



SASOG

South African Society of Obstetricians &
Gynaecologists

Medico-legal Crisis in South Africa Summit 5 May 2019

SASOG Presentation Executive summary

1. **The South African Society of Obstetricians and Gynaecologists (SASOG)** is devoted to the welfare of our members and our patients, the women of South Africa.
2. **The increase in medico-legal claims** in civil courts against Obstetricians and Gynaecologists has adverse effects on the discipline, the public at large and specifically on women. Obstetricians have basically become “uninsurable” and many have left or plan to leave obstetrics. Claims against the public sector will weaken the health system further and may send maternity services in a downward spiral.
3. **Criminal cases and recent jail sentence** for professional negligence are of huge concern to all health care workers.
4. SASOG works to **prevent medical negligence** claims by providing clinical care and governance programmes. BetterObs aims to improve maternity care at patient and hospital level and BetterGynae is in design phase with similar aims for gynaecology.
5. Attempting prior **alternative dispute resolution** via mediation should be formalised and probably be made obligatory before court dates are given.
6. **Expert witnesses** must meet the standards set by the profession and internationally; SASOG has drafted a guideline which we would like to see implemented.
7. Medical malpractice claims relating to **changes in the legal landscape** must be addressed to limit unfair financial gains. There should be clearer guidance and stricter limits regarding contingency fee payments. Large lump sum payments may contribute to motivation for legal action and to unfair monetary gain for legal professionals.
8. SASOG supports appropriate, fair, and sustainable **compensation of victims** of medical negligence as well as support, education and care to all people with injury, disabilities or special needs whether linked to sub-standard care or not.
9. SASOG suggests maintaining once-off payments for past expenses, but a change to periodic payments for future expenses as well as to dependents compromised by an untimely death from a separate budget ring-fenced for medico-negligence claims to prevent a negative impact on health service delivery.
10. There should be no **disparities in care** between public and private sectors in terms of right to compensation for victims of medical negligence. Compensation for future medical expenses and care needs should be based on a model of care that ensures standardisation and equal opportunity.
11. SASOG supports the establishment of **specialised courts for medico-legal matters** to address shortcomings in bureaucratic processes and complex hearings in different forums.
12. The **criminal liability for professional negligence** of professional health care workers must be addressed.
13. SASOG acknowledges the need to work with all interested parties to address the current medico-legal challenge in a fair way allowing continuation of care women of South Africa.



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MEDICO-LEGAL CRISIS IN SOUTH AFRICA SUMMIT 5 MAY 2019

SASOG Presentation

We appreciate this opportunity to provide input and proposals on law reform needed to protect maternity and general medical services in our country.

INTRODUCTION

The South African Society of Obstetricians and Gynaecologists (SASOG) is a professional body of free association dedicated to the furtherment of the discipline at clinical and academic levels.

- We are devoted to the welfare of our members and our patients, the women of South Africa.
- We are committed to improvement of women's health, human-rights, and reduction of disparities in healthcare.

The increase in medico-legal claims in civil courts against Obstetricians and Gynaecologists has adverse effects on our discipline, the public at large and specifically on women.

- The frequency and severity of claims against our members has increased cost of indemnity insurance such that many are basically "uninsurable" and many have left or plan to leave obstetrics.
- Claims against the public sector will weaken the health system further and may send maternity services in a downward spiral.

Criminal cases and recent jail sentence for professional negligence are of huge concern to all health care workers.

- Professional negligence and individual liability within complex care systems are complicated and relative judgements to be considered during sentencing.

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- We fear for devastating effects on the health care workers concerned, their families and community, as well as on the medical and obstetrical profession.

REDUCING MEDICO-LEGAL DAMAGE

THOUGHTS ON LAW REFORM

SASOG works to **prevent medical negligence** claims by our clinical care and governance programmes.

- BetterObs aims to improve maternity care at patient and hospital level and BetterGynae is in design phase with similar aims for gynaecology.
- These programmes also try to improve mechanisms of defence by providing clinical guidelines, informed consent forms, and assist in documenting care and outcomes.

Attempting prior **alternative dispute resolution** via mediation should be formalised and probably be made obligatory before court dates are given.

- The settlement quantum is usually much smaller due to immediacy and reduced legal costs
- The other benefits in terms of time, privacy, etc. to plaintiff and defence are obvious

Expert witnesses must meet the standards set by the profession and internationally; SASOG has drafted a guideline which we would like to see implemented.

- Expert witnesses must be true experts with recent experience in the same field and sector as the accused and must assist the court by providing objective evaluation.
- SASOG has formed an Expert Opinion Panel of trained experts to assist all parties and FIGO has a similar process underway internationally.

Medical malpractice claims relating to **changes in the legal landscape** must be addressed to limit unfair financial gains.

- There should be clearer guidance and stricter limits regarding contingency fee payments.



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- Large lump sum payments may contribute to motivation for legal action and to unfair monetary gain for legal professionals.

SASOG supports appropriate, fair, and sustainable **compensation of victims** of medical negligence as well as support, education and care to all people with injury, disabilities or special needs whether linked to sub-standard care or not.

