UNIVERSITY OF KWAZULU-NATAL

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A CRITICAL EXAMINATION OF THE STATE LIABILITY AMENDMENT BILL (2018) AND ITS IMPLICATIONS FOR MEDICAL NEGLIGENCE LITIGATION IN SOUTH AFRICA

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DECLARATION

I .....Huben Yenkanna..... declare that—

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ACKNOWLEDGEMENTS:

This dissertation is dedicated to all healthcare workers on the frontline of the COVID-19 pandemic. I salute you for the sacrifices you have made and continue to make to save precious lives.

ABSTRACT:

Medical negligence litigation in South Africa is an ever-growing problem that places a great burden on public hospitals and threatens their ability to render health care services. The number and monetary value of these claims against the State have reached alarming levels. The causes of this increase in claims are multifactorial, but they appear to follow a similar global trend of increasing medical negligence litigation. While other countries have developed legislation to deal with this problem, South Africa has yet to pass legislation to solve the problem. The State Liability Amendment Bill (2018) aims to make changes that would help mitigate the financial burden arising from this litigation against the Department of Health. The Bill's provisions appear to favour the State at the expense of compromising the rights of victims of medical negligence. These provisions include replacing lumpsum payments in favour of periodic payments and having public healthcare facilities render future medical care instead of awarding monetary damages. So far, the State Liability Bill has not been kindly received by various legal commentators, and it is unlikely to withstand the inevitable constitutional scrutiny it will face if passed. The recent Constitutional Court ruling in *Member of the Executive Council for Health, Gauteng Provincial Government v PN obo EN (Member of the Executive Council for Health, KwaZulu-Natal Provincial Government and other as Amici Curiae)* [2021] JOL 49995 (CC) will allow for greater use of the Public Healthcare Defence and Undertaking to Pay Defence which will help lessen the financial impact of successful claims against the Department of Health. This will allow the State more time to give greater thought and consideration into making the State Liability Amendment Bill a fairer proposition for all parties involved in medical negligence litigation.

CONTENTS

CHAPTER 1 – INTRODUCTION

1.1 Introduction:

The South African health care industry is at a pivotal point in its history. Presently, South Africa, and the rest of the world, are facing its biggest medical challenge in the form of the COVID-19 pandemic that has a devastating impact on the lives of its citizens and its economy, the likes of which have never been seen before. At the time of writing, South Africa is in the middle of combating the second-wave of pandemic (as is the rest of the world). There are obvious increased costs to the Department of Health for dealing with this pandemic. The biggest of which will probably be the vaccination program expected to cost the State R4.8 billion to vaccinate only twenty percent of its population.[1] All of this is coming at the time when the Gross Domestic Product of the country is expected to shrink by as much as 5% and when the present ruling government wants to fulfil one of its many promises it has made to South African citizens by implementing a universal healthcare-based system in the form of the National Health Insurance (NHI).[2] The proposed NHI health insurance has been gathering pace in the recent few years, with the release of the green paper in 2011 and the white paper in 2017. Fundamental to the realisation of the NHI is the addressment of the medical negligence litigation that has grown at a tremendous rate over the past 20 years. The Department of Health initially estimated, with no evidence to support this figure, that the NHI would costs around 256 billion when fully implemented in the year 2025.[3] The Institute of Race Relations has commented that the actual figure may well be in the region of R700 billion in the year 2026.[4] Even if you consider an in-between figure, this will still put the NHI at a much higher cost than what the South African government is currently spending on its health budget. With the staggering number of claims against the department and with the potential costs required to realise a fully functioning NHI, it simply cannot afford to lose precious funds to medical litigation. This does not include future litigation which may arise against the State because of its handling of the current pandemic. One avenue that is bound to be problematic for the State is the number of healthcare workers (HCW) infected with COVID-19 and those who sadly died from the infection. By mid-December 2020, South Africa had recorded

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[1] O Singh 'Cost of Covax estimated at R4.8bn to cover 20% of SA population, says Zweli Mkhize' 18 November 2020 *TimesLive* available at *https://www.timeslive.co.za/politics/2020-11-18-cost-of-covax-estimated-at-r48bn-to-cover-20-of-sa-population-says-zweli-mkhize/*, accessed on 25 December 2020.

[2] C Arndt . . . et al 'Impact of Covid-19 on the South African economy: An initial analysis' April 2020 *SA-TIED Working Paper 111* available at *https://sa-tied.wider.unu.edu/sites/default/files/pdf/SA-TIED-WP-111.pdf*, accessed on 14 December 2021.

[3] L Daniel 'Aaron Motsoaledi admits R259 billion NHI figure a thumbsuck.' 2 June 2018 *The South African* available at *https://www.thesouthafrican.com/news/motsoaledi-admits-r259-bn-nhi-figure-a-thumbsuck/*, accessed on 24 December 2020.

[4] 'Government's silence on cost of NHI is worrying, says IRR' available at: *https://www.iol.co.za/news/politics/governments-silence-on-cost-of-nhi-is-worrying-says-irr-51058959*, accessed on: 24 December 2020.

38 000 public HCW's who contracted COVID-19 and 391 of these HCW's who eventually succumbed to the illness.[5] The reason for litigation could come from the fact that a study was conducted into the efficacy of KN95 respirators that were distributed to HCW's in South Africa, with the conclusion noting that, 'The KN95 masks tested failed the stipulated safety thresholds associated with protection of healthcare workers against airborne pathogens such as SARS-CoV-2.'[6] Another avenue of increased litigation due to the pandemic may come from patients who are made to wait longer for elective procedures. An article published online in October 2020 showed a backlog of thousands of procedures in state hospitals.[7] There is always the danger that South Africa may neglect its TB/HIV and Immunisation programs to direct its resources towards fighting the pandemic.

Over the last two decades, there has been a dramatic rise in medical litigation both overseas and in South Africa. In South Africa, the figures are nothing short of alarming. According to an article appearing in the Sunday Times, approximately 80% of claims against doctors for medical negligence arises from doctors in the public sector, with as many as 70% of cases settled out of court.[8] This figure is not surprising as it has been shown that the majority of South African citizens use public health facilities; therefore, it stands to reason they would also bear the burden of increased litigation.[9]

1.2 The causes of medical negligence litigation:

- The causes of medical negligence are well documented. They are multifactorial, which is perhaps the reasons the solution to this problem is complex. It is alleged that changes in the Road Accident Fund (RAF) legislation are one of those reasons.[10] The changes made to the Road Accident Fund Act, 56 of 1996, include capping on the loss of future earnings and loss of support as well as only paying for general damages if serious injury is

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[5] H Isilow 'S.Africa: Over 390 healthcare workers claimed by virus. President tightens COVID-19 restrictions ahead of festive season.' 15 December 2020 *AA.com* available at *https://www.aa.com.tr/en/africa/safrica-over-390-healthcare-workers-claimed-by-virus/2077832*, accessed on 11 January 2021.

[6] L Mottay , J Le Roux , R Perumal , A Esmail , L Timm , S Sivarasu , K Dheda 'KN95 filtering facepiece respirators distributed in South Africa fail safety testing protocols' (2020) *S Afr Med J* 2020 Dec 9;0(0):13162. doi: 10.7196/SAMJ.2021.v111i3.15381. PMID: 33334390.

[7] T Jeranji 'COVID-19: How provinces are catching up on elective procedures' 6 October 2020 *Spotlight* available at *https://www.spotlightnsp.co.za/2020/10/06/covid-19-how-provinces-are-catching-up-on-elective-procedures/*, accessed on 11 January 2021.

[8] S Naidoo 'Thousands of Doctors 'negligent'' *Sunday Times* 6 June 2010 available at *https://www.timeslive.co.za/sunday-times/lifestyle/2010-06-06-thousands-of-doctors-negligent*, accessed on 18 December 2020.

[9] 'General House Survey 2018' 28 May 2019 available at *http://www.statssa.gov.za/publications/P0318/P03182018.pdf*, accessed on 18 May 2020. The survey showed that 71.5% of those survey indicated that the health facility first consulted would be a public clinic, public hospital, or other public institution.

[10] G Howarth, & E Hallinan 'Challenging the cost of clinical negligence.' (2016) Vol. 106(2) *South African Medical Journal* 147. See also G Howarth 'The Rising Cost of Litigation; a Threat to Private Obstetric Care? : Review.' (2013) Vol 23(4) *Obstetrics and Gynaecology Forum* 33-36.

sustained.[11] Personal Injury lawyers are now earning less from RAF claims because of the changes and have now identified medical negligence as a more lucrative area. Other reasons include the Consumer Protection Act, 68 of 2008 (discussed later) as been more favourable to claimants. Patients are also now more aware of their rights. Lawyers are noted to be more aggressive with their advertising. I think it is safe to say that most of the general population has at some point witnessed these advertisements either on television or in the newspapers. It is not simply that there are more litigation cases, but it is also a fact that the value of these claims has risen. The increase in the value of these claims has been attributed to increased medical costs and advancements in medical technology, which results in patients living longer and claiming more for future medical expenses.[12] Malherbe does mention that a 'decline in professionalism' may be a reason for increased litigation; however, he also notes that there 'certain commentators' who do not hold this opinion.[13]

- Van Dokkum also gives mention of the various conducts which may give rise to a medical negligence claim. He lists the following as potential causes[14]:
    - Misdiagnosis[15]
    - Negligence in an operation[16]
    - Negligence in post-operational treatment[17]
    - negligent exposure of a patient to the risk of infection[18]
    - negligence in allowing a dangerous person at large[19]
    - inadequate supervision of inexperienced staff[20]
    - failing to listen to and investigate the patient's complaints[21]
    - negligent in advice or the failure to warn about the risks of an operation[22]

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[11] Road Accident Fund Amendment Act, 19 of 2005.
[12] C Bateman 'Medical Negligence Pay-Outs Soar by 132%--Subs Follow.' (2011) Vol 101(4) *South African Medical Journal* 216, 218. See also G Howarth et al. 'Public Somnambulism: A General Lack of Awareness of the Consequences of Increasing Medical Negligence Litigation.' (2014) Vol 104(11) *South African Medical Journal* 752-3; L Pienaar 'Investigating the Reasons behind the Increase in Medical Negligence Claims' (2017) *Potchefstroom Electronic Law Journal*, *19*, 1-22 available at *https://doi.org/10.17159/1727-3781/2016/v19i0a1101*.
[13] J Malherbe 'Counting the cost: The consequences of increased medical malpractice litigation in South Africa.' South African Medical Journal 2013;103(2):83-84. DOI:10.7196/SAMJ.6457.
[14] N Van Dokkum 'The evolution of medical malpractice law in South Africa' (1997) Vol 41(2) Journal of African Law 181 doi:10.1017/S0021855300009384.
[15] *Buls and Another v Tsatsarolakis* [1976] 2 All SA 89 (T).
[16] *S v Kramer and Another* [1987] 3 All SA 264 (W); *Pringle v. Administrator, Tvl.* [1990] 3 All SA 410 (W).
[17] *Blyth v Van den Heever* [1979] LNQD 1 (A); *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W); *Magware v Minister of Health NO* 1981 (4) SA 472 (Z).
[18] *X v SA Blood Transfusion* Service 1991 TPD (unreported).
[19] *Tarasoff v Regents of the University of California* (1976) 551 P 2d 334.
[20] *S v Kramer and Another* (*supra*).
[21] *Giurelli v Girgis* (1980) 24 SASR 264.
[22] *Esterhuizen v Administrator, Tvl* [1957] LNQD 4 (T); *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C).

The Department of Health paid out R100 million in successful negligence claims in 2010,[23] with this figure rising to R1.9 billion in 2018/2019.[24] The claims against the State for medical negligence were R104 billion in 2019.[25] It should be noted that South Africa is spending only R230 billion on its health budget for 2020/2021.[26] To further emphasise the dramatic rise of medical litigation, let us consider the costs of professional indemnity cover for obstetric specialists. It previously costs obstetricians 'almost R4000 a year in 2000'.[27] This figure rose from R250 000 to R850 000 in the four years between 2013 to 2017.[28] Indemnity costs are now thought to be over R1 million rand per year for obstetricians, with a reported 700% increase in fees over the past 9 years.[29] In terms of the global problem, the UK has spent £1.8 billion on medical negligence claims against its National Health Service (NHS).[30] The claims against the NHS were £56.4 billion 2015-2016 and rose to £65.1 billion in 2017-2018.[31] The obstetric and neonatology specialities were responsible for fifty percent of the value of claims against the NHS.[32]

The public and private health systems are not the only ones to suffer from the consequences of increased litigation. Patients, too, are adversely affected. According to Malherbe, the consequences of litigation include:[33]

- Increased consultation fees for patients.
- More and possibly unnecessary tests were conducted (defensive medicine).
- Health care practitioners are refusing to practice or offer their valuable services to the community.
- Health care practitioners (HCP) are less likely to pursue careers in those professions identified as being highly litigious.

