# Reopening the Debate on Medical Malpractice Claims in South Africa: Examining the intersection between quality Health Professional Training and Bioethics

**By**

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# DECLARATION

I, Zakithi Charity Zondo declare that

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# ABSTRACT / SUMMARY

Medical malpractice claims are a growing trend in South Africa that is crippling the Department of Health thus impacting on the provision of healthcare to the population. This dissertation revisits the hotly debated topic of whether there is a link between malpractice claims and the medical professional training, and conditions in South Africa? This dissertation presents an overview of the origin of health as a human right and the steps taken by the South African government to bring about the realisation of that right. An analysis of the conditions that lead to patient injury will be undertaken together with the procedures or lack thereof in place to ensure patient safety. Case law and South African legislation regarding healthcare services are consulted for comparative purposes with other countries who are also dealing with an increase in medical malpractice claims. The relevance of a shortage of resources and the implications thereof are discussed in this work. South African medical professionals' adherence to the set standards of good medical practice is analysed before conclusions are reached and recommendations to curtail the rise of malpractice claims are provided.

# DEDICATION

This dissertation is dedicated to the memory of my late father, Mandlakhe Sydney Johannes Zondo, who supported me through my undergraduate studies and cheered the loudest at my graduation. His pride in my academic endeavours has inspired me to pursue and complete this research.

# ACKNOWLEDGMENTS

I would like to honour My Lord and Saviour for blessing me with the opportunity to actively pursue my academic dreams and providing me with the strength and perseverance I needed in the hard times.

Philippians 4:13 – “I Can Do All Things Through Christ Who Strengthens Me.”

I would further like to acknowledge and thank my supervisor, Advocate Victoria Balogun-Fatokun, for her guidance and mentorship during the past eighteen months.

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| | |
|---|---|
| **AE** | Adverse event |
| **AIDS** | Acquired immunodeficiency syndrome |
| **ANC** | African National Congress |
| **ARV** | Antiretroviral |
| **CEO** | Chief Executive Officer |
| **CESCR** | Committee on Economic, Social and Cultural Rights |
| **CPA** | Consumer Protection Act |
| **EDL** | Essential Drug List |
| **HIV** | Human Immunodeficiency Virus |
| **HPCSA** | Health Professions Council of South Africa |
| **ICESCR** | International Covenant on Economic, Social and Cultural Rights |
| **IPSG** | International Patient Safety Goals |
| **NDP** | National Drugs Policy |
| **NHA** | National Health Act |
| **PHC** | Primary Health Care |
| **PSI** | Patient Safety Incidents |
| **RABS** | Road Accident Benefit Scheme |
| **RAF** | Road Accident Fund |
| **RDP** | Reconstruction and Development Programme |
| **SAC** | Safety Assessment Code |
| **SADAP** | South African Drug Action Programme |
| **SANC** | South African Nursing Council |
| **TAC** | Treatment Action Campaign |
| **UDHR** | Universal Declaration of Human Rights |
| **WHO** | World Health Organization |

# CHAPTER 1

## 1.1 Introduction

The right to health and wellbeing is one of the fundamental human rights in South Africa.[1] The realisation of this right has made the provision of health care services to the South African population a widely known state obligation.[2] Consequently, this has led to a rise in the demand for health care services.[3] The Department of Health has in recent times seen a marked increase in medical negligence and medical malpractice claims.[4] Between 2017 and 2018 the Limpopo Department of Health's contingent liabilities in this regard rose from R 2.1 billion to R 4.35 billion, Gauteng from R 17.8 billion to R 22 billion, and the Eastern Cape from R 16.8 billion to R 24.3 billion.[5] This has resulted in funds allocated to said department being depleted before the expected date. The depletion of budgeted funds has a direct impact on planned upgrades to the health sector as resources must be redirected to compensate patients who have suffered as a result of negligence or malpractice at the hands of health professionals.[6] Malpractice is generally defined as illegal, improper or negligent professional behaviour.[7] Medical malpractice occurs when the treatment provided by a medical professional results in further injury or harm to a patient.[8] Medical malpractice claims are therefore generally based on a