- In the interest of sustainability and fair distribution of resources, we call for a limit to the magnitude of awards
- We suggest maintaining once-off payments for past expenses, but a change to periodic payments for future expenses as well as to dependents compromised by an untimely death.
- A separate budget should be ring-fenced for medico-negligence claims to prevent a negative impact on health service delivery.

There should be no **disparities in care** between public and private sectors in terms of right to compensation for victims of medical negligence.

Compensation for future medical expenses and care needs should be based on a model of care that ensures standardisation and equal opportunity.

- Public sector facilities should be enabled to provide such high-quality care to injured and disabled patients whether due to negligence or not.

We support the establishment of **specialised courts for medico-legal matters** to address shortcomings in bureaucratic processes and complex hearings in different forums.

- Such a single special tribunal has been successful in other areas of the legal fraternity.
- This court should be assisted by a selected panel of experts rather than having opposing experts.



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The **criminal liability for professional negligence** of professional health care workers must be addressed.

- We believe court processes should be inquisitorial rather than adversarial and sentencing should be for rehabilitation rather than retaliation.
- Sentencing should consider the complexities of establishing and quantifying professional negligence as well as individual liability within the health care system.
- SASOG does not consider jail sentence to be an appropriate sentence for a patient's death due to clinical negligence.

CONCLUSION

SASOG wants to work with all authorities to address the medico-legal issue in a fair way which will allow us to continue to serve the women of South Africa with care and dignity.

We have presented some thoughts on a very complex matter which has had devastating effects on our specific high-risk medical discipline. We support the principles of justice, the right to compensation, and equity in access to quality health care and legal services.

Prof Greta Dreyer

President: SASOG

Dated 5 May 2019

SASOG Presentation at the Parliamentary Committee:

STATE LIABILITY AMENDMENT BILL

INTRODUCTION

I will be presenting the views of The South African Society of Obstetricians and Gynaecologists (SASOG) and the South African Society of Anaesthesiologists (SASA). Both societies are professional bodies dedicated to the furtherment of their disciplines at both clinical and academic levels, and furthermore, we are devoted to the welfare of our members and the patient population we serve. SASOG is committed to the improvement of women's health and human-rights, and to the reduction of disparities in healthcare available to women and newborns. Although the interests of our members and patients may seem to be in conflict with the matter at hand, the increase in medico-legal claims is not in the interest of the public at large or women as a group and possibly not even the successful claimants. Frequent and large claims threaten to weaken the health system further and may send maternity services in a downward spiral.

SASOG is particularly concerned about the increase in medico-legal claims against its members and strongly support comprehensive law reform. SASOG members have been particularly targeted by the explosion of medico-legal claims as obstetrics is inherently a high-risk profession. The frequency and severity of claims against our members has made them basically "uninsurable" by medical protection societies. Medical insurance cover for our members in private practice is close to 1 million rand per annum. This is an untenable situation. Our members are leaving obstetrics and there are parts of the country where NO private obstetric service is available. In a 2017 questionnaire to SASOG members, 220 out of 330 respondents indicated that they would stop practicing obstetrics if no changes are forthcoming. This would mean that approximately 140 000 deliveries from the private sector will be referred to the state every year.

However, we also firmly believe that appropriate compensation should be granted to parties in cases where definite cases of medical negligence have been identified. In addition appropriate support, education and care should be available to all people with

disabilities or special needs whether or not these can be linked to an act of unlawful medical management. Payment of large sums to some individuals will further cripple the system and increase disparities in care.

We therefore appreciate this opportunity to provide input on the proposed State Liability Amendment Bill.

GENERAL COMMENTS ON THE BILL

We believe that this legislation seems to be of a nature which only addresses one component: namely the fiscal liability. The medico-legal problem facing our country must be dealt with in a more holistic approach and this will require sector wide law reform. Firstly there should be a drive to prevent medico-negligence matters. The process of mediation or dispute resolution should be formalised and given more prominence. The advantage of mediation is that quantum's are immediate and are a fraction of medico-legal quantum's as it does away with legal costs which are currently a huge cost driver in litigation. There should also be some guidance regarding contingency fee payments. Currently many cases are poorly managed because of bureaucratic bungling. Consideration should be given to the establishment of specialised courts dealing in medico-legal matters. The concept has been successful in certain areas of the legal fraternity for eg the formation of specialised criminal and children's courts. As stated previously, the State Liability Amendment Act only addresses financial liability. What about other liabilities? Following the fatal outcome of a case, the criminal liability of doctors and healthcare workers is of concern. The complexity of repetitive legal action must be addressed. We are also committed to the principle of a single special tribunal with a selected panel of experts rather than the current system of inquest, criminal prosecution, civil case and HPCSA inquest, each with multiple, separate and opposing experts. This process should be inquisitorial rather than adversarial. To this end, SASOG has already formed an Expert Opinion Panel of trained experts to assist all parties including state, private practice and attorneys. A similar process is currently underway internationally under the administration of the International Federation of Gynaecology and Obstetrics, FIGO.

Malpractice claims are currently paid from general healthcare budgets. Every effort must be made to ensure that funds allocated to medico-negligence claims do not negatively impact on health service delivery. A separate budget should be ring-fenced for this purpose.

