rely on Section 25(1) which provides: "No one may be deprived of property except in terms of law of general application, and no law may permit arbitrary deprivation of property.

The above findings by the Court, it is submitted, could play a very significant role when a court in future is called upon to decide the issue of capping of claims for general damages in medical negligence matters. But first, such a move will have to be preceded by a legislative enactment, especially given the devastating crisis in which both the public health care sector as well as the private health care sector find itself. In amplification, the court may very well consider that the capping of non-pecuniary damages is essential to curb expenditure in the payment of compensation in both sectors, depleting budgets. A compelling argument can also be put up that paying out large amounts to individuals, have the effect that it impairs services to the greater populace. Any savings could be utilized for improving health care services. The lack of adequate facilities poses a risk to the well - being of many patients.

A compelling argument may also be presented by those who are opposed to limiting non- pecuniary damages. Let us use the example where a patient sustains a serious injury resulting from a medical negligence episode. The immediate pain and discomfort as well as the continued pain and suffering, can be quite severe. The result could be far reaching in that, some never live normal lives again. The sequelae could impact on the patient's physical abilities which in turn, may affect his or her emotional condition as well. [124] From a constitutional point of view, both the patient's right to dignity and right to physical and bodily integrity, may be impaired.

From the two opposing arguments highlighted above, the following question may be begged: whose interests, those of the general public or the individual should prevail? What is at stake are individual rights as opposed to community rights to better health care. Given the current health care situation in South Africa, a better health care system will only come to fruition through sufficient funding. Given our ailing economy in South Africa, drastic times call for drastic measures. Judging by the Court's reasoning in the Law Society of South Africa and others v The Minister of Transport [125] it is more than likely that if this issue is raised before the Constitutional Court that the Court will make

[124] See the MPhil unpublished thesis submitted by J.W. Joubert "A Case Study of the Constitutionality of Proposed Financial Limitations on Medical Negligence Claims" (University of Pretoria Nov. 2016).

[125] 2011 (1) SA 400 (CC).

new inroads in our current system by capping claims for general damages. It is, however, uncertain to what extent these heads of damages ought to be capped.

The following limitations or caps have been placed in many foreign jurisdictions on non-economic damages, namely: in a number of states in the United States of America, the maximum amount that can be recovered ranges from $350,000 to $750,000.[126] With the current exchange rate in Rand terms, it amounts to R 4,308,500.00 to R9, 232,500.00. In Australia, in particular New South Wales, non-pecuniary damages are now capped in Australian dollars at $551,500.[127] In Rand it amounts to R5, 503,000. Canada, commenced capping their claims for pain and suffering as recent as 2014 at approximately $350,000. But the maximum amount for general damages are very rare and reserved for the most severe cases. Converted in Rand, it amounts to R3, 472,000.

It is however suggested that should the Law Reform Commission recommend that non-pecuniary damages be capped, a panel of experts first be appointed to work out realistic and uniform amounts for general damages or non-pecuniary damages in the different categories according to the seriousness of the injuries sustained. In this regard see the comments made in Ad paragraph 6.7 on page 35 above.

Ad sub-paragraph 6.8.13

This aspect was fully ventilated in the case of The Law Society of South Africa v The Minister of Transport and another [128] albeit not in medical malpractice matters. But, the law is fairly settled as more fully discussed in Ad paragraph 6.8.13 above. It therefore, needs no further discussion save to state that the principles may very well be applied to medical negligence matters.

Ad sub-paragraph 6.8.14

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[126] See Boeschen "Damage Caps and Other Limits on Personal Injury Compensation" www.alllaw.com/articles/nolo/personal-injury/damage-caps-limits-compensation.html (accessed 2018/01/06).

[127] See the Australian Law Reform Commission Paper "Remedies and Costs" https://www.alrc.gov.au/publications/11-remedies-and-costs/cap-damages (accessed 2018/01/06)

[128] Ibid.

Prescribing a net discount rate for future medical care is an area that needs to be pursued by an expert, preferably an actuary, who is more suited to make a meaningful contribution.

Ad sub-paragraph 6.8.15

Prescribing guidelines for the calculation of compensation to determine life expectancy etc. is a field that require the expertise of an actuary and/or a neurosurgeon who is generally equipped to make a more meaningful contribution.

Ad sub-paragraph 6.8.16

The South African Medico-Legal Association is of the view that while there is a disparity between private and public health care establishments, the under-resourcing of the latter establishments has led to poor quality of care. Until such time as health services are improved, the treatment of certain classes of patients especially those to whom serious harm is inflicted and who are awarded damages, cannot be expected to be treated further in those establishments. [129] Monetary compensation should be given to them subject to the treatment first being given to them. Depriving patients who suffer serious injuries of adequate care and subjecting them to treatment in public health establishments would be a breach of section 12 read with sections 7(2) and 27(1)(a) as well as 27(2) of the Constitution.[130]

Ad sub-paragraph 6.8.17

The instruction 'define benefits' is very ambiguous and creates a degree of confusion. The word 'benefit' however, signifies something tangible and capable of calculation, for example, the genesis of special damages consists inter alia of lost earnings and lost earning capacity, including employment benefits. Employment benefits include various non-wage compensation provided to employees in addition to the normal wage or salary of the employee. It is also sometimes referred to as fringe benefits or perks. Examples can be found in housing allowances or accommodation; group insurance, including

[129] See the case of The Law Society of South Africa and others v The Minister of Transport and another 2011 (1) SA 400 (CC) paras [87] to [101}.