[1] Constitution of the Republic of South Africa, section 27 in Chapter 2, titled the Bill of Rights', governs the right to health care, food, water and social security. Section 27 (1) (a) in particular states that "Everyone has the right to have access to health care services, including reproductive health care".
[2] Ibid. Section 27 (2) states that "The state must take reasonable legislative and other measures, within it's available resources, to achieve the progressive realisation of each of these rights".
[3] General Household Survey 2018, Stats SA, Department: Statistics South Africa, last accessed on 28 May 2019. This survey found that seven out of ten South African households (71.5%) first consulted public health care facilities when members require health care services.
[4] Kahn, T, "It's sickening: The alarming rise of medical malpractice claims", Financial Mail, accessed 19 May 2019. Available from:
https://www.businesslive.co.za/fm/features/2018-07-19-its-sickening-the-alarming-rise-of-medical-malpractice-claims/
[5] Ibid.
[6] "Medical malpractice litigation: Undermining South Africa's health system.", Africa Health, 2020. Available from: https://www.africahealthexhibition.com/en/media/news/Medical-malpractice-litigation-Undermining-South-Africas-health-system.html
[7] Saner, J*, Medical Malpractice in South Africa*, LexisNexis South Africa, 2018.
[8] Cambridge English Dictionary, Cambridge University Press, 2019. Accessed on 20 April 2019. Available from: https://dictionary.cambridge.org/dictionary/english/malpractice

negligence theory. Negligence in a medical context occurs when a nurse or doctor breaches a duty of care to a patient.[9]

Malpractice claims are intrinsically linked to health professions as they are the ones providing the health service.[10] One therefore cannot look at one without investigating the other. It is imperative that the circumstances leading to the claims be thoroughly investigated, be it inadequate training, lack of proper resources or basic lack of adequate patient care when carrying out a health service. Information obtained from these investigations could lead to better control over the gradual rise of malpractice claims.[11] In *H N v MEC for Health, KZN*,[12] the court laid out steps that ultimately proved that the defendant's servants had been negligent in carrying out their duty of care to the then pregnant woman, which resulted in harm to the child subsequently born via caesarean section. This was said to be as a direct result of procedural delay and neglect by the medical staff. In order to provide the best level of care possible as foreseen in the Constitution,[13] the Department of Health and medical professionals will have to address the root causes of personal injury claims against medical professionals and attempt to curtail the steady escalation of funds spent on settling claims as opposed to the acquisition of resources necessary to medical infrastructures in South Africa. In consideration of these instances, the writer hereby establishes the importance of quality health care training and how the human factor plays a role in malpractice claims when this is not displayed carrying out everyday duties.[14]

## 1.2 Outline of the research problem

In as much as malpractice claims have an adverse effect on the Department of Health and medical professionals in the private sector, there are individuals who have suffered, and in some cases continue to suffer, from poor treatment provided by health professionals.[15] Solving the issue of malpractice or, alternatively, bringing awareness to the issue and ensuring due diligence by health professionals, will result in decreased claims and suffering by individuals who seek treatment. The Department of Health will be the main focus as it provides treatment

[9] Duhaime, Lioyd, Duhaime's online Legal Dictionary.
[10] Supra.
[11] Pienaar, L, "Investigating the Reasons behind the Increase In Medical Negligence Claims", *PELJ/PER* 2016(19). Available from: http://www.saflii.org/za/journals/PER/2016/3.html
[12] Available from: http://www.saflii.org/za/cases/ZAKZPHC/2018/8.pdf
[13] Supra.
[14] Supra.
[15] General Household Survey 2018, Stats SA. This found that 5% of the population was somewhat dissatisfied with the public health care facilities, and 5.2% was very dissatisfied.

to the majority of the South African population, with private practice in the health care sector occupying a secondary role in the study.