The State Liability Amendment Bill currently only addresses law suits against service providers in the public sector. This is a matter of concern because it means that a patient who has a claim in the public sector will be afforded remedies in law that is different and possibly inferior to a person who has a similar claim in the private sector. We therefore believe that the whole field of malpractice law should be revisited and there should be no disparity between public and private sectors.

SUGGESTED AMENDMENTS TO THE BILL

PERIODIC PAYMENTS PROPOSED BY THE AMENDMENT BILL (SECTION 2A(i))

SASOG supports the amendment to have periodic payments which may not be less often than once a year. Once-off allocations may be misused or inefficiently spent by recipients, or perhaps not even utilised for future medical treatment. We also recommend that lump sum/once-off payments should remain the norm for past expenses. We do however believe that the Bill needs to be more specific. Legislation does not address fatal outcomes cases and the financial burden on the family. Provision should be made in cases where dependents are compromised by an untimely death due to medical negligence. The specifics of how the quantum pay-out will be managed downstream should also be clarified. The phrase “on such terms as the court considers necessary” in section 2A(ii) should be clarified further. There should be a need-to-need or yearly review of pay-outs in place. Consideration should also be given to the fact that costs of medical devices and other imported goods may increase beyond the CPI.

COMPENSATION FOR FUTURE MEDICAL TREATMENT

Wrongful life, wrongful birth, cerebral palsy, Downs syndrome and birth defect claims are the most common reasons for obstetric medical liability claims. Maternal deaths and surgical complication also contribute to medical negligence claims. Section 2(d) states: “the liability of the state shall be limited to the potential costs that would be

incurred if such care was provided in a public health establishment.” SASOG agrees that if the failed treatment has occurred in a public hospital then the right to compensation should be based on treatment at a similar competently run institution. There is a considerable variation in the standard of care at the different levels at state institutions. There is also variation between provinces. A model of care needs to be developed for the most common disabilities claimed for. This will ensure standardisation of care and equal opportunity for victims of medical negligence. In fact, the care rendered in such a model should be of such a quality that it is also the chosen model for victims of failed care in the private sector. Disparities in care is not supported by our professional bodies.

CONCLUSION

Some of the fundamental causes of the escalating medical malpractice claims are changes in the legal landscape, growth in contingency fee litigation and larger awards made by the courts. This challenge must be tackled through sector-wide law reform. The current public healthcare system is over-burdened and under severe budget constraints and drastic action needs to be undertaken to curb this onslaught. SASOG supports the reform of medical management and clinical governance and have instituted programs such as the Better OBs program and morbidity and mortality review meeting to show our commitment. SASOG therefore appreciates the effort and changes in terms of the Amendment Bill. We trust that this Bill will be improved and comprehensive law reform will follow to address this serious threat.

Presented by Prof Priya Soma-Pillay on behalf of the South African Society of Obstetricians and Gynaecologists 2018

Addressing the litigation crisis in Obstetrics & Gynaecology

Obstetricians & Gynaecologists in South Africa currently face a medico-legal crisis of serious proportions. The premium of occurrence-based indemnity insurance is now more than R1 million per annum, forcing many obstetricians to reconsider not only their choice of indemnity cover provider, but also their ability to provide obstetric care to patients in private practice. Although data is not available, this state of affairs most likely affects choices potential registrars with an interest in the discipline is making, resulting in the potential loss of high quality registrars to the profession.

Although the situation experienced in private practice is threatening the discipline on many fronts, the magnitude of the problem is far more extensive in the public sector, where the provincial health departments face literally billions of rands in contingent liability. The cost of medical litigation in the public sector comes from the health budget and is funded by taxpayers.

High indemnity cover insurance premiums are a reflection of risk as assessed by actuarial calculations based on the number and quantities of claims received by the respective providers. In a model where every discipline basically covers its own risk from contributions of the members of that specific discipline, the consequence of very high risk is, of course, very high premiums.

The natural reaction by many gynaecologists in the discipline to the rapid escalation in fees has for many years been basically a case of “shooting the messenger”, with very limited concrete actions. The BetterObs Programme, started by the immediate past president of SASOG, has been the first concrete attempt to address the problem via improved clinical practice, and many readers in private practice would be familiar with this initiative. This programme includes adhering to South African guidelines for specific conditions, attending mortality and morbidity meetings and improved record keeping.

Limited information has been made available to enable a clear picture of what exactly the problems are that needs to be addressed with regards to litigation in both obstetrics and gynaecology cases. In obstetrics, cerebral palsy (CP), missed trisomy 21 and

structural abnormalities are the main cost drivers. There has been a steady rise in the number of these cases as well as in the quantum associated with settling these cases.

According to limited local obstetric litigation data, around 30% of obstetrics claims are CP related. Of these, 68% were regarded as potentially not defensible claims, with incorrect interpretation of CTG tracing the reason in 52% and poor maternal and foetal monitoring a problem in 28% of cases. In the USA data showed that 70% of all obstetric related claims involved substandard care [1].