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[23] 'Medical Claims against the state skyrocket' 4 March 2018 *Fin24* available at *https://www.fin24.com/Economy/medical-claims-against-the-state-skyrocket-20180302*, accessed on 11 May 2020.
[24] T Kahn 'Medical-negligence claims soar to R104 billion' 27 January 2020 *Business Day* available at *https://www.pressreader.com/south-africa/business-day/20200126/281956019755891* accessed on 11 May 2020.
[25] Ibid.
[26] D Meyer 'Budget Speech 2020: Increased spending on education and health' 26 February 2020 *The South African* available at *https://www.thesouthafrican.com/news/finance/budget-speech-2020-education-nhi-tito-mboweni/*, accessed 11 May 2020.
[27] M Naidoo 'Obstetrics is in a state of crisis' 4 September 2016 *Iol news* available at *https://www.iol.co.za/news/south-africa/kwazulu-natal/obstetrics-is-in-a-state-of-crisis-2064315* accessed on 12 May 2020.
[28] Ibid.
[29] E Ellis 'Why Specialists won't deliver babies' 14 February 2019 *The Herald Live* available at *https://www.heraldlive.co.za/news/2019-02-14-why-specialists-wont-deliver-babies/*, accessed on 12 May 2020.
[30] 'Medical Negligence: There Are No Winners.' (2018) Vol 391(10135) *The Lancet* 2079.
[31] Ibid.
[32] Ibid.
[33] J Malherbe 'Counting the cost: The consequences of increased medical malpractice litigation in South Africa.' *South African Medical Journal* 2013;103(2):83-84. DOI:10.7196/SAMJ.6457.

- Hospitals will need more money from the provincial budgets to continue operating, resulting in taxpayers paying more to cover these expenditures.

It is no surprise then that Dr. Aaron Motsoaledi, the former Minister of Health from 2009-2019, has on several occasions lamented the current situation that faces the Department of Health. He has even alleged that lawyers may be working with health care workers as a 'syndicate' to defraud the State or purposely lose cases against the State.[34] The former Minister has called on several occasions for legal reform to help rectify the problem.[35] He has even recommended capping malpractice compensation pay-outs.[36] The Department of Health has to its credit, previously held a Medic-Legal Summit in 2015 and a Medical Malpractice Workshop in 2017 to find innovative ways to address these problems. It is no surprise then that the Department of Health (together with the State Attorney and the Minister of Justice and Correctional Services) wrote to the South African Law Reform Commission (SALRC) to 'conduct an investigation into medico-legal claims, especially claims against state…'[37] Issue Paper 33 was published by the SALRC on 20 May 2017, 'which will serve as the basis for the SALRC's deliberations on this investigation.'[38] Issue Paper 33 made many recommendations to address the problem at hand, with one of them being the amendment of the State Liability Act 20 of 1957. This leads us to the State Liability Amendment Bill 2018 (hereafter referred to as the Bill), which was introduced to the National Assembly by the Minister of Justice on 30 May 2018. It is currently under consideration by the National Assembly, having lapsed on 7 May 2019 before being revived on 29 October 2019.[39] According to the Bill, its purpose is to 'provide for structured settlements for the satisfaction of claims against the State as a result of wrongful medical treatment of persons by servants of the State.'[40] The changes it proposes and how they will affect the various parties involved in medical litigation will be the focus of this dissertation. It is also interesting to note

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[34] X Mbanjwa 'Motsoaledi: Negligence claims affect healthcare, hike doctor's fees' 9 March 2015 *City Press* available at *https://www.news24.com/SouthAfrica/News/Motsoaledi-Negligence-claims-affect-healthcare-hike-doctors-fees-20150309* accessed on 15 May 2020. Dr. Motsoaledi was quoted as saying, 'We are aware that these syndicates consist of lawyers and some within the health profession itself to make as much money from the state and other doctors as possible. We are aware that members of these syndicates in the various State Attorneys Offices are mismanaging cases deliberately so that the state must lose at all times.'

[35] C Ndaliso 'Bid to cap medical malpractice payouts' 4 February 2015 *IOL* available at *https://www.iol.co.za/news/politics/bid-to-cap-medical-malpractice-payouts-1813364*, accessed on 15 May 2020.

[36] Ibid.

[37] South African Law Reform Commission 'Medico-legal claims' *Issue Paper 33, Project 141* 20 May 2017 available at *https://www.justice.gov.za/salrc/ipapers/ip33_prj141_Medico-legal.pdf*, accessed 10 April 2020.

[38] South African Law Reform Commission 'Media Statement by South African Law Reform Commission concerning release of Issue Paper 33 on Project 141 - Medico-Legal Claims' available at *https://www.justice.gov.za/salrc/media/20170713-IP33-Pr141.pdf*, accessed on 18 May 2020.

[39] Parliamentary Monitoring Group 'State Liability Amendment Bill' available at: *https://pmg.org.za/bill/797/* accessed 19 May 2020.

[40] State Liability Amendment Bill B16-2018.

that Judge RM Keightley has, as recently as December 2019, ruled in the medical negligence lawsuit of *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government*[41], that 'compensation in kind' replace monetary compensation for future medical expenses.[42] This allows the Gauteng Department of Health to provide for all the plaintiff's future medical expenses rather than a 'once and for all' lump sum. Whilst this ruling was made by developing the common law, it is also one of the Bill's proposed amendments.

1.3 Rationale for the study:

Medical negligence is a massive problem that affects millions of patients around the world. Many countries have implemented changes in legislation to address the problem, which is both fair and just to all parties concerned; however, South Africa has not yet developed any legislation that deals with this specific problem. The Bill, therefore, is one of the actions taken by the government to address this gap. The dramatic rise of medical negligence litigation in South African within a short period also threatens the ability of the Department of Health to meets its constitutional obligations towards the health care needs of its' citizens. If it is to survive, urgent changes are required. However, amendments to current law must be fair and equitable and must not offend any constitutional rights, namely the right to access health care and access to courts. It is the responsibility of the Minister of Health to 'endeavour to protect, promote, improve and maintain the health of the population.'[43] It can be argued that this means providing appropriate compensation to any patients that may suffer because of negligence at the hands of state-employed medical practitioners.

This study will provide insight into the changes that the Bill hopes to achieve and the implications for the concerned parties to medical litigation. At the time of writing this proposal, there does not appear too much academic writing on this topic. The dissertation, therefore, hopes to fill this void for the benefit of medical and legal scholars. It should also rather interesting to noted that changes in the State Liability Amendment Bill will only affect the Department of Health and no other state departments such as the South African Police Services (SAPS) and the Department of Education.[44] The provisions in the State Liability Amendment Bill are directed at addressing claims arising from medical negligence and not claims arising from other forms of negligence by state employees. This is surprising as the SAPS is also costing the State large

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[41] *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* [2019] ZAGPJHC 504; [2020] 2 All SA 177 (GJ).

[42] *KBM* supra. The Judge made the order that, '1. The common law rule requiring that delictual damages must be compensated in money is developed so as to permit a court to order compensation in kind in appropriate cases,…'.

[43] National Health Act 61 of 2003, (ss) 3(1) 'The Minister must, within the limits of available resources- (a) endeavour to protect, promote, improve and maintain the health of the population.'.

[44] Y Sobuwa 'Litigation costing education department' 16 August 2019 *Sowetan Live* available at *https://www.sowetanlive.co.za/news/south-africa/2019-08-16-litigation-costing-education-department/*, accessed on 25 December 2020.

amounts of money evidenced by the fact that the SAPS has paid out R1.5 billion rand for 'wrongful arrests over the past five years', with R535 million being paid out in 2019 alone.[45]

1.4 Statement of purpose:

The purpose of this dissertation is to critically examine the changes proposed within the State Liability Amendment Bill (2018) and its implications for medical negligence litigation in South Africa.

1.5 Research questions:

Main question:

- What are the proposed changes in the State Liability Bill and how will it affect those involved in medical negligence lawsuits?

Sub-questions:

- What is the purpose of the Bill?
- Who are the parties affected by the change in the Act?
- How are they affected?
- Why is there a need for a change in legislation?
- What is the current legislation surrounding medical negligence litigation?
- What were the reasons for the rise in medical negligence lawsuits?
- How do countries compare with litigation pay-outs?
- Are the proposed changes fair and legal to those involved in medical litigation?
- Is the Bill fair to victims of medical negligence?

1.6 Research methodology:

This dissertation was completed using a doctrinal approach. Data was collected from journal articles, textbooks, case law (both local and international), local statutory law. The data was obtained by searching the various databases available to me on the internet and in the UKZN libraries. The collected data was appropriately referenced and stored on my personal computer. The information collected was read and sorted. Its relevance to the dissertation was evaluated and used accordingly. The end date for references used is 30 May 2021.

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[45] E Naidu 'Big payouts, little sanctions in SAPS wrongful arrest cases' 18 October 2020 *IOL* available at *https://www.iol.co.za/sundayindependent/news/big-payouts-little-sanction-in-saps-wrongful-arrest-cases-09b45ef6-df6c-44bb-a5f0-360a92a7450e*, accessed 25 December 2020.

1.7 Outline/structure of dissertation:

The dissertation is structured into chapters. The content of which are as follows:

- Acknowledgements
- Chapter 1: Introduction
- Chapter 2: Medical negligence and the law
- Chapter 3: Vicarious Liability
- Chapter 4: The implications of the State Liability Bill
- Chapter 5: Conclusion

CHAPTER 2 – MEDICAL NEGLIGENCE AND THE LAW

The history of medical negligence dates back thousands of years. The earliest findings on the consequences of medical negligence for the practitioners can be found in the Hammurabi Code in 2030 BC.[46] The code states that 'If the doctor has treated a gentlemen with a lancet of bronze and has caused the gentleman to die, or has opened an abscess of the eye for a gentleman with a bronze lancet, and has caused the loss of the gentleman's eye, one shall cut off his hands.'[47] It is noted that in ancient Greece, death was a form of punishment if a patient died due to negligence.[48] The Germanic empire allowed for the practitioner to be handed over to the family of the victim.[49] Thankfully, the law regarding medical negligence has come a long way since these times, and we now have more reasonable ways to determine the outcome of medical malpractice claims. This is because the law has been developed and legislation created to deal with these matters fairly and equitably. There has been much written regarding the extensive problem of medical negligence lawsuits and its concern for those affected by them. Much of the writing is from first world countries such as the USA, Canada, Australia and the United Kingdom. This is most likely because these countries have been dealing with malpractice lawsuits earlier than the rest of the world. These first world countries also have a higher literacy and education rate, resulting in patients who are more aware of their rights and will therefore more likely to prosecute when their rights are infringed. There is now much literature written in a local context because South Africa is currently experiencing enormous amounts of these claims.

Medical negligence is defined as the failure of a doctor 'to exercise the degree of skill and care that is expected of a reasonable competent practitioner in that particular branch of the profession'.[50] Medical malpractice is a term often used interchangeably with medical negligence, but the meaning is slightly different. Medical malpractice is regarded as a broader term that includes medical negligence and 'intentional acts or omissions.'[51] As recently as 2017, a prominent gynaecologist was given a five-year prison sentence for negligently and deliberately failing to assist a patient who had a post-partum haemorrhage.[52]

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[46] B S Bal 'An Introduction to Medical Malpractice in the United States' (2008) *Clinical Orthopaedics and Related Research*, 467(2), 339–347 doi:10.1007/s11999-008-0636-2 available at *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628513/*, accessed on 24 May 2020.
[47] Ibid.
[48] Pienaar (note 12 above).
[49] Ibid.
[50] D J McQuoid-Mason 'What constitutes medical negligence?' (2010) 7 *Journal of the South African Heart Association* 248–251.
[51] Ibid.
[52] 'High Court rejects gynae's appeal against 5-years' jail for deadly negligence' 24 April 2019 *Medical Brief* available at *https://www.medicalbrief.co.za/archives/high-court-rejects-gynaes-appeal-5-years-jail-deadly-negligence/*, accessed on 13 January 2021.

Innes CJ laid out the test for medical negligence in the case of *Van Wyk v Lewis*[53] where it was said:

> It was pointed out by this Court, in *Mitchell v Dixon*, that 'a medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care'. And in deciding what is reasonable, the Court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs. The evidence of qualified surgeons or physicians is of the greatest assistance in estimating that general level.

Using this 'reasonable doctor' test, the conduct of medical practitioners will be compared to persons of similar skill and knowledge. In other words, a specialists' conduct will be compared to another specialist and medical officer to that of a medical officer.