## 1.3 Aims and objectives

The aim of the research is to investigate the causes of the rise in malpractice claims with the intention to prevent circumstances that lead to negligence, which in turn results in a medical negligence claim. The research also intends to establish a link between malpractice and medical negligence claims, poor training, lack of resources and/or due diligence. The objective establishes that in as much as a lack of resources has been hailed as a factor in malpractice claims[16] health care professionals in their personal capacity are equally if not more so to blame for incidents that give rise to such claims. By highlighting this, the objective shifts focus from the acquisition of resources in the health care sector and sheds light on the need to ensure that medical staff are adequately trained and adhere to the principles of bioethics. In conclusion, the research establishes a way forward in order to curtail malpractice claims and ensure that individuals who seek treatment do not go away worse off after receiving said treatment from medical professionals and institutions.

## 1.4 The focus, strengths and limitations of the dissertation

The focus of the study maps the origin and root causes of malpractice claims, and whether these claims are more prominent in the private or public sector? The study also analyses the historical progression of malpractice claims in the past few decades to the present. In addition, it further analyses the steps taken by the Department of Health to address the rise of malpractice claims and whether these steps have been effective. The training provided to health professionals is investigated and the measures that are in place to ensure adherence to this training will also be analysed.

In the last few decades, medical technology has advanced at a rapid rate,[17] with the resultant consequence being that health care professionals are now tasked with examining and deciding on the ethical dilemmas that have been raised.[18] Furthermore, the dissertation analyses the

[16] Cullinan, K. "Staff shortages, poor leadership cripple healthcare", Health-e News. Accessed on 21 April 2019. Available from: https://www.health-e.org.za/2016/05/05/staff-shortages-poor-leadership-cripple-healthcare/
[17] Russell, L. *Technology in hospitals: Medical advances and their diffusion*, Brookings Institution Press, 2010.
[18] Kaye, J., et al, "Ethical implications of the use of whole genome methods in medical research", European Journal of Human Genetics 18 (4), pp 398-403, 2010.

effect of the principles of bioethics and significance accorded to bioethics by the South African health departments and professionals. In conclusion, the study provides possible solutions to address the rise of malpractice claims. As this is a desktop study and not a field study, it may be limited in that first-hand experience of the affected patients and the treatment they received, medically and interpersonally, will not be fully investigated. However, case law, existing statistics and literature about the study should be enough to establish the cause and effect of malpractice claims. The strength and importance of the study lies in that it will further highlight the basis of malpractice claims, the financial and personal implications, and the areas that need attention and action regarding curtailing the recent increase in malpractice claims.

## 1.5 Research questions

### 1.5.1 Main question

Is there is a direct link between malpractice claims and the training provided to health professionals in South Africa?

### 1.5.2 Sub questions

How adequate is the medical training provided to medical professionals in South Africa?

Do current policies and health regulations adequately provide for adherence to acceptable bioethical standards and due diligence?

How can we prevent medical negligence in South African hospitals?

## 1.6 Preliminary literature review

The Constitution,[19] under the Bill of Rights, and Section 27, aims to ensure that every individual has the right to access healthcare. The implication being that treatment must be to the benefit of an individual and must not result in harm. On the international stage, the World Health Organization (WHO) established the Constitution of the World Health Organization[20] as far back as 1946 in order to uphold the right to health and access to health care, and defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Internationally, it was not until the International Covenant on Economic, Social and Cultural Rights (ICESCR)[21] multilateral treaty was adopted that there was a legally binding commitment imposed on the signatories to uphold the right to 'health and

[19] Supra.
[20] Constitution of the World Health Organization, 1946.
[21] Adopted by the United Nations General Assembly Resolution 2200 A (XXI) 16 December 1966.

well-being'.[22] South Africa was heavily influenced by the ICESCR when drafting the Bill of Rights, even though the country only became a party to the agreement in 1994. It is clear from these sources that the right to health care is of great importance and has led South Africa to put legislation in place to ensure access.

The legal implications to the right to health and access to health care as guaranteed by the Constitution of South Africa were exposed during the case of *Minister of Health v Treatment Action Campaign* (TAC).[23] The TAC launched a campaign alleging that the government was in violation of the right to access health care services as they had failed to make anti-retroviral (ARV) drugs – Nevirapine, widely available to people living with HIV/AIDS throughout the county, particularly, to minimise the vertical transmission of HIV/AIDS from mother to child. According to the state, there were insufficient resources to make the drug available nationwide and therefore must be piloted in one province. The court found in favour of the TAC and upheld, *inter alia*, the right of HIV positive pregnant women to have access to health care services that prevented the transmission of HIV from mother to child. As a result of the TAC case, the public health system began rolling out treatment for people living with HIV/AIDS, thereby addressing the right to health and health care services for all. The TAC case further ensured that the right to reproductive health and maternal health was addressed and that progressive realisation of the right to health was prioritized even if resources were constrained, thereby demonstrating the existence of an important link between obtaining civil rights as well as socio-economic rights simultaneously.