Although it is well-known that most CP cases are not due to intra-partum asphyxia, CP claims can be extremely challenging to defend, especially in the presence of abnormal CTG tracings, which is another unreliable special investigation frequently used against the profession in litigation. Cerebral palsy is a complex condition, with many causes and several different pathophysiological mechanisms, but in litigation cases it is frequently described as a simple matter of missed diagnosis of foetal distress or misinterpretation of CTG tracings, with obstetric, neonatology, paediatric neurology and radiography expert witnesses confidently rendering opinions years after the event on almost exactly when the brain injury during labour occurred.

There seems to be a risk in labour wards in private practice that needs to be urgently addressed to reduce obstetric litigation risk. Hospital groups must ensure labour ward nursing staff are well trained and adequate staff numbers are on duty to monitor patients in labour. The possibility of having medical doctors on duty in labour wards, similar to what is available in these hospitals' Accident and Emergency Units in private practice, needs to be urgently investigated and considered for implementation. Similar strategies have been proposed and implemented with some levels of success elsewhere [1,2].

Litigation in gynaecology cases to a large extent follows surgical complications, regardless of the mode of entry. As most surgical procedures in gynaecology are still being performed through laparotomy, complications of open hysterectomy such as bladder and ureteric injuries leaves the gynaecologist at high risk of having to deal with litigation from patients assisted by their personal injury lawyers.

In gynaecologic litigation 63% of cases are deemed not being defensible. Procedures that are not indicated and delayed diagnosis of complications are the two main issues in this regard. More than 30% of litigation can be avoided by ensuring inappropriate procedures are not being performed.

We are currently paying a high price for litigation risk. The public, who is very prone to litigate against doctors, and law practices specialising in personal injury litigation undoubtedly contribute to the current crisis. Unfortunately a large part of the problem results from the practice environment we are functioning in, and we need to improve on this. We need to urgently expand on the initiatives already in place to lower the cost associated with the litigation risk in obstetrics & gynaecology, and we need to find and implement creative solutions to further reduce this risk. The cost of indemnity is our challenge to solve for the sake of our own professional security as well as that of the patients we serve. We will not solve it without changing practice and by continuing to do more of the same.

Prof Leon Snyman

Chair: Medico-legal committee SASOG

5 May 2019

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2. Clark SL, Belfort MA, Byrum SL, Meyers JA, Perlin JB. Improved outcomes, fewer cesarean deliveries, and reduced litigation: results of a new paradigm in patient safety. *Am J Obstet Gynecol* 2008;199:105.e1-105.e7.

SASOG MEDICO-LEGAL COMMITTEE

AVAILABLE INDEMNITY INSURANCE OPTIONS TO OBSTETRICIANS AND GYNAECOLOGISTS IN SOUTH AFRICA

Introduction

The cost of medico-legal insurance has become a huge challenge and many SASOG members simply cannot afford the cover they used to have. This has resulted in many SASOG members not providing obstetric services anymore, to the detriment of society at large and women in particular in South Africa. It is not the intention of this document to address the underlying issues that have contributed to the current medico-legal crisis.

Over the last two to three decades, many role players providing indemnity cover has entered the South African market at premiums undercutting that of the MPS, who has been, and currently still is, the largest indemnity cover provider in South Africa for the past 60 odd years. Historically, none of these alternative role players had been sustainable options, and as a result, MPS has been the sole provider of indemnity cover to doctors in South Africa and to SASOG members for a very long time, resulting in a monopoly. Being the sole provider of a service in a market without competition is not an ideal setting, neither for the medical profession nor for the MPS, who have in this process attracted a lot of criticisms and have been seen by many SASOG members as being part of the problem of unaffordable indemnity cover.

The indemnity cover provider landscape has changed quite significantly in recent times, with some new entries in the indemnity insurance market in South Africa. EthiQal, the medico-legal indemnity insurance arm of Constantia Insurance Ltd, entered the market in 2017, and PPS, who is the most recent entry into this market launched their product on 15 February 2019.

Overview of the available options

SASOG has engaged in the last few months with all these role players and we are fortunate to have been able to establish sound professional relationships with MPS, EthiQal, PPS and Natmed.

The SASOG Medico-legal committee has provided a detailed document describing the business models, philosophies and entities under which the three companies function, and SASOG members are referred to this document on the SASOG website for more information. In essence, MPS and PPS function as mutual organisations. MPS has no profit motive and surplus funds (if any) are invested back into the member fund and used to meet the needs of members. In the PPS model, surplus funds (if any) are allocated to members through the existing models. MPS is a discretionary provider registered in the UK and not regulated by South African financial services sector regulators and regulations. PPS and EthiQal are registered in South Africa and provide insurance products regulated by financial services sector regulators and regulations.

Calculation of subscription premiums

The main difference between EthiQal and MPS (and PPS to some extent) in as far as premiums are calculated, relates to the underlying philosophy used to calculate future risk and the cost thereof. Both MPS and PPS use actuarial calculations based on claims frequency and the projected quantities of claims to enable them to hopefully have enough funds to cover current and future claims that might arise. EthiQal has a different model. Mr Volker von Widdern explained to SASOG that EthiQal has calculated that in most instances it will not be necessary to settle “the R40 million claim”, and their strategy will be to engage with litigation lawyers, professional societies, and other stake holders, including the option of mediation and becoming involved in efforts to care for children with cerebral palsy, in an effort to avoid settling these large claims. This philosophy or strategy, which has not been validated elsewhere, is what is allowing EthiQal at this stage to have premiums much cheaper than the other two providers.