It should be noted that whilst a court may be guided and regard evidence provided by fellow medical professionals, the courts will ultimately determine whether conduct by the accused medical professional was unprofessional or not.[54] It will not be a medical practitioner who determines this.

Because there is said to be a contractual agreement between a doctor and his patient, victims of medical negligence may bring a lawsuit against their doctor based on both a breach of contract and a commission of a delictual act.[55] Due to this, damages may be sought for both actions if a plaintiff can prove negligence.[56] Contractual damages are intended to put the person affected back in a position he was in previously; therefore, non-pecuniary damages cannot be recovered in a contract. Whilst delictual damages are intended to compensate affected persons for loss suffered and allow for non-pecuniary damages and patrimonial damages.[57]

According to Van Dokkum[58], the most advantageous claim to the plaintiff will be awarded by the Court. Van Dokkum further states that the following damages may be awarded:
'- Actual pecuniary loss, for example, loss of earnings and medical expenses
- pain and suffering
- prospective loss, for example, future medical expenses and loss of earnings.'

It is the responsibility of the plaintiff to prove to the Court the extent of the damages.[59] Losses or damages are usually actuarially calculated based on numerous reports prepared by experts in

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[53] *Van Wyk v Lewis* 1924 AD 438.
[54] N Van Dokkum 'The evolution of medical malpractice law in South Africa' (1997) Vol 41(2) *Journal of African Law* 175-191 doi:10.1017/S0021855300009384.
[55] Ibid, 179.
[56] Ibid, 179.
[57] Ibid, 178.
[58] Ibid, 180.
[59] Ibid, 180.

their field after having investigated the medical records as well as the patient, taking into account the 'inflation rate, (in terms of loss of future earnings), depreciation, life expectancy, retirement age.'[60] Non-pecuniary damages is more difficult to calculate and are based on 'policy considerations and comparable precedent' on a case by case basis[61]. It should be noted that South Africa does not allow for punitive damages (whilst a country such as the USA may impose punitive damages).[62]

2.1 Elements of Delict:

It is well established that there exist five elements of delict, namely[63]:

- Conduct
- Harm or damage
- Causation
- Wrongfulness
- Fault or Blameworthiness/negligence

All these elements need to be proven by the plaintiff to make a successful claim for medical negligence. As mentioned previously, the doctrine of delict is based on common law. A short discussion on each element and its relation to medical negligence litigation will benefit our understanding of delict.

2.2 Conduct:

Conduct refers to an act of commission or omission by a person. An example of an act of commission would be a surgeon who negligently amputates the wrong leg, whilst an example of act omission would be the failure to perform a caesarean section timeously when clearly indicated, resulting in harm to the foetus and/or mother. It should be noted that the conduct or act referred to here is those that are voluntary in nature.[64] Involuntary acts are not regarded in this context as delictual, provided a person was not negligent in creating a circumstance where he or she lost control of their actions. For example, an epileptic person who suffers a seizure whilst driving a car that causes an accident, the conduct would be involuntary as the person had no control over his action whilst having the seizure. However, this person, knowing that he has epilepsy and intentionally defaults on his treatment, should not have placed himself in such a situation. Therefore, this conduct of driving with a serious medical condition after defaulting on treatment may be regarded as negligent conduct.[65]

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[60] L C Coetzee & P A Carstens 'Medical Malpractice and compensation in South Africa' (2011) Vol 86(3) *Chicago-Kent Law Review* 1258.
[61] Ibid, 1286.
[62] Ibid, 1287.
[63] *MTO Forestry v Swart* [2017] ZASCA 57 (SCA); 2017 (5) SA 76 (SCA); [2017] 3 All SA 502 (SCA).
[64] J C Van der Walt and J R Midgley *Principles of Delict* 4th ed (2016) 90.
[65] Ibid 91.

2.3 Harm or Damages:

A plaintiff must have suffered harm to claim delict. This harm does not have to occur at the same time as the conduct.[66] For example, a patient who has an instrument left in his abdominal cavity during surgery may only discover the harm caused years later. As discussed previously, the damages should be quantifiable in terms of patrimonial and non-patrimonial losses. The aim is to compensate the plaintiff for the losses incurred. The nature of the damages awarded is dependent on whether the harmful act was intentional or due to negligence. Negligent acts are proved by illustrating that the harm could have been prevented if reasonable steps were taken, additionally onus needs to be placed on proving how the person or act was negligent. However, negligent acts are easier to prove than intentional acts and awards for negligent acts are generally lesser than awards for intentional acts. Awards for intentional acts would be higher and the act would have to be defined as direct, indirect or *dolus eventualis*, which is often why it is harder to prove than negligence.

2.4 Causation:

Causation refers to the link between the harm suffered by the plaintiff and the actions of the defendant. Both factual and legal causation must be proved. The test for factual causation is the 'but for' test. This test asks whether the harm would have occurred to the plaintiff 'but for' the defendant's actions.[67] Further to this, there is the legal causation that also needs to be proven. This test asks, 'whether the wrongful act is linked sufficiently closely or directly to the loss for legal liability to ensue or whether, as it is said, the loss is too remote.'[68] The tests for legal causation include the 'foreseeability test, the direct-consequence test and the adequate-cause test.'[69] The foreseeability test stipulates that a reasonable person would have foreseen harm arising from his actions or omissions. It does not require a person to have foreseen the exact nature or extend of the harm. The direct-consequence test says that a person is liable if his actions or omissions led to the harm suffered by the plaintiff and there were no intervening acts between the defendants' actions and the harm suffered.[70] The adequate-cause test holds a person liable if their actions are closely associated with the harm suffered.

In *S v Mokhethi*,[71] the Court held that the above-mentioned tests are 'subsidiary tests', which can be used to guide the court 'in a flexible manner so as to avoid a result which most right-minded people will regard as unjust and unfair.'

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[66] Ibid 60.
[67] D J McQuoid-Mason 'Public health officials and MECs for health should be held criminally liable for causing the death of cancer patients through their intentional or negligent conduct that results in oncology equipment not working in hospitals.' *South African Journal of Bioethics and Law* 10.2 (2017): 83-85.
[68] J C Van der Walt and J R Midgley *Principles of Delict* 4th ed (2016) 285.
[69] McQuoid-Mason 2017 (note 67 above).
[70] Ibid.
[71] *S v Mokgethi* 1990 (1) SA 32 (A).

2.5 Wrongfulness:

According to Van der Walt, 'The conduct is wrongful, not because of the breach of the statutory duty per se, but because it is reasonable in the circumstances to compensate the plaintiff for the infringement of his legal right'.[72] The test for wrongfulness is based on the 'legal convictions of the community'.[73] Given this definition, if the doctor's actions violated rights that a patient is legally entitled to, then the doctor's conduct would be regarded as wrongful. Van der Walt further adds that consideration to 'legal policy, constitutional norms and values, the notion of justice, the interests of the litigants balanced against those of the community as a whole, and the consequences flowing from that conduct', must be considered when determining if an action is wrongful or not.[74]

2.6 Fault or Blameworthiness/Negligence

Blameworthiness is assessed by examining the intentions and conduct of the defendant. Intent is assessed subjectively whilst negligence is assessed objectively. Fault is deemed to have occurred if 'the defendant…acted either in a reprehensible state of mind (intent) or with insufficient care (negligence).'[75] It should be remembered that a claimant will not be able to claim double damages for the same injury if intention and negligence are both present.

2.7 Consequences to medical litigation:

According to Malherbe, the consequences of litigation include:[76]

- More and possibly unnecessary tests conducted (defensive medicine).
- Health care practitioners refusing to practice or offer their valuable services to the community.
- Health care practitioners (HCP) are less likely to pursue careers in those professions identified as being highly litigious.
- Hospital will need more money from the provincial budgets to continue operating, and this may result in taxpayers having to pay more to cover these expenditures.

Malherbe also goes one step further by hypothesizing that should private obstetric care end, and all those obstetric deliveries would then need to be done in state hospitals.[77] This would cause an increase in the number of patients in our already overburdened public hospitals.[78] It would also pass the litigation risk of managing these patients from the private sector to the public sector.[79]

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[72] J C Van der Walt 'Delict' *The Law of South Africa* vol 8 First Reissue (2002) part 1 para 61.
[73] *Clarke v Hurst NO and Others* 1992 (4) SA 630 (D).
[74] Van der Walt (note 55 above; 99).
[75] Van der Walt (note 55 above; 225).
[76] J Malherbe 'Counting the cost: The consequences of increased medical malpractice litigation in South Africa.' South African Medical Journal 2013;103(2):83-84. DOI:10.7196/SAMJ.6457.
[77] Ibid
[78] Ibid
[79] Ibid

2.8 Recommendations to improve litigation

There have been several recommendations to remedy the problem. Dhai, in her article 'Medical negligence: alternative claims resolution an answer to an epidemic', recommends capping the value of claims.[80] The author notes that this will help decrease the value of the claims and the number of cases brought to the courts. However, the author also notes that capping of claims may not be fair to the patient and may result in them being inadequately compensated for damages suffered from negligence. Capping of claims can be seen in certain states in the USA. Dhai also believes that any capping of claims in South Africa would inevitably welcome a constitutional challenge.[81] Dhai also feels that 'Apology laws' should also be considered. Apology laws prevent the apology from the health care practitioner from being used as evidence in a litigation case. According to Dhai, apology laws have been shown to reduce payment amounts and have improved the time it takes to settle cases. Apology laws are derived from the disclosure of medical errors and are something that practitioners are hesitant to do for fear of litigation. Dhai also believes that 'specialized health court systems with specialized judges and state-appointed experts' and 'screening panels to weed out frivolous complaints and encourage swift settlement of meritorious claims' will help remedy the problem. Howarth and Pepper also support the introduction of specialized health courts in their articles.[82] Howarth makes further recommendations, including changes of legislation. This includes introducing mediation to settle cases before they get to the court systems. It is noted that mediation is a cheaper alternative when considering the amount of time a case can take to be decided in the court system.

In fact, in 2017, the Gauteng Department and the South Africa Medico-Legal Association (SAMLA) launched a pilot project to utilize mediation to resolve medical negligence cases.[83] This has saved the department money. According to an article published in the Sunday Times, the department was able to save R10 million in just two months of initiating the project.[84] SAMLA also continues to offer workshops to develop more mediators and also provides a register to find qualified mediators who are bound by its code of conduct. Certificates of merit were recommended by Howarth. An independent expert would issue a certificate of merit after

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[80] A Dhai 'Medical Negligence: Alternative Claims Resolution an Answer to the Epidemic?' (2016) Vol 9(1) *South African Journal of Bioethics and Law* 2-3.

[81] A Dhai 'Medico-legal litigation: Balancing spiralling Costs with fair compensation.' (2015) Vol 8(1) *South African Journal of Bioethics and Law* 2

[82] G Howarth 'The Rising Cost of Litigation; a Threat to Private Obstetric Care? : Review.' (2013) Vol 23(4) *Obstetrics and Gynaecology Forum* 33-36. See also M S Pepper & M Nöthling-Slabbert 'Is South Africa on the Verge of a Malpractice Litigation Storm?' (2011) Vol 4(1) *South African Journal of Bioethics and Law* 29-35.

[83] J Simon-Meyer 'Mediation could ease SA's medico-legal woes but it's no quick fix.' 23 August 2017 *Bhekisisa Centre for Health Journalism* available at *https://bhekisisa.org/article/2017-08-23-00-mediation-could-ease-sas-medico-legal-woes-but-its-no-quick-fix/*, accessed on 11 January 2021.

[84] M Zuzile 'Mediation saves Gauteng health millions in negligence cases.' 14 February 2020 *The Sunday Times* available at *https://select.timeslive.co.za/news/2020-02-14-mediation-saves-gauteng-health-millions-in-negligence-cases/*, accessed on 11 January 2021.

reviewing the case. This would help weed out cases without merit from making their way to Court. Many authors have also proposed a no-fault compensation system.[85] This system would allow for patients to be compensated for negligence without suing doctors directly. It is thought that doctors would be more willing to participate in the process of compensation.[86] The use of one independent expert for both parties has also been suggested.[87] This would reduce the costs that parties have to pay for the use of expert witnesses, and it will also prevent bias and conflict of opinions.

2.9 Legislation surrounding medical malpractice:

Pienaar, in her article titled, 'Investigating the Reasons Behind the Increase in Medical Negligence Claims', identified the Constitution of South Africa 108 of 1996, the National Health Act 61 of 2003, the Children's Act 38 of 2005 and the Consumer Protection Act[88] (hereafter referred to as CPA) as reasons for increased litigation.[89] Pienaar notes that these legislations are 'patient-centred'.