The demand for the right to access health care and services via the courts has been followed by utilizing the right to legal recourse by individuals who have received subpar services from medical professionals. In a case similar to the *H N v MEC for Health, KZN*,[24] a causal link was established between the child suffering from cerebral palsy due to negligence by medical professionals. This was in the case of *Lushaba v MEC for Health, Gauteng*.[25] A pregnant woman presented at the hospital and she was noted as pale and suffering from dizziness and constant pain in her abdomen. These symptoms were said to be an indication of an extremely dangerous condition called *abruptio placentae* which can lead to a foetus being deprived of

[22] Universal Declaration of Human Rights, adopted by the United Nations General Assembly Resolution 217 A (III) 10 December 1948. This established a wider context to the right to health to include environmental factors which determine health.
[23] *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC).
[24] Supra.
[25] *Lushaba v MEC for Health, Gauteng* (17077/2012) [2014] ZAGPJHC 407.

oxygen and subsequently suffering from cerebral palsy.[26] While leading evidence, medical experts advised that upon diagnosis of this condition, a caesarean section should be performed immediately as this condition is regarded as a medical emergency. The plaintiff had been admitted at 12h00 and the possibility of an abruption was mentioned at 13h00 upon admission into the labour ward, treatment in the form of analgesics was provided with a review in 4 hours noted. This was gross negligence as the suspected condition was not afforded the seriousness it warranted. A definite diagnosis of the condition was noted at 13h45 and a caesarean section carried out immediately thereafter. The court found that the medical professionals had been negligent in permitting the abruption to progress, therefore causing or materially contributing to the child's cerebral palsy.

According to the Medical Protection Casebook,[27] between 2011 and 2016, claims against South African health care professionals rose by 35%, with the value of the claims increasing by 121%. This increase supports the conclusion that a significant decrease in these claims is unlikely to occur in the near future and will not be achieved without intervention. Saner *et al* appear to be of the opinion that health professionals must develop an understanding of the law relating to malpractice and to also be aware of the legal tests applied if they are ever subject to a claim against them.[28] Knowing what to expect in the case of litigation will not only ensure that health professionals have a basic understanding of the process, but also of what steps need to be taken daily as they carry out of their duties so as to avoid situations that may potentially result in litigation.

Otto, in his review article on medical negligence set out the test that needs to be fulfilled in order to prove negligence.[29] The article goes beyond the legal test and provides examples of actions or lack thereof by health professionals that constitute negligence. These include incorrect diagnosis, improper treatment, errors when carrying out procedures, foreign bodies being left in patients, and incorrect administration of drugs. The employer is vicariously liable for the negligence of the medical professional where a master-servant relationship exists, and

[26] Yamada, T. et al, "Clinical features of abruptio placentae as a prominent cause of cerebral palsy", National Center for Biotechnology Information, U. S. National Library of Medicine, 2012. Accessed on 19 May 2019. Available from: https://www.ncbi.nlm.nih.gov/pubmed/22805996 This study found that abruption placentae was the cause of cerebral palsy in one out of four cases determined to be as a result of antenatal and/or intrapartum hypoxic conditions in Japan.
[27] Medical Protection Casebook, Volume 25, Issue 1, August 2017.
[28] Saner, J, Medical Malpractice in South Africa, LexisNexis South Africa, 2018.
[29] S F Otto, *Medical Negligence, South African Journal of Radiology*, Volume 8, number 2, pp 19-22, 2004.

the medical professional was negligent while carrying out their duty within the course and scope of their employment.