SASOG also met with Natmed, who is essentially a broker and not an indemnity insurance provider in the same sense as the other three companies. Natmed in essence underwrites the EthiQal product.

Expert Opinion Panel

Both MPS and EthiQal have signed memorandums of understanding with the SASOG expert opinion panel (EOP), and although not binding, they appear willing to use and promote alternative dispute resolution of complaints as the initial port of call in finding resolutions, basically in the quest to attempt to reduce litigation. According to Dr Ismail Borhat of the EOP, this is definitely a step forward and only by further engaging with them can we hope to progress even further.

Other relevant matters

SASOG is engaging with indemnity insurers on amongst others, clearer guidelines with regards to reporting of incidents under claims made cover, the conditions that are relevant that will result in the termination of membership, and the sharing of data. All stakeholders have indicated their willingness to engage with SASOG on these issues, and members will be informed regarding developments in this regard. SASOG is available to assist members where required in the process where termination of membership is at stake.

Disclaimer

SASOG is an organisation looking after the interests of its members in the interest of women's health in South Africa. The purpose of this document is to provide SASOG members with information regarding the options available for indemnity cover in South Africa. SASOG does not endorse any one service provider over the other and cannot provide advice to members regarding their choice in this regard. Members are urged to thoroughly investigate the available options before any decisions are taken in this regard.

On behalf of the SASOG Medico-legal committee

Prof Leon Snyman (Chair)

Prof Bash Goolab (bgoolab@iafrica.com)

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Released March 2019

GUIDELINES FOR EXPERT WITNESSES IN OBSTETRICS AND GYNAECOLOGY:

DEFINITION OF AN EXPERT WITNESS

Education, training and experience all contribute to define an expert

- Generally, an expert should have at least five years of practical experience
- An expert should have been actively involved in the relevant field during the last five years
- The specific field and context of each case is relevant and defines who an expert will be
- An expert should have an unblemished academic and clinical standing and must be objective and fair
- The expert should have current knowledge about standards and practise in:

The division or sub-speciality relevant to the case

The relevant health care sector where the case arose

MOTIVATIONS TO BE AN EXPERT WITNESS

The wish to assist the justice system to reach a fair evaluation and conclusion should be the main objective and motivation.

The following motivations are common:

- Personal satisfaction from the competitive nature, variation and status of the work
- Monetary gain or a secondary profession

Regular witnesses must take special care to be objective and available to both parties

Tariffs are set by negotiation; general guidelines to a fee structure are from:

R15 000 for a report

R15 000 for a day or part of a day

R1 500 per hour for consultations

CODE OF CONDUCT

The following principles are critical and can serve as a guideline for experts:

- Remain in the field of special expertise and provide a CV relevant to the case
- Obtain and list the pleadings, evidence and assumptions available at the time of the report
- Never base your opinion and report on the opinion or letter of the plaintiff
- Obtain and research the most current scientific evidence about the case
- Critically and objectively assess the issues relevant to the case
- Logically evaluate the probabilities and reach an opinion
- Motivate how the opinion was reached and summarise

**Prepared by the executive and medico-legal committees of SASOG
with assistance from the Expert Opinion Panel**

Dated: November 2018

The South African Society of Obstetricians and Gynaecologists (SASOG)

CONCERNS OVER MEDICAL NEGLIGENCE SENTENCE

The recent sentencing of an Obstetrician-Gynaecologist to a jail term for manslaughter in a professional negligence matter has received much publicity. This ruling will compel all health care workers and professional societies to rethink their position on this important matter. While SASOG believes that appropriate compensation should be granted when indicated, it is difficult to conceive how this judgement can be in the best interest of any individual or community.

The definition of professional negligence depends on what can be expected from the 'reasonable caring doctor' and not on the actions expected of the 'perfect doctor without any human error'. Distinguishing between these two concepts can be tricky. This distinction, along with the difficulties in evaluating individual liability within a complex health care system, and the benefit of hindsight can complicate judgements regarding negligence and liability. These complexities and the relative nature of the verdict should be kept in mind when sentencing is formulated.

When an increasingly retributive and litigious society believes that someone should carry the responsibility for a bad outcome, it is the medical doctors who bear the inherent risks of invasive medical procedures, interventions and even natural processes like pregnancy and childbirth. In the case under discussion, the pregnant patient elected to have a vaginal delivery, following the advice of her mother above that of the treating obstetrician.

Childbirth carries many inherent risks and complications can occur even in the most experienced hands. The professional advice of the specialist aims to assist a patient to make the safest choice and is usually based on a multitude of factors that influence risk, including complex clinical assessment; quality of nursing care; logistics; available technology; etc. The constitutional autonomous right of a patient to make their own choice regarding treatment is recognized, but with this right comes the responsibility to note and accept the risks inherent to the choice. Professionals are thus placed in a difficult situation when they must continue care of patients choosing not to follow well-considered advice.