2.10 The Constitution of South Africa: the Bill of Rights

Chapter 2 of the Constitution of South Africa (Bill of Rights) guarantees several rights which supports this 'patient-centred' idea. Section 12(2) states that, 'Everyone has the right to bodily and psychological integrity, which includes the right – (*b*) to security in and control over their body;…' Medical negligence is often seen as an infringement in this right as the patients right to bodily integrity is compromised by the negligent action of the health care practitioner, especially when there are allegations of practitioners not taking consent from patients for their treatment. It appears that lack of informed consent is a significant cause of litigation.[90] Section 11 states that 'Everyone has the right to life'. This is self-explanatory, and we know that many lives have been lost over negligence. Section 27 of the Bill of Rights deals with access to health care services. The Bill of Rights also guarantees access to courts (section 34), allowing patients to pursue legal action through our court system.[91] However, this must be taken in context considering that section 36 of the Constitution provides for limitations of any constitutional rights provided 'that the limitation is reasonable and justifiable in an open and democratic society…'[92].

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[85] G Howarth & P Carstens. 'Can private obstetric care be saved in South Africa?.' (2014) Vol 7(2) *South African Journal of Bioethics and Law* 69-73. See also Pepper (note 73 above; 29-35); Howarth (note 73 above; 33-36).
[86] K A Wallis 'No-fault, no difference: no-fault compensation for medical injury and healthcare ethics and practice.' 2017 Vol 67(654) *The British Journal of General Practice* 38-39 doi:10.3399/bjgp17X688777
[87] 'Medical Negligence: There Are No Winners.' (2018) Vol 391(10135) *The Lancet* 2079.
[88] 68 of 2008.
[89] Pienaar (note 12 above).
[90] A Gogos, R Clark, M Bismark, R Gruen and D M Studdert 'When informed consent goes poorly: a descriptive study of medical negligence claims and patient complaints' (2011) Vol 195(6) *Medical Journal of Australia* 340-344. doi: 10.5694/mja11.10379.
[91] Constitution of South Africa 108 of 1996, Chapter 2: The Bill of Rights s. 34 'Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.'.
[92] Constitution of South Africa 108 of 1996 ss. 36(1).

2.11 The National Health Act:

According to the National Health Act[93], the Minister of Health must 'endeavour to protect, promote, improve and maintain the health of the population'. This requirement sets a high standard that the Department of Health must adhere to.

Pienaar suggests that the National Health Act's confidentiality provisions may be a cause of litigation against the state. Pienaar also feels that the informed consent requirements as set out in Section 7 of the National Health Act will also lead to litigation. Pienaar states that patients may use this provision to sue when not adequately consented, whilst previously patients relied on the constitutional right to bodily integrity.[94]

2.12 The Consumer Protection Act

An article by Pepper et al. discusses the CPA[95] and the effect it can have on medical malpractice. They feel that two specific sections favour the consumer in medical litigation.[96] The first deals with section 51 of the Act. The CPA[97] states in Section 51(1) 'A supplier must not make a transaction or agreement subject to any term or condition if— (c) it purports to— (i) limit or exempt a supplier of goods or services from liability for any loss directly or indirectly attributable to the gross negligence of the supplier or any person acting for or controlled by the supplier;' This section prevents health care practitioners and facilities from exempting themselves from liability for gross negligence. Previously the common law prevented gross negligence from being excluded in agreements[98], however this is now incorporated into the Consumer Protection Act.

The next section is Section 61, which deals with liability for damages caused by goods.[99] Applying this section to the medical profession, Pepper feels that negligence on behalf of the doctor does not need to be proved. Instead, one needs only to prove that they suffered harm from

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[93] 61 of 2003.
[94] Pienaar (note 12 above).
[95] 68 of 2008.
[96] M S Pepper & M Nöthling-Slabbert 'Is South Africa on the Verge of a Malpractice Litigation Storm?' (2011) Vol 4(1) *South African Journal of Bioethics and Law* 29-35.
[97] 68 of 2008.
[98] *Afrox Healthcare BPK v Strydom* 2002(6) SA 21 (SCA).
[99] Consumer Protection Act 68 of 2008 s. 61 states that '(1) Except to the extent contemplated in subsection (4), the producer or importer, distributor or retailer of any goods is liable for any harm, as described in subsection (5), caused wholly or partly as a consequence of—
(a) supplying any unsafe goods;
(b) a product failure, defect or hazard in any goods; or
(c) inadequate instructions or warnings provided to the consumer pertaining to any hazard arising from or associated with the use of any goods,
irrespective of whether the harm resulted from any negligence on the part of the producer, importer, distributor or retailer, as the case may be.
(2) A supplier of services who, in conjunction with the performance of those services, applies, supplies, installs or provides access to any goods, must be regarded as a supplier of those goods to the consumer, for the purposes of this section.
(3) If, in a particular case, more than one person is liable in terms of this section, their liability is joint and several.

a product. For example, a doctor may appropriately and correctly prescribe a medication for a patient. If that medication causes harm to the patient, then the patient may sue the producer or the prescriber. Pepper feels that it will probably be easier to sue the doctor, and this may result in more litigation. However, it must be noted that Section 61 (4) (c) does provide a defence for the doctor should the product defect be a manufacturing fault.[100]

2.13 Contingency Fee Act

The Contingency Fee Act 66 of 1997. Section 2(2) states that 'Any fees referred to in subsection (1)(b) which are higher than the normal fees of the legal practitioner concerned (hereinafter referred to as the 'success fee'), shall not exceed such normal fees by more than 100 per cent: Provided that, in the case of claims sounding in money, the total of any such success fee payable by the client to the legal practitioner, shall not exceed 25 per cent of the total amount awarded or any amount obtained by the client in consequence of the proceedings concerned, which amount shall not, for purposes of calculating such excess, include any expenses.'[101] In other words, an attorney is entitled to take no more than double his or her normal party-and-party fee or no more than 25% of the claim amount, whichever amount is the lesser. The Contingency Fee Act[102] allows lawyers to take on cases on a 'no win, no pay' basis. This gives victims, who otherwise would not have pursued legal action, better access to courts for legal recourse. It is well known that pursuing legal action for medical negligence cases is very costly and can take years; therefore, this Act allows for poorer disadvantaged victims to get justice. However, it is noted that the Contingency Fee Act[103] is one of the reasons for increased litigation by Oosthuizen et al., although it must also be noted that this Act allows patients, who not otherwise able to afford it, access to our court systems.[104] It is alleged that the increased fees that the Act allows for is a motivation for lawyers to take on these cases. Basically, it will enable lawyers to charge double their normal fees, up to twenty-five percent of the total value awarded to the plaintiff. When one considers that the cases are usually settled for millions of Rands, one can see why lawyers would be enthusiastic about taking on such cases on a contingency basis. Howarth also alleges that because lawyers are allowed up to twenty-five percent of the total awarded, it causes them to increase the value of the claim.

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[100] Consumer Protection Act 68 of 2008 s. 61(4) states that Liability of a particular person in terms of this section does not arise if (c) it is unreasonable to expect the distributor or retailer to have discovered the unsafe product characteristic, failure, defect or hazard, having regard to that person's role in marketing the goods to consumers; or'

[101] Contingency Fee Act 66 of 1997 ss. 2(2).

[102] 66 of 1997.

[103] Ibid.

[104] W T Oosthuizen & C Pieter 'Medical Malpractice: The Extent, Consequences and Causes of the Problem.' (2015) Vol 78 *Journal of Contemporary Roman-Dutch Law* 269-84.

2.14 The Prescription Act

The Prescription Act 68 of 1969 also allows for victims of medical negligence to bring forth cases against the state three years after the negligence occurs.[105] This, however, does not mean that the prescription period starts immediately at the time of the negligence; rather, it starts from the time the victim became aware of the negligence.[106] In the case of a minor, the prescription period will only start running when the victim becomes a major at the age of eighteen.[107] The Prescription Act[108] is also a contributing factor to medical negligence as it allows a generous time period for litigation cases to be brought forward by victims.

2.15 Conclusion:

There is, without doubt, a significant problem of increased medical litigation that requires urgent action to save our health system. As we can see, there is no specific legislation that deals directly with this problem. If anything, the available legislation supports plaintiffs in their pursuit of litigation for negligence. In South Africa, medical negligence litigation cases are still addressed by the common law, namely the law of delict and the law of contract. It is understandable then that our Government would seek to address this problem through the legislature, namely the amendment of our State Liability Act 20 of 1957.

[105] Prescription Act 68 of 1969 s. 11. 'The periods of prescription of debts shall be the following – (d) save where an Act of Parliament provides otherwise, three years in respect of any other debt.'.
[106] Prescription Act 68 of 1969 ss. 12(3) 'A debt shall not be deemed to be due until the creditor has knowledge of the identity of the debtor and of the facts from which the debt arises: Provided that a creditor shall be deemed to have such knowledge if he could have acquired it by exercising reasonable care.'.
[107] Prescription Act 68 of 1969 ss. 3(1) 'If – (a) the person against whom the prescription is running is a minor or is insane, or is a person under curatorship, or is prevented by superior force from interrupting the running of prescription as contemplated in section 4; or … (c) the period of prescription would, but for the provisions of this subsection, be completed before or on, or within three years after, the day on which the relevant impediment referred to in paragraph (a) or (b) has ceased to exist, the period of prescription shall not be completed before the expiration of a period of three years after the day referred to in paragraph (c).'
[108] 68 of 1969.

CHAPTER 3 – VICARIOUS LIABILITY

According to Price, public entities may be held accountable for damages in four potentially overlapping 'liability regimes'.[109] The first regime is founded on the law of delict; for example, State entities may be held vicariously liable under the State Liability Act[110]. Secondly, 'statutory compensation schemes' such as the Road Accident Fund Act[111] (RAF) and The Compensation for Occupational Injuries and Diseases Act (COIDA) allows for compensations for damages.[112] The RAF provides financial compensation to those involved in motor vehicle accidents in South Africa, whilst COIDA includes compensation for injuries, illnesses and death suffered in the course of employment. Thirdly, Section 38 of the Constitution[113] allows courts to grant 'appropriate relief' for persons who have had their constitutional rights infringed.[114] Lastly, the Promotion of Administrative Justice Act 3 of 2000 (PAJA) has provisions that allow courts to order compensation to be paid.[115] The purpose of PAJA[116] is to hold state organs accountable for administrative decisions taken 'in order to promote an efficient administration and good governance…'.[117] The following chapter will pay attention to vicarious liability and its relationship with state liability.

The doctrine of vicarious liability arose from English Law in the nineteenth century. Neyers defines vicarious liability as 'a liability that is imposed on one person (B) for the torts of another (A) in situations where B has not committed any legal wrong.'[118] Carstens further describes vicarious liability as 'the delict of the tortfeasor is imputed to another person who has a particular relationship of authority over the tortfeasor in the absence of fault on the part of that other person.'[119] In *Minister of Safety and Security v F*[120] vicarious liability was defined as 'the liability that one person incurs for a delict that is committed by another, by virtue of the relationship that exists between them.'

Van Dokkum sets out the following requirements that need to be met in hospital negligence cases for vicarious liability to be proved:[121]

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[109] A Price 'State Liability and Accountability.' 2015 *Acta Juridica* 313-335.
[110] 20 of 1957.
[111] Road Accident Fund Act 56 of 1996.
[112] Compensation for Occupational Injuries and Diseases Act 130 of 1993.
[113] 108 of 1996 s. 38.
[114] The Constitution of South Africa s. 38 states, 'Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights.'.
[115] Promotion of Administrative Justice Act 3 of 2000 ss. 8(1)(c)(ii)(bb).
[116] 3 of 2000.
[117] Promotion of Administrative Justice Act 3 of 2000 preamble.
[118] J W Neyers 'A Theory of Vicarious Liability' (2005) 43 *Alta. L. Rev* available at *https://www.albertalawreview.com/index.php/ALR/article/download/1254/1243/1365*, accessed on 31 January 2021.
[119] P Carstens & Debbie Perlmain *Foundational Principles of South African Medical Law* (2007) 545.
[120] *Minister of Safety and Security v F* (592/09) [2011] ZASCA 3
[121] N Van Dokkum 'The evolution of medical malpractice law in South Africa' (1997) Vol 41(2) *Journal of African Law* 175-191 doi:10.1017/S0021855300009384.

> 'that the person who committed the delict was an employee of the hospital; that he or she performed the act in the course and scope of his or her employment; and what that employee's duties were or with what work he or she was entrusted with at the relevant time.'