The National Health Act[30] (NHA) is a cornerstone of health care and services in South Africa. The NHA's importance lies in that that it aims to "regulate national health and to provide uniformity in respect of health services across the nation". The NHA also sets out the rights and duties of health professionals while respecting the rights of individuals within the borders of South Africa, thereby ensuring quality medical treatment for all.[31]

The Health Professions Council of South Africa (HPCSA) Guidelines for Good Practice in the Health Care Professions[32] establishes general ethical guidelines that are aimed at regulating the conduct of health care professionals. These guidelines go far beyond the four core principles of bioethics, which are listed as respect for autonomy, non-maleficence, beneficence and justice.[33] These guidelines aim to ensure the best level of healthcare available.

In order to prove malpractice, four elements must be proven, being (1) a professional duty must be owed to the patient (2) there must be a breach of such duty (3) injury must have been caused by the breach and the (4) breach must result in damages. In *Lushaba v MEC for Health, Gauteng*, the courts were able to prove these elements. As there is a human factor involved, the recent judgment in a medical negligence case in Uganda is worth noting, with a view to examine how another African country had dealt with the issue of malpractice claims. In *Kimosho vs Wakapita & Others*,[34] Wakapita unlawfully and negligently prescribed a drug to the plaintiff which effectively put her life and that of her unborn child at risk. She subsequently suffered a miscarriage. The court held that Wakapita acted negligently and that the employer was vicariously liable for his professional negligence. In awarding damages, the court held that Wakapita and the employer were jointly and severally liable for compensation to the plaintiff. This judgment aims to hold both the medical institution and medical professional jointly and severally liable in medical negligence claims, thereby distributing the burden of monetary compensation. This will ensure due diligence by medical professionals in carrying out their duties. The Road Accident Fund (RAF), which also pays out for personal injury claims, is

[30] The National Health Act 61 of 2003.
[31] Ibid. Section 18 (1) of Chapter 2 of the Act states that "any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated".
[32] Health Professions Council of South Africa, Guidelines for Good Practice in the Health Care Professions, May 2008.
[33] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Seventh Edition, October 2012.
[34] *Kimosho vs Wakapita & 2 Others* (Civil Suit No. 385 of 2014) [2018] UGHCCD 71 (27 November 2018), accessed on 20 May 2019. Available at: https://ulii.org/ug/judgment/hc-civil-division-uganda/2018/71

heading towards the introduction of the Road Accident Benefit Scheme (RABS). This will limit lump sums paid out till retirement age and will instead have proven future losses paid out monthly. The medical profession and institutions will also benefit from this approach as there is no guarantee that the injured will in fact survive to retirement age.

## 1.7 Rationale for the dissertation

The writer has noted that a number of attorneys are now building their firm around personal injury claims as there is money to be made in such claims.[35] The settlement amounts can range between conservative figures to millions. As a party involved in the settlement process of Road Accident Fund[36] claims, the writer has seen first-hand the millions made from road accident claims, with R29.8 billion compensation being paid out in 2017.[37] It is further noted that attorneys in recent times are now targeting malpractice/medical negligence claims as people are becoming more aware of their rights, and that they have a legal right of recourse when they have suffered harm at the hands of medical professionals.[38] Every problem by its nature has a way to address it and measures capable of being put in place to ensure that a situation is contained. This research is aimed at examining and establishing ways that preventative measures can be successfully implemented with regard to malpractice and medical negligence claims in the health sector as both parties are suffering loss.

## 1.8. Research design and methodology

The research will be a desktop analysis as readily available data and literature will be analysed.[39] No field research will be conducted. Primary and secondary sources will be utilised for the purpose of the research in the form of existing statistical compilations, legal documents, as well as literature by scholars and writers who have already analysed, interpreted and provided their evaluation of the primary sources. In the circumstances, the research will require

[35] Supra. In her article investigating the possible rise of medical negligence litigation, L Pienaar notes that the stricter measures introduced by the RAF limited the compensation received and contributed to attorneys seeking alternate means of making money in the personal injury environment, thus turning to medical negligence litigation.
[36] Road Accident Fund Act 56 of 1996.
[37] Business Tech, 'Road Accident Fund payouts – how much can you claim?', 17 December, 2018. Accessed on 20 June 2019.
Available from: https://businesstech.co.za/news/general/289462/road-accident-fund-pay-outs-how-much-can-you-claim/
[38] Patrick van den Heever, ''Medical Malpractice: The other side', De Rebus, 26 September, 2016. Accessed on 18 August 2019. Available from: http://www.derebus.org.za/medical-malpractice-side/
[39] Collins English Dictionary, 2019.

that a qualitative method[40] of analysis be applied to gain a better understanding of the challenges faced.