[130] ibid

medical aid, life insurance; retirement benefits, sick leave benefits and transport benefits. In most instances those benefits are taxed as they are regarded as taxable income.

Ad sub-paragraph 6.8.18

A claim for general damages is part of the genesis of non-pecuniary damages, also known as non-patrimonial damages. Part of the head of general damages are the following components, namely, pain and suffering, disfigurement, loss of amenities of life, shock and injury to personality. This type of damages, unlike special damages, is not easily determinable hence the term non-patrimonial damages. Because the degree of pain and suffering, discomfort and loss of amenities of life because of the nature of the injuries sustained, differ from person to person and from case to case, the courts have been given a wide discretion to award what it considers to be fair and adequate compensation to the injured party. [131]

Our courts have also approached the determination of the measure of damages by considering all the relevant factors and circumstances and have had regard to the 'general pattern of previous awards'. [132] But, our courts have also demonstrated the difficulty that courts have in determining the quantum of damages in non-pecuniary cases.[133] Because of the uncertainty of determining with greater accuracy the amount to be awarded, a tariff for general damages is an elusive term.

It is therefore suggested that the Law Reform Commission consider recommending that a panel of experts meet to formulate with greater certainty tariffs applicable to general damages. Reference is again made to the South African Medico-Legal Association's suggestion in Ad paragraph 6.7 above and repeated in Ad paragraph 6.8.12.

Ad paragraph 6.8.19

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[131] See Road Accident Fund v Marunga 2003 (5) SCA 164 para [23].

[132] See Protea Insurance Company v Lamb 1971 (1) SA 530 (A) at 535A-B and other cases cited there.

[133] See Wright v Multilateral Vehicle Accident Fund a case decided in the Natal Provincial Division discussed in Corbett and Honey Vol 4 E3-31. The Wright case as discussed in Honey at E3-34 to E3-37 is mentioned as authority in the case of Road Accident Fund v Marunga fn 128 supra.

The support and reasons for the support for structured settlements, including periodic payments for future special damages for loss of earnings, medical care and treatment apply *mutatis mutandis* to periodic payments for future care and maintenance costs. It, therefore, is not necessary to repeat the discourse in Ad paragraph 6.5 here.

Ad paragraph 6.8.20

Depending on the needs of the injured party to whom the periodic payments are made, advice must be sought from experts how frequent payments must be made and at what amounts? Depending on the outstanding debts the injured has when the first periodic payment falls due, the amounts payable may be more frequent in the beginning until it tapers off. It is therefore suggested that for the first year, the frequency of payments could be monthly. The injured may thereafter seek an adjustment to say quarterly payments. It would also be advisable for the injured to consult a tax expert to establish what tax implications are applicable to which category of frequency in periodic payments. It is also suggested that payments be made directly into a banking account.

Ad paragraph 6.8.21

Motivating for or against providing for the payment of annuities or staggered payments is also an area that needs to be pursued by an expert, preferably an insurance specialist in consultation with an actuary, both of whom are more suited to make a meaningful contribution towards the financial science under question.

Ad paragraph 6.8.22

Providing guarantees or undertakings towards paying future medical expenses is not alien to the legal landscape in South Africa. It is a process that is widely used in terms of the RAF Act in South Africa[134] and works as follows. After the injured claimant has been successful in claiming compensation against the Road Accident Fund, part of the settlement could be a written undertaking offered by the Fund to pay for any reasonable future medical expenses. The undertaking serves as a guarantee for the payment of

[134] See section 17 (4) (a) of the RAF Act

future medical expenses to be incurred for medical serves. But the injured party will have to show that the amount of money to be paid is reasonable and in respect of valid medical expenses. The treatment will also have to be tried-and-tested treatment. Therefore, the Fund will not payout any unproven types of treatment nor experimental ones.

Because it is a system that has been tried and tested and despite some administrative frustrations that are encountered from time to time, it is a process that can be recommended to be utilized in medical malpractice litigation in an endeavor to prevent large lump sum pay-outs. The identity of the guarantor who will make such payments in respect of future medical treatment, may pose a practical problem. In view of the current financial straights in which Provincial Health Departments are finding themselves, a guarantee supplied by them may not be persuasive enough for private clinics to render such future medical treatment. A special fund will have to be established by government which will always be able to make such payments in order for such guarantee to be trusted by private clinics and hospitals requested to render the required future treatments.

Ad paragraph 6.8.23

The assessment of pecuniary damages in particular loss of future earnings or, as some writers prefer, for reduced earning capacity, is not a simple mathematical calculation. The uncertainty of how long an injured party will live; the likelihood of him or her not completing his or her working life and other financial implications, bear heavily on accurate calculations. Hence, allowances have to be made on a case by case basis for a variety of contingencies.