Professional indemnity insurance safeguards doctors against financial loss due to claims of clinical negligence and usually provides a somewhat safe environment for medical professionals to continue their careers in service of their patients. However, the relative protection that indemnity insurance provides is undermined by this judgement which, alarmingly, introduces the possibility of jail time as a consequence of medical negligence claims.

When claims arise, public sentiment often favours the claimant who struggles with the consequences and costs of the unexpected poor outcome and courts grant large amounts in compensation. This has caused insurance premiums for specialities carrying higher risk to skyrocket as patients tap into this resource to obtain financial compensation after a sub-optimal medical outcome.

The judgement and sentencing upheld by the Gauteng High Court in this case place enormous pressure on the discipline of Obstetrics - already under siege due to increasing medicolegal onslaught. Comprehensive obstetric indemnity insurance of about R1 million per year is onerous considering the medical aid rate of around R4000 per delivery. This causes fears that more Obstetricians may leave the profession leaving pregnant patients in jeopardy.

Both financial and personal freedom are threatened when a potential jail sentence awaits doctors found guilty of clinical negligence. Inevitably, this finding will affect career choices, scope of practise choices and will probably contribute to the explosion of defensive medicine which already drives medical costs.

Sadly, a life has been lost, the health system has lost a professional and the public will ultimately pay the price of this judgement when costs are passed on to the consumer and a greater number of Obstetricians elect to leave the profession for a lower risk alternative.

Prof Greta Dreyer

SASOG President

May 2019

SASOG voices concerns over jail sentence for gynaecologist

Without having access to the full judgement, the South African Society of Obstetricians and Gynaecologists notes with significant concern the court judgement that upheld the sentencing of a respected colleague to jail in a case of professional negligence. We lament the loss of the young mother following a complicated normal delivery and our hearts go out to the family that lost a mother, sister and daughter.

SASOG supports all efforts to prevent loss of life during childbearing and our own programme to support excellence in clinical practise in Obstetrics, called BetterObs, has been implemented in most private institutions in South Africa. Generally, South African professionals are renowned for their excellence and our private health care sector is world class. Obstetrics is a specialty at high risk for unexpected poor outcomes for both mother and child, which cannot always be prevented. The accompanying significant medicolegal risks has led to an exodus of specialists and defensive medicine is gaining momentum.

In cases of poor outcome and suspected clinical negligence, it should be investigated, and SASOG respects the findings and verdicts of our courts. The sentence passed in this case is however of concern, due to the precedent it creates, the plight of skills in our country, as well as the effects on the individual doctor, his community and the medical and obstetrical profession.

We further hold the opinion that the complexity and expense of repetitive hearings in different forums place an undue burden on the profession. As part of our submission to a recent parliamentary committee, SASOG voiced our support of the principle of a single special tribunal assisted by a selected panel of experts which follows an inquisitorial rather than an adversarial process. SASOG also has serious ongoing concerns about escalating medical malpractice claims relating to changes in the legal landscape, contingency fee litigation and the magnitude of awards made by the courts. We call for urgent sector-wide law reform to address these issues.

The Society is dedicated to the furtherment of our discipline, we are devoted to the welfare of our members and the improvement of the health and wellness of the patient population that we serve. We will continue to support our members and seek the best possible solutions to bring justice and restitution to those harmed during medical treatment whether associated with clinical negligence or not.

Prof Greta Dreyer: President SASOG on behalf of the executive committee 30 April 2019

Litigation in Obstetrics & Gynaecology

Leon C Snyman

B Med Sci, MBChB, M Prax Med, M Med(O&G), FCOG(SA), PhD

Chair: SASOG Medico-legal committee



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OBSTETRICS AND GYNAECOLOGY



UNIVERSITY OF PRETORIA



UNIVERSITEIT VAN PRETORIA
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YUNIBESITHI YA PRETORIA

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Medico-legal committee

Over the past decade – multiple attempts to address this issue



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South African Society of Obstetricians &
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UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

ML crisis and society

“It has never been safer to have a baby and never been more dangerous to be an obstetrician”

MacLennan A, Nelson KB, Hankins G, Speer M. Who will deliver our grandchildren? Implications of cerebral palsy litigation. JAMA 2005;294(13):1688-1690.