An evaluative critique and analysis will be the main approach of the research. The research will be largely based on the cognitive dissonance theory as there is clearly a disconnect from the objectives of the policies of the health care sector to the service provided by some health care professionals in South Africa.

## 1.9 Structure of the dissertation

**Chapter 1: Introduction**

This chapter provides a rationale for the choice of the research question. This is a discussion of the current state of medical malpractice, the consequences thereof and why it is important that the subject be revisited. It will also contain the schematic outline of the dissertation, as well as the scope of the research question.

**Chapter 2: Evolution of human rights and the right to health**

The chapter will elaborate on the history of health as a right, and health service delivery dynamics by the South African Health sector. Furthermore, an analysis of recent legislation and policies that have been put in place to ensure the right to health as envisioned in the Constitution and adherence to international guidelines is undertaken. Furthermore, this chapter analyses and critiques the effectiveness or lack thereof of said measures. In addition, it also analyses whether there are circumstances that have changed significantly over this period and whether this has any adverse effects on service delivery.

**Chapter 3: International principles on health service delivery and the South African best practice stance**

This will contain or discusses the guidelines and standards set out by international bodies and whether South African health care services and professionals are in line with these guidelines. In the event of a discrepancy, the basis of these discrepancies and their implications will be analysed. The best standards for everyday practice, with the best adaptability to South African health care institutions, will be discussed.

[40] Hammarberg, K, Kirkman, M, de Lacey S, "Qualitative research methods: when to us them and how to judge them", Human Reproduction, Volume 31, Issue 3, pages 498-501, March 2016. Accessed on 1 May 2020. Available from: https://academic.oup.com/humrep/article/31/3/498/2384737

**Chapter 4: Malpractice versus medical negligence - the rise of personal claims**

This chapter distinguishes between malpractice and medical negligence and their various components. In doing so, it establishes which approach is favoured in litigation and is therefore regarded as easier to prove. Furthermore, the chapter evaluates the circumstances in health care institutions which have or may give rise to malpractice and/or medical negligence claims by drawing inspiration from case law. In addition, it will also analyse the consequences of a finding of malpractice and negligence and the reasons thereof. A comprehensive analysis of the data relating to malpractice and medical negligence claims and the circumstances commonly associated with origins of a claim will be conducted, together with analyses of case law relating to malpractice and negligence claims, both successful and unsuccessful, as well as the degree of harm suffered by patients who have felt compelled to lodge claims. The chapter will analyse the motivation of reported claims as they have a direct effect on the number of claims lodged.

**Chapter 5: Steps required to curtail the progressive rise of malpractice and negligence claims**

This chapter will demonstrate the steps required to curtail the progressive rise of malpractice and negligence claims. It will also contain a summary of the research findings and provide recommendations that may be utilised to not only curtail the rise in malpractice and medical negligence claims, but also work towards reducing the need for such claims to arise. A comprehensive conclusion will be made with useful recommendations.

**Chapter 6: Recommendations and conclusion**

This final chapter provides a conclusion based on the research and further provides recommendations on a way forward.

## 1.10 Summary

In the past few years there has been a noticeable increase in both the number of medical malpractice claims and the amounts paid out when settling these claims. Litigated cases have revealed that the infringement of patient rights and lack of due diligence and failure to act professionally by medical professionals will be addressed by the courts via judgments that seek to compensate patients and decide on the competency of medical professionals to continue to practice medicine. The prevalence of medical negligence claims raises questions about the circumstances that give rise to these claims and the consequences thereof with particular attention to the sustainability or lack of settling medical malpractice claims through litigation. The increase in medical malpractice claims has coincided with the granting and realisation of

human, civil and socio-economic rights for the South African population, which will be discussed in the following chapter.