An example of a prominent case where vicarious liability in South Africa was adjudicated on includes *Carmichele v Minister of Safety and Security*[122]. In the *Carmichele* case, the plaintiff Carmichele was attacked by a perpetrator who had been released on bail. Carmichele accused the investigating officer and prosecutor of failing to give all pertinent information to the magistrate, which would have resulted in the magistrate not granting the bail application of the perpetrator and therefore, the perpetrator would not have been able to attack Carmichele. Both the trial court and Supreme Court of Appeal held that there was no duty on the prosecutor and police to protect Carmichele; therefore, there was no liability. This decision was overturned by the Constitutional Court, which ruled that the State owed a 'constitutional duty to protect the public in general and women in particular against violent crime.'[123]

The requirement that an employee must be acting within the scope of his or her employment is essential because employers are not always required to bear the damages caused by employees. This was reaffirmed in *K v Minister of Safety and Security*[124], where the court noted that, 'damages should not be borne by employers in all circumstances, but only in those circumstances in which it is fair to require them to do so.'

Whether the delict was committed in the course and scope of the employment has been a problematic issue for courts as many employees' 'deviate' from their scope of practice or job description. This problem was considered in the two high profile cases of *F v Minister of Safety and Security*[125], and *K v Minister of Safety and Security*.[126] On both occasions, the respective plaintiffs were raped by police officers. In *K v Minister of Safety of Security*[127], two tests were developed to determine vicarious liability in 'deviation cases.'[128] The first test looks at the intention of the defendant and whether they 'were acting in pursuit of their own interests or those of their employer.'[129] The second test asks whether there was a close enough link between the conduct and the employment.[130] Although the officers were acting in their own selfish and evil

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[122] *Carmichele v Minister of Safety and Security* (CCT 48/00) [2001] ZACC 22; 2001 (4) SA 938 (CC); 2001 (10) BCLR 995 (CC).
[123] *Carmichele* supra.
[124] *K v Minister of Safety and Security* (CCT52/04) [2005] ZACC 8; 2005 (6) SA 419 (CC); 2005 (9) BCLR 835 (CC); [2005] 8 BLLR 749 (CC).
[125] *F v Minister of Safety and Security* 2012 (1) SA 536 (CC).
[126] *K v Minister of Safety and Security* supra.
[127] *K v Minister of Safety and Security* supra.
[128] H Barnes '*F v Minister of Safety and Security*: Vicarious liability and state accountability for the criminal acts of police officers.' (2014) Jan./Mar. *SA Crime Quarterly* 29-34.
[129] Ibid
[130] Ibid

interests in the above two cases, there was a close relationship between their conduct and their employment. In both cases, the court found in favour of the respective plaintiffs.

Contrast this with the case of *Phoebus Apollo Aviation CC v Minister of Safety and Security*.[131] In this case, the appellant was robbed of a large sum of money. The investigating officer finally traced the money back to the house of one of the robbers' father. Unfortunately, by the time the investigating officer could reach the home, three policemen already visited the father and convinced him to hand over the money to them. Although the trial court ruled in favour of Phoebus Apollo Aviation CC, both the Supreme Court of Appeal and Constitutional Court found that the State was not to be held vicariously liable. Reasons include that the police officers were not on duty, and neither were they performing any of their duties for which they had been authorised to do. The Supreme Court did admit that it can be a very fine line between acts performed in the course of the employment and acts performed for one's own purposes.

Vicarious liability is also subject to further development. Section 39(2) of the Bill of Human Rights states that 'When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purpose and objects of the Bill of Rights.'[132] Judge Nugent, in the matter of *Minister of Safety and Security v Van Duivenboden*[133], noted that the government must 'serve the interests of others', and that Section 41(1) of the Constitution calls for a 'government that is accountable.'[134]

3.1 Theories Relating to Vicarious Liability

There are various reasons for the employment of vicarious liability in the law of delict. J W Neyers explain these in his article entitled, 'A Theory of Vicarious Liability.' These theories include 'control, compensation, deterrence, loss-spreading, enterprise liability, and mixed policy theory.'[135]

The 'theory of control'[136] aims to explain vicarious liability by implying that employees are always under the employers' control. However, the shortcomings of this theory are that although employers oversee employees, they cannot be fully in control of their actions.

The 'compensation theory'[137] holds that the plaintiffs are more likely to be adequately compensated for delictual claims if they sue the employer, as opposed to the employee. This theory is probably the one that is most applicable in the South African context of medical

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[131] *Apollo Aviation CC v Minister of Safety and Security* (CCT19/02) [2002] ZACC 26; 2003 (1) BCLR 14; 2003 (2) SA 34 (CC).
[132] Constitution of South Africa 108 of 1996 ss. 39(2)
[133] *Minister of Safety and Security v Duivenboden* [2002] 3 All SA 741 (SCA)
[134] Constitution of South Africa 108 of 1996 ss. 41(1)
[135] J W Neyers 'A Theory of Vicarious Liability' (2005) 43 *Alta. L. Rev* available at *https://www.albertalawreview.com/index.php/ALR/article/download/1254/1243/1365*, accessed on 31 January 2021.
[136] Ibid
[137] Ibid

negligence. Claims for medical negligence can quickly run into the tens of millions of Rands, which an employee may not be able to pay, or would bankrupt them if they do, whilst the State has deeper pockets due to revenue obtained from continuous tax income. Neyers points out that the source of compensation should not play a part in the decision of who compensates a plaintiff. He also feels that if employers are to be held responsible for the actions of their subordinates, then there should be no need for the requirement that the delict was committed in the course of employment nor that the employee caused it.

The 'theory of deterrence'[138] holds that vicarious liability will be a preventative measure against both employers and employees from committing delictual acts. Neyers explains that employers are 'in the best position to reduce accidents through efficient organisation and discipline of staff,'[139] then they should be held accountable for delictual conduct. This theory extends to employees in that they can be disciplined and reprimanded by their employers should they act negligently and cause legal liability for their superiors.

The 'loss-spreading theory'[140] tries to explain and justify vicarious liability by asking that the loss incurred to the employer be distributed among 'his customers and insurers.' An obvious problem with this is that it is not applicable in all situations. For example, a public hospital that is required to pay out compensation to plaintiffs will have to take money from their annual budget. There is no indemnity insurance available to public hospitals. It also seems unfair that taxpayers, who did not contribute to the wrongdoing at all, will inevitably be the ones to which the loss is 'spread'.

The theory of 'enterprise liability'[141] explains the use of vicarious liability of employers on the basis that since they have created, own and manages the business or/ enterprise, and they should subsequently be responsible for any injury or damages suffered by a plaintiff. According to Neyers, this is based 'on the notion of reciprocity between benefit and burden.'[142] The problem that Neyers finds with this theory is that even a non-profit charitable organisation can be held vicariously liable. However, their primary purpose is to benefit the community they work in without receiving any financial gain.

The mixed policy theory[143] aims to explain vicarious liability by combining the other theories, with the shortcomings of each theory counterbalanced by advantages of other theories.[144]

It should be noted that although public hospitals will carry the burden of vicarious liability and the costs entailed in financially compensating plaintiffs, the Department of Health (DoH) is well

[138] Ibid
[139] Ibid
[140] Ibid
[141] Ibid
[142] Ibid
[143] Ibid
[144] Ibid

within its rights as an employer to recover these losses from the employees who were involved in committing the delict. According to Khoza, provisions within the Basic Condition of Employment Act 75 of 1997 (BCEA)[145], allow employers to approach the court to recover the costs from the employee.[146] They, of course, must prove that the conduct of the employee breached the terms of their employment contract and that loss was suffered as a result. Khoza goes on to state that employers need not always go to court to recover these costs. They can make deductions from the employee's salary (not more than twenty-five percent in a single month), provided they give the employee an opportunity to show why they should not be held responsible for these losses.[147] The Gauteng DoH head, Professor Mkhululi Lukhele, in 2019, wrote a circular regarding the recovery of medical negligence losses from the personnel responsible for the negligence.[148] It does not appear if the Gauteng DoH has acted on this circular at the time of writing. This directive would undoubtedly open a can of worms for the department and would not go down well with healthcare workers or their unions. The difficulty is, if this is indeed imposed on health care workers, negligence in a public hospital setting and context is rarely the result of a single person. It can sometimes be systematic failures such as lack of resources, personnel, malfunctioning equipment, lack of medicines, and long working hours rather than individual failures. How would the department then apportion the blame if there were more than one person responsible? Health care workers should be able to challenge these decisions in courts successfully. It should also be remembered that courts may also hold public health officials personally responsible for negligent failure to ensure that health facilities have proper working equipment.[149]

3.2 The State Liability Act 20 of 1957

The State Liability Act[150] originates from the doctrine of vicarious liability. According to Milton, the doctrine of vicarious liability emerged to oppose the immunity that the State had because of the doctrine that 'the King can do no wrong.'[151] An example of this immunity can be found in *Binda v Colonial Government*[152], where the Cape Supreme Court held that the government could

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[145] ss. 77(3) states that 'The Labour Court has concurrent jurisdiction with the civil courts to hear and determine any matter concerning a contract of employment. irrespective of whether any basic condition of employment constitutes a term of that contract.'.

[146] T Khoza 'Can an Employer Recover Losses from Employees?' *Adams & Adams* available at *https://www.adams.africa/commercial-law/can-employer-recover-damages-employees/* accessed on 31 January 2021.

[147] Ibid

[148] T Broughton 'Gauteng to make doctors, nurses pay out of own pockets for liability claims.' *Sunday Times Daily* available at *https://select.timeslive.co.za/news/2019-09-03-gauteng-to-make-doctors-nurses-pay-out-of-own-pockets-for-liability-claims/* accessed on 31 January 2021.

[149] D J McQuoid-Mason 'Public health officials and MECs should be held liable for harm caused to patients through incompetence, indifference, maladministration or negligence regarding the availability of hospital equipment.' *South African Medical Journal* 2016; 106(7): 681-683.

[150] 20 of 1957

[151] J R L Milton 'The Vicarious Liability of the State for the Delicts of the Police.' (1967) Vol 84(1) *South African Law Journal* 25-36.

[152] *Binda v Colonial Government* (1887) 5 SC 284.

not be held liable for the actions of its employees because 'the government (and by extension the crown) could not be subject to the jurisdiction of its own courts.'[153]. In the same case, the judges felt that immunity was unfair and asked for legislation to correct the problem. This led to the development of the Crown Liabilities Act 37 of 1888.[154]

Subsequently, the Crown Liabilities Act 1 of 1910 repealed the Crown Liabilities Act 37 of 1888 (Cape of Good Hope), Crowns Suits Act 14 of 1894 (Natal), Crown Liabilities Ordinance 51 of 1903 (Transvaal) and the Crown Liabilities Ordinance 44 of 1903 (Orange Free State). The State Liability Act[155], repealed the Crown Liabilities Act.[156]

3.3 The State Liability Amendment Bill 2011:

The State Liability Act[157] was amended in 2011. This change was to address the problem in Section 3 of the Act, which made it difficult for plaintiffs (judgement creditors) who successfully sued a state department to receive the remuneration awarded by the courts. Section 3 of the Act previously stated that:

'No execution, attachment or like process shall be issued against the defendant or respondent in any such action or proceedings or against any property of the State, but the amount, if any, which may be required to satisfy any judgment or order given or made against the nominal defendant or respondent in any such action or proceedings may be paid out of the Consolidated Revenue Fund.'[158]

This meant that the Act did not specify a suitable timeframe for monies to be paid and prevented courts from issuing orders attaching assets and such if the State failed to pay what is owed. The landmark case that drove the change to the Act is *Nyathi v MEC of Department of Health, Gauteng*.[159] Mr. Nyathi was injured on 1 August 2002 after suffering burns due to a paraffin stove being thrown on him. He was treated at Pretoria Academic Hospital and subsequently transferred to Kalafong Hospital. Unfortunately, a central venous line was inserted, by Pretoria Academic Hospital, into the carotid artery rather than the subclavian vein. This led to him suffering a cerebrovascular accident and was left with left-sided hemiplegia that was permanent. He instituted legal action against the Gauteng Department of Health and the Minister for Justice and Constitutional Development in the amount of R1 496 000.

The Department of Health conceded liability; however, they did not pay him timeously. His lawyer wrote a letter to the State Attorney on 27 July 2006 asking for an interim payment. His lawyer then approached the High Court in 2007. The High Court found that Section 3 of the State

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[153] *Zwane v Attorney General and Another* [2004] SZHC 134.
[154] L Boonzaier 'State Liability in South Africa' (2013) 130 *South African Law Journal* 332.
[155] 20 of 1957.
[156] 1 of 1910.
[157] 20 of 1957.
[158] 20 of 1957 s. 3
[159] *Nyathi v MEC for Department of Health, Gauteng and Another* [2008] ZACC 8.