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Society

Needs obstetricians

Practice evidence based medicine

Provides affordable care



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The disconnect

The deteriorating claims environment does not reflect a deterioration in professional standards



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Society

SASOG view: The patient is not the enemy

Patients need to be cared for

Compensated when indicated

Sustainable, fair, appropriate



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The obstetric cost drivers

Cerebral palsy

Missed Down's Syndrome

Missed structural abnormalities



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CP

Biggest cost driver

Is a complex issue

Many causes, around 5 – 10% happens during labour

CTG poor test used in court cases as the yard stick

Litigation

Neonatal, paediatric neurology, radiology and obstetric experts
years later confidently opine on when the brain injury occurred



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CP

It is not that simple to confidently know exactly when the brain injury occurred

Despite what might have happened during labour



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Medical litigation is a complex issue

Multi factorial

Causes and some contributors

Internal factors

External factors



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External factors

Lack of patient centred, robust complaints system

Law firms making a living out of medical litigation

The legal process itself

Slow, expensive

Financial incentives to litigate

Contingency – subjective “experts”



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External factors

Clinical negligence

Is very adversarial

Inquest, HPCSA inquiry, civil litigation, prosecution
by the criminal justice system



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Internal factors

Obstetrics

Training midwives, numbers

Insufficient monitoring

Lack of resources in public sector

Many levels: staff, beds, equipment, medicine,
emergency transport



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Medico-legal experts

Contributes to the problem

“hired guns”

“harsh system”

providing an opinion with the benefit of knowing the outcome, clinical picture at the time not as clear cut when the situation is assessed by an “arm chair critic”



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Suggestions

External factors

Remove from the current legal system

Nobody should benefit financially from patient's adverse outcomes

Consider patient centred complaints mechanism with a tribunal or specialist court

Mandatory mediation and dispute resolution efforts



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Suggestions

External factors

Periodic payments – not lump sum

Model that provides care for future medical costs

Same for all



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Suggestions

Internal factors

Ensure safe labour wards

Public and private

Address the issues around surgical complications

Improve the private practice model



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Suggestions

Internal factors

Proper training of expert witnesses



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Conclusions

We can try to reduce risk but we cannot take risk away

Pregnancy has inherent risk

Three maternal deaths a day



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Conclusions

Cerebral palsy

All parents of CP children needs support – not only the few who manage to successfully sue for millions



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Address this urgently

We are running out of time

It is possible that 100 – 150 000 women will soon have to deliver in state facilities

Shift in workload

Shift in medical litigation liability



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Thank you

OBSTETRICS AND GYNAECOLOGY



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EXPERT OPINION PANEL (EOP)

The EOP which is an expert opinion organisation, grouping or panel has been constituted to deal with the enormous medicolegal challenges facing Obstetrics and Gynaecology today.

The vision for the EOP began a few years ago amid the hopeless realisation that litigation in Obstetrics and Gynaecology was spiralling out of control and the major consequence of this was that insurance premiums were rising at an unsustainable rate that was working obstetricians out of the system. A fight back strategy was advanced and out of this realisation emerged 2 fundamental transformational concepts which over time was going to change things. The one fundamental programme was the acceptance that we had to get our own house in order as well as to prevent those adverse events by creating proper management and academic guidelines and maintaining consistency of care and creating benchmarks for standard of care and this has been rolled out in many facilities with many institutions adopting the guidelines, and thus was born the BetterObs programme. The 2nd fundamental transformational concept was how we deal with adverse events from a medicolegal perspective and hence the EOP was born which endeavours to deliver fair, impartial, scientifically based and evidenced based opinions in contradistinction to the serial or hired gun expert rendering biased, singular, maverick and monetary based opinions which is a major issue feeding into the problem. These 2 concepts are intertwined, since if we are going to render an opinion we would be looking at whether optimal or best care practice was followed and whether proper management guidelines were followed. The aim of BetterObs guidelines is not that each and every patient is managed the same way; in fact there is going to be variations in accordance with the clinical scenario but management of a particular case will be judged according to certain accepted benchmarks and in this context to establish if reasonable standard of care was applied.

The EOP is not only about delivering opinions, but is also endeavouring to change the trajectory of the medicolegal course in this country through its structures and academic gravitas by achieving a paradigm and mindset shift to how disputes are approached— by embracing and promoting alternate dispute resolution mechanisms.

The EOP consists of an executive, a board of directors and 50 experts drawn from around the country in all the subdisciplines of Obstetrics and Gynaecology. All experts are vetted and peer reviewed. For each case 3 experts will be allocated to deliver an opinion and from these opinions a consensus will be attempted to be reached which will result in a coalesced single report signed off by the respective chair of the panel. A strict standard operating procedure is in place with checks and balances to render impartial, neutral and fair opinions.

However if the EOP is going to have any significant impact on the medico-legal situation in Obstetrics and Gynaecology, it should become a legal entity or have some legal status. If the complaint is frivolous or vexatious and the opinion reflects that then the case should stop dead in its tracks. If there is merit in the case then mediation or alternate dispute resolution mechanisms should be instituted and a settlement reached. This could be attractive to all parties as there are certainly advantages in immediate settlement, without it going through a costly trial and reputations tattered. This model or variants of it has been successfully used in many countries including Australia, Ireland and Singapore.

The vision for the EOP is thus one of great expectation if the legality comes through as it may become the primary body where medicolegal disputes of the discipline will be directed.

Expert Opinion Panel (EOP)

- Dr Ismail Bhorat:
 - MBChB (NTL), B.Sc (UDW), DA (SA) Dip Mid COG (SA), FCOG (SA), PhD (UKZN), PhD Senior (UKZN)
Fetal-Maternal Medicine (HPCSA Accredited)

Chairman: Expert Opinion Panel

What is the EOP?