Where a plaintiff suffers a permanent impairment of earning capacity, the court will first calculate the present value of the future income which plaintiff would have earned if it was not for the disability. The court will then calculate the present value of plaintiff's estimated future income. The difference between the two figures will then be subjected to certain factors and contingencies, where after the final award for this head of damage is determined.[135] The adjustment will be made, in consideration of the possibility of

errors in the estimation of the plaintiff's life expectation and retiring age; the likeliness of illness and unemployment which would have occurred in any event or which in fact may occur; inflation or deflation of the value of money in future; alteration in cost-of-living allowances; cost of transport to and from work and pension contributions; accidents or contingencies which would have affected earning capacity in any event; liability for income tax; loss of pension or provident fund benefits.[136] The percentage deduction made by our courts vary between ten percent and twenty percent. Perhaps, expert consideration should be given to finding a standard percentage to bring about uniformity to the percentage deducted.

Whether provision should be made for a reduction of contingency fees is an area that needs urgent attention. This aspect is fully dealt with in paragraph 11 above and calls for no further discussion.

Ad sub paragraph 6.8.24

The Guardians Fund is a fund that falls under the administration of the Master of the High Court. It is a fund created to hold and administer funds that are paid to the Master of the High Court on behalf of various persons including minors or persons incapable of handling their own affairs. The Fund could safeguard payments made for the benefit of children or those persons who, by virtue of their mental incapacity, cannot administer their own affairs. The funds utilized could be in respect of education, clothing, accommodation, transport and other motivated needs. Although the Fund may serve as a safeguard, it is not an ideal system as, administratively, some of the offices of the Master of the High Court in South Africa are in a state of decay, posing a risk to the efficient payout of funds. In particular, where large amounts are involved which include the payment of hospital and medical expenses urgently required, this system is not ideal. The creation of trusts, as will be discussed in sub paragraph 6.8.25 herein after is a better option to be implemented.

Ad paragraph 6.8.25

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[135] See Gauntlett in Corbett The Quantum of Damages Vol. 1 4 th Ed (2004) 48.

[136] See Gillbanks v Sigournay 1959 (2) SA 11 (N); Sigournay v Gillbanks 1960 (2) SA 552 (A); Goldie v City Council of Johannesburg 1948 (2) SA 913 (W) quoted in Corbett page 51 fn 232.

The South African Medico-Legal Association supports the suggestion of the provision for the creation of trusts for minors who are awarded large sums of moneys for compensation, arising from personal injury claims. The same applies to awards being made to adults who, by virtue of mental incapacity cannot administer their financial affairs themselves. It was stated in Sing v Ebrahim [137] that "the interest of a minor is best served by a cautious and conservative management of his affairs." That comment applies equally, to adults placed under curatorship because of impaired mental capacity. Our courts have been particularly concerned that compensation be paid to those unable to manage their own affairs and if monies are paid over to them, that they may lose the money or spend all the money; or that the parents or others take, invest and utilize the monies for their own benefit.

Creating trusts and appointing responsible people to administer the trusts under the auspices of the Master of the High Court will reduce the risk of the embezzlement, misuse or withholding monies belonging to the injured. The trust deed created, could provide for what is called a blocked banking account which could for example only be utilized for necessary expenses, motivated for by the parents or those who care for the injured etc.

The benefits to the mandatory creation of trusts besides the fiscal control aspect mentioned before, could also include the growth of the trust assets, thus enlarging the estate of the injured.

Ad paragraph 6.8.26

Save for the pointers to legislation or measures introduced by other jurisdictions around the world that may be considered in our own environment in medico-legal matters, the South African Medico-Legal Association has nothing further to add.

CONCLUSION

[137] See Singh v Ebrahim (413/09) [2010] ZASCA 14 (26 November 2010) para [93].

Our healthcare system in South Africa is facing enormous challenges. We cannot allow the situation to continue. Various extraneous factors have been identified in our comments that are possible causes for the position that the healthcare system is in. There can be no denial that the abuse of litigation by some lawyers has impacted heavily on healthcare budgets. Consequently, what is mooted in the South African Medico-Legal Association's recommendations is the necessity for a paradigm shift in the way the medico legal community deals with medical negligence disputes.

The situation is not unique to South Africa. Elsewhere around the world, other jurisdictions once faced similar challenges where, after much consideration, reform measures were put in place to deal with issues impacting on sustainable healthcare systems.

The recommendations suggest that South Africa needs to learn from the *modus operandi* followed by those countries that brought about reform. Public interests also dictate that we need to focus our attention on addressing those challenges that adversely impact on the medico legal society as well as the broader community. By considering and introducing some of those measures identified herein before, we may just move in the right direction and so prevent a major catastrophe.

20 March 2018

Prepared by: Judge Neels Claassen.

Chairperson of SAMLA

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Dr Henry Lerm

Deputy Chairperson Legal SAMLA