Liability Act[160] to be invalid as it infringed on Mr. Nyathi's constitutionals rights. The decision to not pay Mr. Nyathi timeously was found to infringe the right to obey a decision taken by a court (Section 165(5))[161]. It also 'constituted a material limitation of the right to access to courts and the consequent right to have the effects of successful access implemented (Section 34).'[162] The Constitutional Court also found that Section 195(1)[163] was violated. Section 195(1) deals with the principles and values governing public administration and holding them accountable. The matter was then referred to the Constitutional Court on 30 August 2007, which then confirmed the invalidity of Section 3 of the Act[164]. Subsequently, the Act was amended by the State Liability Amendment Act 14 of 2011. Provisions in Section 3[165] now give specific time frames for when monies should be paid, failure of which can lead to the attachment and sale of state assets. Where once there was no time period for payment, the amended State Liability Act now provides for 75 days for payment calculated from the time of judgment to the date of execution.[166]

3.4 The State Liability Amendment Bill of 2018 & Changes Proposed

The State Liability Amendment Bill B16-2018 was first introduced before the National Assembly on 30 May 2018 by the Minister of Justice. This was followed by public hearings on 31 October 2018 to discuss the Amendments. The Bill lapsed on 7 May 2019 in terms of National Assembly Rule 333(2)[167], but was subsequently revived on 29 October 2019 by the National Assembly. There have been no further developments to this Bill, with the most likely reason being the global impact of the COVID-19 pandemic.

The purpose of the Bill, as stated, is to address the 'surge in medico-legal claims' affecting provincial public hospitals. The changes are specifically applicable to cases of medical negligence only.

The changes in the Bill include:[168]

- replacing once-off lump sum compensation payments for damages with a periodic payment structure for amounts greater than R1 million. This will apply to both past and future expenses;[169]
- the periodic payments will increase annually in line with the consumer price index;[170]

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[160] 20 of 1957 s. 3
[161] Constitution of South Africa 108 of 1996 ss. 165(5).
[162] *Nyathi* supra.
[163] Constitution of South Africa 108 of 1996 ss. 195(1).
[164] State Liability Act 20 of 1957 s. 3.
[165] Ibid.
[166] *Minister of Justice and Constitutional Development v Nyathi and Others* 2010 (4) BCLR 293 (CC).
[167] National Assembly Rule 333 (2) states: 'All Bills before the Assembly or any Assembly committee on the last sitting day of a term of the Assembly or when the Assembly is dissolved, lapse at the end of that day.'
[168] State Liability Amendment Bill B16-2018
[169] State Liability Amendment Bill B16-2018 s. 2A(1)
[170] State Liability Amendment Bill B16-2018 s. 2A(3)

- the court may reduce compensation for future medical expenses by either replacing or reducing the amount, by ordering the State to provide such treatment at one of its institutions;[171]
- future medical care will be provided at an institution that is compliant with standards set by the Office of Health Standards Compliance;[172]
- should future medical care be rendered at a private institution, it shall be done at public hospital rates;[173]
- the proposed changes will be applicable to medical negligence cases that are yet to be concluded in our court;[174]
- the State or injured party may ask the court for a 'variation' in the amount and frequency of periodic payments depending on the circumstances of the case.[175]

An in-depth critique and analysis of these proposed modifications to the State Liability Act[176] will follow in the next chapter.

[171] State Liability Amendment Bill B16-2018 s. 2A(2)(*b*)
[172] State Liability Amendment Bill B16-2018 s. 2A(3)(*c*)
[173] State Liability Amendment Bill B16-2018 s. 2A(2)(*d*)
[174] State Liability Amendment Bill B16-2018 s. 4(2)
[175] State Liability Amendment Bill B16-2018 s. 2A(4)
[176] 20 of 1957

CHAPTER 4 – IMPLICATIONS OF THE STATE LIABILITY BILL

4.1 Introduction

The State Liability Amendment Bill's B16-2018 (hereafter referred to as the Bill) implications are profound as the numerous changes will affect all role-players in medical negligence litigation. However, as this chapter will show, these changes are somewhat one-sided in terms of serving to benefit state health institutions at the expense of patients and their lawyers. The following chapter will further expound on the changes and whether they are fair, reasonable, and equitable in our society without offending our much-lauded progressive constitution.

Before we go further, it must be pointed out that there appears to be a lack of specifics when it comes to the issue of periodic payments. The Bill states that periodic payments and the other provisions are applicable in cases where the amount of compensation to be paid is above R1 million. The Bill, however, does not state the maximum number of years these payments can run before concluding. Neither does the Bill given a minimum amount in each periodic payment. This will be decided by the courts. Why an amount of R1 million was chosen as the threshold for these provisions is also not explained by the Minister of Justice or the Bill itself. Given that medical negligence litigation cases easily run into millions of Rands, the likelihood is that most cases will fall into this over R1 million category and be subject to the provisions of the Bill.

4.2 The State and its Health Facilities

As mentioned earlier, the parties that stand to benefit from this Bill will be the State, the Department of Health, and public health institutions. Hospitals generally do not budget specifically for the paying out of compensation for litigation claims.[177] Money that would have been allocated for the compensation of employment, medication, equipment, security, and other essential services required to keep a health facility operational must now be redirected towards the compensation of successful claimants and their lawyers. As it was mentioned in the previous chapter, the provisions within the current State Liability Act require that compensation must be paid within a maximum of 75 days of judgement.[178] The State does not any longer enjoy the freedom and luxury to pay when they want to or when they can afford to. This means billions of Rands in our health budget are, in fact, not for service provision but for litigation and compensation, resulting in service provision that is compromised in one way or the other through a lack of funds.

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[177] N Nkosi 'Money for health services diverted to pay legal costs.' 19 December 2019 *DispatchLive* available at *https://www.dispatchlive.co.za/news/2019-12-19-money-for-health-services-diverted-to-pay-legal-costs/* accessed on 10 March 2021.

[178] *Minister of Justice and Constitutional Development v Nyathi and Others* 2010 (4) BCLR 293 (CC).

Allowing State hospitals to render future medical care to patients stands to significantly reduce the amount of compensation given to patients. Future medical expenses tend to form the major bulk of the compensation paid out to plaintiffs, as evidenced by *R v MEC of Health,*[179] where the plaintiff's child was left with a right-sided hemiparesis due to negligence of the medical personnel at Job Shimankane Thalane Hospital in the North West Province. In this case, future medical expenses accounted for seventy-five percent of the total compensation handed down in the final judgement.[180]

It is common knowledge that services rendered in a state facility cost significantly less than those rendered in a private health setting. According to a WHO article highlighting this discrepancy in spending, public health spending is less than half of the total spent on health care. Yet, eighty per cent of the population used public health facilities.[181] Given this, it stands to reason that rendering health care at public costs is much less than private healthcare costs and would result in a significant saving for the State. The increased costs of private health were also confirmed by the Health Market Inquiry conducted by the Competition Commission. According to the final report that was published in 2019,[182] the Competition Commission found that '…South African private healthcare market we found that it is characterised by high and rising costs of healthcare and medical scheme cover, and significant overutilisation without stakeholders having been able to demonstrate associated improvements in health outcomes'.[183] Public health facilities already have full-time employees at their disposal who are on a fixed salary. These hospitals have already budgeted to provide these services; therefore, having to see a few additional patients to fulfil this requirement of the Bill will allow significant savings in compensation. Whilst it can be argued that public hospitals are understaffed and under-resourced, the money saved through the Bill may help alleviate the staffing and resource issues. Public health doctors are also not financially incentivised to provide unnecessary appointments, surgical procedures, and assistive devices therefore further bringing down costs of future medical care.

The payment of compensation in structured amounts also saves the State money and minimises the impact that litigation has on their budgets each year. For example, suppose there were five cases awarded against the State at R10 million each. In that case, the court could order that R2 million be paid out each year, and future medical expenses be rendered at a state facility. Therefore, instead of paying R50 million for that year, the State only must pay R10 million. This

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[179] *R v MEC for Health* [2017] ZANWHC 55.
[180] R10 346 385 was awarded to the plaintiff of which R7 774 795 was for future medical expenses.
[181] 'Bridging the gap in South Africa.' (2010) Vol 88(11) *Bulletin of the World Health Organization* available at *https://www.who.int/bulletin/volumes/88/11/10-021110/en/* accessed 10 March 2021.
[182] GN 1533 of GG 42861, 29/11/2019 24-280.
[183] M Sibanyoni 'Competition Commission slams high cost of private healthcare and medical scheme cover.' 30 September 2019 avialable at *https://www.sowetanlive.co.za/news/2019-09-30-competition-commission-slams-high-cost-of-private-healthcare-and-medical-scheme-cover/,* accessed on 10 March 2021.

potential saving could mean the difference of hospitals being allocated additional staff and resources to carry out their duties. Additional hiring of staff could improve South Africa's poor doctor: patient ratio. According to George et al., South Africa had a ratio of 0.8 doctors to 1000 people in 2016.[184] The same article ranks South Africa as the '16th worst doctor: patient ratio of 67 countries.'[185] The shortage of medical staff has long been recognised as a factor contributing towards adverse patient health outcomes; hence addressing this could help alleviate the problem of medical negligence. Compensation for future medical expenses is calculated, taking into consideration the life expectancy of the patient. In this regard, should a patient pass away at an earlier than expected age, the hospital would further save money as they would not have to render further services to this patient. The same can be assumed if the courts had ruled that future medical expenses should be paid in money. Should the patient pass away, the Bill provides for stopping periodic payments for future medical expenses and future loss of earnings as the patient does not need this money. This is an obvious and major benefit over the lumpsum payments, where the money for future medical expenses would be lost even if the plaintiff passed away sooner than expected.

Similarly, the healthcare environment and resources available to doctors has also been identified as a cause of medical negligence in South Africa.[186] Additional available funds could very well improve this factor if the money is spent correctly. Doctors are often expected to exercise reasonable skill and care, yet we do not consider the difficult environments that they are expected to practice these skills. Prudent spending of their funds that would have otherwise be lost to litigation could result in current facilities being brought up to the standards required as set out by the Office of the Health Standards Compliance and building new facilities.

4.3 The Patient

Whilst state facilities stand to benefit the most from the changes in the Act; the converse is true that victims of medical negligence will be the ones who stand to lose the most. Almost every change will have negative implications for patients. It should be prefaced that patients face difficulties and are somewhat of a disadvantage in litigation cases. Challenges faced by patients include what Van Dokkum regards as a 'conspiracy of silence', whereby doctors are hesitant to give evidence against their colleagues.[187] Another deterrent faced by patients is that in medical negligence litigation in South Africa, the loser of the case will be responsible for paying for his

[184] A George … et al. 'Doctor retention and distribution in post-apartheid South Africa: tracking medical graduates (2007–2011) from one university.' (2019) Vol 17 *Human Resources for Health* 100.
[185] Ibid.
[186] W T Oosthuizen & P Carstens 'Medical Malpractice: The Extent, Consequences and Causes of the Problem' (2015) Vol 78 *Journal of Contemporary Roman-Dutch Law* 269-284
[187] N Van Dokkum 'The evolution of medical malpractice law in South Africa' (1997) Vol 41(2) *Journal of African Law* 175-191 doi:10.1017/S0021855300009384.

own legal costs and that of his opponent.[188] Fighting medical negligence cases can easily run into the millions when you consider the time involved and the number of expert witnesses required to make a claim successfully. Van Dokkum also mentions that South African courts do not tend to use the doctrine of '*res ipsa loquitor*'. This doctrine has been used successfully in the USA as it helps negate the 'conspiracy of silence' employed by medical professionals. Translated, it means 'the facts speak for themselves' and can be defined as a doctrine that 'allows the plaintiff to infer negligence of the alleged wrongdoer merely from the fact that the incident, which was under the exclusive control of the defendant, actually happened, that the incident would not have happened in the absence of negligence and that the plaintiff did not contribute to the harm by his own negligence.'[189] Patel advocates that using this doctrine (which is used in other countries) would help a patient in medical negligence cases. Therefore, it would support their right in terms of Section 34 of the Constitution.[190]

The first issue to be addressed is whether it is fair to patients to have future medical care at a public health facility. In this scenario, it may well be that the patient will have to return to the same health facilities where they became the victims of negligence. It may also be that they will be treated by the same health care workers responsible for negligence in the first place. It would appear to be an infringement of the right to dignity. Having to force patients back to the same facility where they were mistreated can only cause a form of secondary trauma and subject the patient to the authority and care of those who failed to protect their health in the first place. It would also infringe upon the right to choose your health facility as promised in the South African Patients' Rights Charter.[191]

While some may argue that the patient does not need to be treated by the same facility and can go to another public facility in the area, this may not always be the case in smaller towns where only one health facility is available. There is also the possibility that the offending facility is the only one in the area that can provide the service or care that the patient requires.