The main objective is to serve the discipline from a medico-legal point of view in dispute resolution → major impact already a year since formation.

- EMPHASIS
- Strictly independent, neutral body → renders scientific evidence based, up-to-date, unbiased and accurate opinions
- Distinguished academic nature of the members of the structure of the EOP will ensure this, strict procedural protocol and checks and balances in place,
- Originally mandated by SASOG → Developed due to spiraling cost of indemnity and unrealistic manner of litigation and inappropriate judgments
- It is a service to our members as well as other third parties in medico-legal disputes with the best evidence out there
- It fantails into the BetterObs program and mediation as a whole to resolve medico-legal conflicts.
-

What is the EOP

- Preferred course of action in disputes → resolution through the Mediation process.
- If mediation fails → seek alternate dispute resolution in preference to litigation
- Reasoning – once a case enters a litigation process → years → “locked in” with millions spent irrespective of the outcome

Structure of the EOMC

- Executive
- Chairman: Dr Ismail Bhorat
- Two vice chairs
- Obstetric Panel- Prof. Priya Soma Pillay and
- Gynaecology Panel—Dr. Paul Dalmeyer

- 6 other members make up the Board of Directors – divided between Obstetric and Gynaecological Panel
- Subpanel of Experts → 50 experts across 6 fields of O&G



EOP

- Subpanel of Experts- 6 Categories
- 1. Feto-Maternal Medicine
- 2. Endoscopy
- 3. Obstetrics
- 4. Reproductive medicine
- 5. General gynaecology/urogynaecology
- 6. Oncology

Who is an Expert?

EOP : Academic + Practical Experience + Clinical Standing → Active

1. Subspecialist in field → experienced, recognised and peer acknowledged → academic gravitas
2. Specialist + PhD → clinically experienced, recognised as an expert → peer acknowledged
3. Generalist → Peer-acknowledged and respected as an expert > 15-20 years experience –proven expertise in a particular field

Who is not an expert?

- Serial" so-called experts may represent clients in cases across different fields of O&G, smoking gun assessments without necessary data, retired clinicians supplementing income with a bias
- Generally these "isolated" experts advising either defendants or plaintiffs suit and "serve" the case they are involved in often for monetary gain
- "Traditional expert opinion system" does not equate to an unbiased and equitable legal remedy → not acceptable → cases are often pronounced on singular diverse and maverick opinions/interpretation of experts → unsuspecting generalist → mercy of an unchecked opinion of the expert → "lamb to the slaughter" or "russian roulette" scenario → dependent on the expert

When will EOP render a report

- A complaint must be laid
- Once a HPCSA charge sheet has been issued or once a summons is issued → a medico-legal report may be requested by insurer representing the member, an independent party or attorney. Member not insured can request directly
- Pre-mediation or Mediation process at the request of the pre-mediator/mediator approved by both parties
- In case of a potential adverse event, the doctor must report to the insurer/protection society → instruct insurer to engage EOP as preferred provider of the expert opinion.

Pre- requisites for a report

- Expedite a report - the party/s seeking a report to collect all clinical detail and consents to EOP in a typed legible and complete format
- Case is registered by the approved Case Management System – by EOP Secretariat: Alison Shaw (contact number: 0825538201)
- Screening letter or summary of the adverse event is helpful.
- Will be available for scrutiny if so required
- EOP will stand by the report
- In mediation report be made available to both parties



Continued

- Report –combined effort of 2 to 3 experts (depending on gravity of case) of the EOP and will if possible reach consensus and coalesce into a single report.
- Expert should be sensitive to relevant health care sector where the case arose
- Report → within 6 weeks or less
- Report will be signed off by Chair of the respective panel and Chair of the EOP
- Experts will be called on by rotation
- Conflict of interest: Independent expert advice and reports by a member of the EOP if approached individually may be given in a dispute but will have to recuse themselves from the EOP until completion of the case if it involves the same case.
- EOP reserves the right to render a opinion

Modus Operandi

Complaint → reported to the Secretariat of EOP



Chair or Chair of respective panel



- Preliminary assessment



- Appoint max of 3 experts from expert subpanel



- Single Combined Report



- Signed off by Chair or Panel Chair

EOP

- Present medico-legal path we are on is unsustainable → if there are no changes → it will lead to demise of Obstetrics in the private sector
- One of the main goals of the EOP is to create a paradigm shift or mindset change that there is an alternative to costly and unsustainable litigation → **alternate dispute resolution or mediation should be the primary path to deal with complaints**

EOP Progress

- Already achieved:
- EOP has concluded MOU with MPS and Constantia – that alternate dispute resolution or mediation will be first port of call in any complaint
- HPCSA case → going to be mediated → template for other HPCSA cases



Future Direction: EOP Legal Entity

- Hope to indemnify EOP as a legal entity – to uphold its function
→ approach DOH and Minister of Health in this regard
 - Reduce frivolous and vexatious litigation by pushing the alternate dispute resolution agenda
 - Hopefully in future it will be the primary body where the medico-legal disputes of our discipline will be directed
 - This will markedly drop costs, reduce costly litigation, reach conclusions timeously – attractive to both plaintiffs and defendants
- 