In terms of Section 2A(2)(d) of the State Liability Amendment Bill, if the patient cannot receive a service at a public institution, he or she must go to a private health facility, but the State will only pay public service rates for that service rendered at the private facility. This is unfair as the private hospitals are under no obligation to charge fees that are in line with public rates, and

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[188] L C Coetzee & P A Carstens 'Medical Malpractice and compensation in South Africa' (2011) Vol 86(3) *Chicago-Kent Law Review* 1258-1286.
[189] B Patel 'Medical Negligence and *Res Ipsa Loquitur* in South Africa' 2008 Vol 1(2) *South African Journal of Bioethics and Law* 57-60.
[190] Ibid.
[191] The Patients' Rights Charter, available at *http://www.kznhealth.gov.za/Patientcharter.htm*, accessed on 25 February 2021. The Patients' Rights Charter states that: 'Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers or facilities, and the choice of facilities in line with prescribed service delivery guidelines.'.

then it will be the patient who must pay the difference. But for plaintiffs who have not been paid money for future medical services will have to pay out of other funds they receive. This problem could happen in areas where the patient has access to only one private medical facility, and there is not an opportunity to shop around for one that will charge fees in line with state prices. The State will have to arrange with private hospitals if they want to make this work. This will require additional administrative work. No specifics are mentioned in the Bill about how exactly this will work, whether patients will pay the private facility and then claim back from the State or whether the patient will have to seek approval from the State before visiting the private facility. Either way, it adds on unnecessary work for the patient, who at this time should only be focusing on their health and not administrative issues. Making a successful claim against the State should empower the patient to live and rectify their health issues, not make their lives harder by asking that they worry about payment issues.

As I have mentioned previously, the cost of private care is higher than public care, and unless the State has some way of regulating what private fees may be charged, it will mean that patients are subject to further hardship and inconvenience. There is also the danger that in smaller rural areas of South Africa, the patient will not receive future medical care from the public facility, and there might not be a private facility available to treat the patient. In this case, a patient who previously would have been paid a sizeable lump sum in compensation could potentially move to an area where the required treatment is available. It will also be more convenient for a patient to attend one facility for all their needs. In the Bill's current provisions, plaintiffs may be required to be patients of both private and public facility (possibly more than two facilities depending on what services they need and what is available). This would mean that the patient has two or more set of doctors that are attending to their needs. Comprehensive and holistic care requires good communication between all treating practitioners. There is a high possibility that since the practitioners are working at different institutions, they may not effectively communicate and discuss with each other regarding the management plan of the patient. There is also a chance that there may be a disagreement regarding the best care for the patient, which may negatively affect the patient's health.

An interesting situation will arise if there is disagreement regarding what is best for the patient. We know that the private industry has been guilty of 'over-servicing' patients as private practitioners are motivated by the prospect of extra income for services provided.[192] What will happen if the State feels that an unnecessary procedure has been performed on the patient? Will they be able to dispute the obligation to pay for that service rendered? In such a situation, how

[192] 'Massive problems with South Africa's private hospitals and medical aids – here's what you need to know.' 30 September 2012 *Business Tech* available at *https://businesstech.co.za/news/lifestyle/343626/massive-problems-with-south-africas-private-hospitals-and-medical-aids-heres-what-you-need-to-know/*, accessed 20 March 2021.

much authority will be given to the patient's autonomy in choosing which treatments he receives? A patient may agree to have the procedure that was offered by the private health care facility but then be denied because a public health facility feels it is unnecessary. Whose voice will be given greater authority in such a case? This is a possibility if patients are co-managed by both state and private facilities. The Bill does not mention whether there will be a case manager appointed who can oversee and coordinate services that will prioritise the patients' health and help avoid conflict between private and public medical practitioners.

Section 2(c) of the State Liability Amendment Bill requires that future medical care at State facilities need to be provided at establishments that are 'compliant with norms and standards as determined by the Office of the Health Standards Compliance (OHSC) established in terms of section 77 of the National Health Act, 2000.' The chances of this being enforced are rather slim if non-existent, as a report by the OHSC in 2017 found that only a meagre five out of 696 hospital and clinics achieved an 80% 'pass mark.'[193] It is rather interesting that this provision was included by the authors of the Bill when considering the State's poor records when it comes to meeting the OHSC requirements.

Periodic payment also creates the possibility that patients may be required to approach the courts again if payments are not made as stipulated by the State. Again, this will create additional work and hardship for the patients. It will also require them to consult their lawyers and pay them.

There is also the issue of delay of justice by enforcing periodic payments. The South African Law Reform Commission report on medico-legal issues illustrated the point that medico-legal claims could take many years before they are settled. The report tabulates 19 cases of various negligence, with cases taking a range from three to sixteen years to be settled.[194] Patients are therefore already waiting a substantial time for judgement to be passed on their claims. Periodic payments create a further delay in finality and, consequently, a delay in justice when judgement has already been passed in the patient's favour.

It also is troubling that the Bill only addresses medical negligence cases and not any other claims against the State. As I have mentioned previously in Chapter 1, the South African Police Services are another department responsible for many litigation cases. Whilst they are nowhere near the scale of the Department of Health in terms of pay-outs, it does not make sense as to why the Bill is only singling out medical negligence when it can, in one swoop, create a blanket rule for all litigation against the State. Victims of medical negligence may very well claim that they

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[193] T Khan 'Only five out of 696 hospitals, clinics got a 'pass mark' in SA.' 6 June 2018 *Times Live* available at *https://www.timeslive.co.za/news/south-africa/2018-06-06-only-five-out-of-696-hospitals-clinics-got-a-pass-mark-in-sa/* accessed 11 March 2021.

[194] South African Law Reform Commission 'Medico-legal claims' *Issue Paper 33, Project 141* 20 May 2017 available at *https://www.justice.gov.za/salrc/ipapers/ip33_prj141_Medico-legal.pdf*, accessed 10 April 2020.

are being discriminated against by this Bill. The question then becomes, is this discrimination, which is based on the type of litigation against the State, fair or unfair? This then would become an issue of equality. Section 9(1) of the Constitution[195] clearly states that, 'Everyone is equal before the law and has the right to equal protection and benefit of the law.' From our discussion so far, we can see that this Bill would not be protecting or benefiting victims of medical negligence when compared to the current system of lumpsum payments and compensation.

The aim of compensation in delict is to put the plaintiff in the same position he or she was previously before harm was suffered. If the Bill was enacted in its current state, one wonders if this will indeed be the case. A concern is also what will happen if the State does not hold up their end of the bargain. As discussed previously, these cases already take a considerably long time before judgement can be passed. We would then be in a situation where we are unnecessarily adding to the longevity of the patient's pursuit for justice.

4.4 The Lawyers

The Contingency Fee Act[196] is one of the methods available to patients to pay for legal fees. The Contingency Fee Act[197] allows lawyers to charge double their usual fees up to a maximum of twenty five percent of the amount awarded to their clients.[198] Taking on cases on a contingency basis is a means of allowing patients access to courts with good legal representation. According to a report conducted in 2015 by Statistics South Africa, almost half of the adult population is living below the 'upper-bound poverty food line.'[199] Many of these patients, therefore, do not have the means to afford high advocate lawyer fees. The fees of an advocate are extremely high in South Africa, as noted by the Socio-Economic Rights Institute report on 'Public Interest Legal Services in South Africa.' The reports state that:

> 'a first year junior advocate charges from approximately R550 per hour or R5 500 per day. Counsel of ten years' standing can charge between R1 500 and R2 400 per hour (or between R15 000 and R24 000 a day). Senior counsel who has been given 'silk' status by the President, charge between R25 000 and R35 000 per day, with some counsel rumoured to charge up to R60 000 per day in high-value commercial matters.'[200]

Interestingly, one wonders how the combination of periodic payments and contingency fees will work in the lawyer-client relationship. If R10 million was awarded to a plaintiff on a periodic

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[195] 108 of 1996 ss. 9(1).
[196] 66 of 1997.
[197] Ibid.
[198] Ibid ss. 2(2)
[199] 'Men, Women and Children - Findings of the Living Conditions Survey 2014/15' 2018 *Stats SA* 13 available at *http://www.statssa.gov.za/publications/Report-03-10-02%20/Report-03-10-02%202015.pdf*, accessed on 22 March 2021. The reports defines, 'Upper-bound poverty line (UBPL) = R992 per person per month. This also uses the food poverty line as a base plus the average amount derived from non-food items of households whose total food expenditure is equal to the food poverty line.'.
[200] 'Public Interest Legal Services in South Africa,' *Socio-Economic Rights Institute* 103–4.

payment basis of R1 million per year, and that plaintiff had agreed to a contingency fee of twenty-five per cent of the total, the lawyer would be entitled up to R2.5 million. How would the lawyer's fee be settled? Would the lawyer take the first two and a half payments (leaving the patient without compensation and further delaying justice), or would the lawyer take a percentage of each subsequent payment till he was fully paid? Would he add interest and any additional admin fees to this amount? This can create complications that a victim of medical negligence should not have to bear, considering what they have already had to endure. As it has already been shown, cases can take several years before judgement is passed; therefore, lawyers will now have to consider this before committing to fight cases against the State. Conversely, the issue of periodic payments and future medical care may prolong the lawyer-patient relationship and could mean more billable hours of work for lawyers if, as explained in the paragraphs above, the plaintiffs may need to approach the courts again regarding these issues after judgement has been passed.

Also concerning for lawyers is Section 4(2) of the Bill[201] that states that claims of medical negligence that have not been concluded yet will be subject to the Bill's provisions. This seems grossly unfair to lawyers who took on cases with the expectation that they would be paid a lump sum figure when judgement was passed. It is possible that some attorneys may not have taken on some of these cases if they had knowledge of the Bill. These lawyers may have already invested a substantial amount of time and resources in the case and may not be fully compensated for it.

4.5. Conclusion:

While some of these possible scenarios mentioned are hypothetical worst-case scenarios, courts may choose to deviate from periodic payments and future medical care by allowing compensation to paid in full as it has always been doing. This, however, will not be in keeping with the purpose and vision of the Bill, which is to reduce the financial burden created by medical negligence litigation on the State. If the Bill were passed in its current state, it would be interesting to see what criteria and determining factors are used for each case to decide whether periodic payment and future medical care would be allowed. As the Bill stands, the clear winner is the State at the expense of the victims of medical negligence. The most concerning aspect of the Bill is its lack of specifics regarding how structured payments will work exactly. Since it is not specific, it means that courts will have the prerogative to decide the nature of the structured payments.

[201] B16-2018 ss. 4(2)

CHAPTER 5 – CONCLUSION

5.1 Introduction

The South African government has a mandate to ensure the provision of quality health services to its citizens. This is enshrined in our Constitution and the National Health Act. It is then understandable that government would take the necessary legislative measures to protect the Department of Health so that it can continue to fulfil its constitutional duty to provide quality health services to its citizens. The State Liability Amendment Bill is a means to ensure that the health system does not crumble and leave millions without health care. It comes at a time when the financial resources of the country are being stretched to a breaking point. This is evidenced by the fact that the State has reneged on a three-year agreement signed in 2018 to increase public servant wages.[202] The Auditor-General Tsakani Maluleke has also recently released her report for the year 2019/2020, stating that the Department of Health has R105.83 billion worth of claims against it.[203] Whilst it has been shown that some of what the Bill proposes is unreasonable and questionable, there is some local and international precedent for these changes. These have been highlighted in the Law Commission's report on medico-legal claims.[204]

Regarding the issue of periodic payments, the Commission's report points out that the Occupational Diseases in Mines and Works Act 78 of 1973, the Compensation for Occupational Injuries and Diseases Act 130 of 1993, and the Road Accident Fund Act 56 of 1996 all allow for structured payments.[205] The Commission's report further explains that countries such as Canada (The Ontario Courts of Justice Act RSO 1990 Chapter C.43), Australia (Civil Liability Act 22 of 2002) and the United Kingdom (Damages Act 1996 c. 48) have all enacted legislation to require periodic payments for medical litigation cases.[206]

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[202] K Magubane 'Directors-general tell ConCourt public service unions' wage bid has no chance of success'. 11 March 2021 *news24* available at *https://www.news24.com/fin24/economy/directors-general-tell-concourt-public-service-unions-wage-bid-has-no-chance-of-success-20210311*, accessed on 2 April 2021.
[203] B Curson 'Auditor-General continues to push for accountability' 1 April 2021 *Moneyweb* available at *https://www.moneyweb.co.za/news/south-africa/auditor-general-continues-to-push-for-accountability/*, accessed 2 April 2021.
[204] South African Law Reform Commission 'Medico-legal claims' *Issue Paper 33, Project 141* 20 May 2017 available at *https://www.justice.gov.za/salrc/ipapers/ip33_prj141_Medico-legal.pdf*, accessed 10 April 2020.
[205] Occupational Diseases in Mines and Works Act 78 of 1973 ss. 94(3)(b) states: '(3) The commissioner may pay any pension or any instalment of a one-sum benefit awarded under the previous Act or this Act— (b) in part to the beneficiary and in part to his dependants.'. See also Compensation Occupational Injuries and Diseases Act 130 of 1993 Section 54 deals with the compensation of an employee with a monthly pension payment and the Road Accident Fund Act 56 of 1996 ss. 17(4)(a) states: '(1) The Fund or an agent shall— (4) Where a claim for compensation under subsection (1)— (b) includes a claim for future loss of income or support, the amount payable by the Fund or the agent shall be paid by way of a lump sum or in instalments as agreed upon'.
[206] Ontario Courts of Justice Act RSO 1990 Chapter C.43 ss 116.1 states: '116.1 (1) Despite section 116, in a medical malpractice action where the court determines that the award for the future care costs of the

5.2 Public Hearings into the Bill

On 31 October 2018, the members of the public were allowed to discuss the Bill at the public hearing. The public hearing into the Bill highlighted many of its shortfalls. The backlash it received during the hearings can be summarized as follows:[207]

- the Bill does not address the issue of negligence from health care workers;
- issue was taken with the Bill stating that the court 'must' order structured payment.[208] It was felt that this leaves court with little discretion to rule in whatever way is best;
- the Bill tackles the problem for the public sector but not the private sector;
- the Bill does not tackle corruption as a means to save money in the health sector;
- possible tax implications for plaintiffs receiving periodic payments;
- CPI increases of periodic payments may not be accurate;
- very few hospitals are Occupational Health and Safety Compliant.

5.3 Alternative Dispute Resolutions

Given that the Bill is facing much criticism, the government may be better off looking at other approaches to remedy the problem at hand. There are many alternatives to a court-based litigation system. These can be broadly termed as Alternative Dispute Resolution (ADR) methods. Susek defines ADR as 'a wide variety of techniques aiming at finding solutions to the disputes between parties without costly and long court procedure'.[209] The same authors suggest that ADR includes 'negotiation, mediation, conciliation, or arbitration, but also complaints and grievance procedures, ombudsman procedures, dispute-resolution board procedures, expert intervention and others'.[210] The benefits of ADR include saving on time, money and improving satisfaction between the parties.[211] Susek states that the average time for litigation in the European Union is 566 days, whilst mediation takes on average 43 days.

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plaintiff exceeds the prescribed amount, the court shall, on a motion by the plaintiff or a defendant that is liable to pay the plaintiff's future care costs, order that the damages for the future care costs of the plaintiff be satisfied by way of periodic payments. 2006, c. 21, Sched. A, s. 17.' The definition of a prescribed amount is noted to be $250 000. See also Damages Act 1996 c. 48 ss. 2(1) states: '(1)A court awarding damages for future pecuniary loss in respect of personal injury—
(a) may order that the damages are wholly or partly to take the form of periodical payments, and
(b) shall consider whether to make that order.' and Civil Liability Act 22 of 2002 s. 15 states: '(1) This section applies if the parties to a claim for personal injury damages make a structured settlement and apply to the court hearing, or with jurisdiction to hear, the claim for an order approving of, or in the terms of, the structured settlement.
(2) The court may make the order even though the payment of damages is not in the form of a lump sum.'.

[207] 'State Liability Amendment Bill: public hearings' *Parliamentary Monitoring Group* available at *https://pmg.org.za/committee-meeting/27412/*, accessed on 2 April 2021.

[208] State Liability Amendment Bill B16-2018 ss 2A(1).

[209] P Šustek & T Holčapek 'Alternative Dispute Resolution in Medical Malpractice Disputes' (2017). RADIC, Zeljko, RONCEVIC, Ante, YONGQIANG, Li et al. Economic and Social Development: 22nd International Scientific Conference on Economic and Social Development – 'The Legal Challenges of Modern World': *Book of proceedings*, 233-242, available at SSRN: *https://ssrn.com/abstract=3213596.*

[210] Ibid.

[211] Ibid.

As previously stated, in South Africa, cases take many years to be settled or adjudicated. This would be a significant improvement for all parties concerned. It would also benefit the courts by lowering the number of cases that come before it. In KZN alone, there were 2600 claims against the KZN Department of Health at the end of 2019.[212] The costs benefit of ADR is also significant. Susek et al. claim that litigation costs 9.179 € on average, whilst mediation only costs 3.371 €.[213] An added benefit of ADR is that less money is wasted on legal and court fees. According to Walters, only 30-45% of settlement money makes its way to the patient. The rest is lost in legal fees and expert witness expenses.[214] In fact, the benefits of mediation are already being felt in South Africa. The Gauteng Department of Health has stated that it saved R10 million in the two months since it launched its pilot project to use mediation.[215] Courts in Florida, USA, are required to refer cases for mediation first, and should that fail, litigation can proceed.[216] Perhaps the State were better off adopting this as a policy in the Bill.

5.4 *MSM obo KBM v MEC for Health* – 'Public Healthcare Defence' and the 'Undertaking to Pay' defence

Special mention must be made of the judgement found in *MSM obo KBM v MEC for Health*[217]. In this case, the minor child K sustained a brain injury during her birth in 2012, resulting in her having cerebral palsy. The MEC asked the court to develop the common law of delict to allow payment in kind, rendering future medical expenses at public facilities rather than paying out a lump sum for such services. This became known as the 'Public Healthcare Defence'.[218] Judge Keightley ruled in favour of the MEC after hearing from many of the State-employed witnesses who convinced the court that the child would receive the same level of care that she would in a private setting. This ruling has great implications for the Department of Health going forward. It grants the Department relief in the same way that Section 2A of the State Liability Amendment Bill would have done so. It provides a tremendous opportunity for the Department of Health to prove on a case-by-case basis that it can provide future medical care for victims of medical negligence. In this way, it can potentially sway detractors and sceptics of the Bill while more work is done on the Bill before it can be passed. It will also force the DOH to create more facilities that are Occupational Health and Safety Compliant and are of the standard of private facilities.

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[212] K Pillay 'Settling negligence cases in kind hailed' 6 January 2020 *IOL* available at *https://www.iol.co.za/mercury/news/settling-negligence-cases-in-kind-hailed-40149259*, accessed on 1 April 2021

[213] Šustek (note 209 above).

[214] J Walters 'Mediation - an alternative to litigation in medical malpractice.' (2014) Vol 104(11) *South African Medical Journal* 717-718.

[215] M Zuzile 'Mediation saves Gauteng health millions in negligence cases.' 14 February 2020 *The Sunday Times* available at *https://select.timeslive.co.za/news/2020-02-14-mediation-saves-gauteng-health-millions-in-negligence-cases/*, accessed on 2 April 2021.

[216] Walters (note 214 above).

[217] [2019] ZAGPJHC 504; [2020] 2 All SA 177 (GJ)

[218] *Mashinini v Member of the Executive Council for Health, Gauteng Province* [2021] ZAGPJHC 26

A similar decision was taken in *Mashini v MEC for Health*.[219] In this case, the plaintiff, Mashini, suffered iatrogenic complications during the removal of her gallbladder at Tambo Memorial Hospital. The High Court ruled that Charlotte Maxeke Johannesburg Academic Hospital provide future medical care whilst awarding the plaintiff a sum of R2 084 250.40 for future loss of income, general damages, and future medical-related expenses.[220]

A recent Constitutional Court ruling in *MEC for Health v PN*[221] was a major win for the DOH and supported the decisions taken in the *Mashini*[222] and *MSM obo KBM*[223] cases. Ms. PN was the mother of a child who sustained injuries at birth due to negligence by the medical staff of Chris Hani Baragwanath Hospital, resulting in the child having cerebral palsy.[224] The mother claimed more than R32 million for damages suffered. Judge Moshidi of the High Court ruled that the MEC must 'pay' for 100% of the damages that can be proven in 2017. However, when the time for the quantum to be determined came, the MEC asked that the common law be developed in this case so that the Public Healthcare Defence and Undertaking to Pay could be used. Judge Van Der Linde of the High Court ruled on 7 February 2019 that the initial judgment by Judge Moshidi did 'not preclude this court from ordering that the defendant renders services and medical and related items instead of paying to the plaintiff an amount of money.'[225] This matter was then taken on appeal to the Supreme Court of Appeal, who found in favour of the mother.[226] The court felt that the word 'pay' used by Judge Moshidi meant payment in money and not in kind. The matter was finally heard by the Constitutional Court (CC), who, on 1 April 2021, set aside the order made by the SCA and ruled that the High Court decision by Moshidi does not prevent the High Court from developing the common law and allowing the MEC to compensate PN 'in a manner other than exclusively in an immediately due lump sum payment'.[227] The reasoning by the CC was that limiting compensation to monetary payments limits the courts' ability to develop the common law and limits the MEC's ability to access the court system.[228] Payment of huge claims may compromise the rights of other citizens to access health care services as enshrined in Section 27[229] of the Constitution.[230] The CC also found that the word 'pay' should be interpreted in context and

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[219] Ibid.
[220] [2021] ZAGPJHC 26 '[63]. The amounts to be awarded to the plaintiff as damages are therefore the following: R380 250.40 – for future hospital, medical and related expenses; R1 254 000 – future loss of income; and R450 000 – general damages = Total amount to be awarded: R2 084 250.40.'.
[221] *Member of the Executive Council for Health, Gauteng Provincial Government v PN* [2021] ZACC 6
[222] *Mashinini* supra
[223] *MSM obo KBM v Member of the Executive Council for Health, Gauteng Provincial Government* [2019] ZAGPJHC 504; [2020] 2 All SA 177 (GJ).
[224] *NP obo NE v Member for the Executive Council for Health of the Gauteng Provincial Government* [2019] ZAGPJHC 24.
[225] Ibid Par 31
[226] *PN v Member of the Executive Council for Health of the Gauteng Division Government* [2020] ZASCA 66
[227] *Member of the Executive Council for Health, Gauteng Provincial Government v PN* supra
[228] Ibid Par 26-27
[229] Constitution of South Africa 108 of 1996 s. 27.
[230] Ibid. Par 28

does not refer to the method of compensation.[231] Given this landmark ruling by the country's highest court, many lower courts will be bound by this judgment to rule in favour of a Public Healthcare Defence and Undertakings to Pay.

5.5 Conclusion:

The South African government is well within its rights to pursue legislation to mitigate litigation against itself. What it is proposing is not drastically new as other countries have already implemented similar laws to deal with medical negligence litigation. However, in creating new legislation, it cannot unfairly discriminate against those whom it has already failed and owes a legal duty to compensate. The Bill, in its current format, is simply not ready to stand the inevitable legal challenges it will face by those opposed to it. It is, however, a start in the correct direction. More time and thoughtful consideration need to be taken to correct the inadequacies of the Bill. In the meantime, the State is better off pursuing other less controversial means of mitigating litigation against itself, such as ADR. It should use the *MSM obo KSM v MEC*[232] case and other similar cases as a way to prove that it is capable of providing future medical care to those it has caused harm. It should not become complacent and hope that all courts rule in a similar manner to the *MSM obo KSM*[233] case. Instead, it should pursue legislation as a means to a more permanent remedy. Time, however, is not on its side. The Department of Health is bleeding money at an alarming rate, and there appears to be no end in sight. NHI is also fast approaching. The economic fallout of the Covid-19 pandemic is still yet to be fully felt. Given that most countries' economies have shrunk in the last year, it is safe to say that there is no money to waste on medical negligence litigation.

[231] Ibid Par 23-24.
[232] [2019] ZAGPJHC 504; [2020] 2 All SA 177 (GJ).
[233] Ibid.

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UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

Dr Huben Yenkanna (200303680)
School Of Law
Howard College

Dear Dr Huben Yenkanna,

Protocol reference number: 00006877
Project title: A critical examination of the State Liability Amendment Bill (2018) and its implications for medical negligence litigation in South Africa

Exemption from Ethics Review

In response to your application received on 7 July 2021 , your school has indicated that the protocol has been granted **EXEMPTION FROM ETHICS REVIEW.**

Any alteration/s to the exempted research protocol, e.g., Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through an amendment/modification prior to its implementation. The original exemption number must be cited.

For any changes that could result in potential risk, an ethics application including the proposed amendments must be submitted to the relevant UKZN Research Ethics Committee. The original exemption number must be cited.

In case you have further queries, please quote the above reference number.

PLEASE NOTE:
Research data should be securely stored in the discipline/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours sincerely,

[redacted]

Mr Simphiwe Peaceful Phungula
obo Academic Leader Research
School Of Law