# CHAPTER 2

## 2.1 Introduction

Human rights and socio-economic rights were first highlighted on an international level.[41] As a result of this focus on the rights of individuals, countries who were signatories to treaties protecting human rights were obligated to review their domestic laws and ensure that these laws and policies were in line with international standards. South Africa, as one of the signatories bound by such treaties was obligated to take steps to ensure the realisation of these human rights domestically.

## 2.2 Human rights in relation to the right to health

The right to health has in previous years not been a legally enforceable right with most notable medical advancements occurring from the 18th century onwards,[42] therefore it follows that society would seek to ensure that access to medical treatment is guaranteed to all. The right to health encompasses socio-economic rights and the right to benefit from scientific interventions and advancements. Whereas this was previously attainable through monetary means and stature in the community, the Universal Declaration of Human Rights (UDHR),[43] proved to be a milestone document in bringing about and declaring health as a human right. This document set about affirming the rights of individuals. Articles 22 - 27 of the UDHR in particular dealt with economic, social and cultural rights of individuals, which includes the right to healthcare.[44] Although the UDHR was not legally binding, it paved the way for the ICESCR,[45] which was binding on all its signatories which South Africa became a member of in 1994. Further powers were endowed on the ICESCR when South Africa ratified the treaty on 12 January 2015.[46] The ultimate duty to provide healthcare to the population fell on the governments of the signatories to the treaty. The Constitution of South Africa drew inspiration

[41] Par 1.6.
[42] Rachel Hajar, M. D. "History of Medicine Timeline", National Center for Biotechnology Information, U. S National Library of Medicine, 2015.Accessed on 19 November 2019. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4379645/
[43] 1948, article 25.
[44] Article 25 states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services."
[45] Supra.
[46] United Nations Depositary Notification, 12 January 2015. Accessed on 12 May 2020. Available from: http://www.seri-sa.org/images/ICESR_CN_23_2015-Eng.pdf

from the ICESCR as evidenced by the Bill of Rights, and thus ensured that the right to health became one of the fundamental human rights in South Africa.

The WHO Constitution of 1946 dealt with human rights and the subsequent right to health. The right to health is regarded as "…the highest attainable standard of health as a fundamental right of every human being." In aligning with the WHO Constitution, the South African Constitution has included the right to health under the Bill of Rights as an equally fundamental right in that it's established that every individual has the absolute right to have access to healthcare services, which includes the right to reproductive healthcare. As the Constitution is the highest law in South Africa, having the right to health is a human right enshrined in the Constitution which ensures absolute protection of this right, as envisioned by the WHO Constitution.

The ICESCR heavily influenced the drafting of the Bill of Rights of the South African Constitution, although the country wasn't a signatory to the ICESCR until 1994. This influence can be seen in the similarity of the structure of the text that lists the basic human rights of an individual which appear to have been directly uplifted from the ICESCR articles in some instances. The ICESCR was in part fulfilling the declaration of human rights as laid out in the UDHR, in that it recognized that human beings could only enjoy the rights listed in the UDHR if they are free from fear and want. Article 25 of the UDHR states that:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.[47]

The UDHR, WHO Constitution and ICESCR have heavily influenced the laws passed in South Africa, including laws dealing with healthcare and access to medical services. The resultant laws passed regarding human rights and the right to health have been comprehensive in nature and covered most foreseeable instances. The major drawbacks in carrying out the vision of the laws are that the intentions contained in said laws have not been effectively implemented as envisioned. However, the Committee on Economic, Social and Cultural rights (CESCR) has made it their mission to review and attempt to ensure compliance of ICESCR member states to promoting social, economic, and cultural rights.[48] The CESCR essentially monitors the

[47] Universal Declaration of Human Rights adopted by the United Nations General Assembly on 10 December 1948 as resolution 217. Available from: https://www.un.org/en/universal-declaration-human-rights/

[48] Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment NO.14 (2000). Accessed on 14 July 2020. Available from: https://www.escr-net.org/resources/general-comment-14

implementation of the ICESCR enshrined rights by states that are bound by the agreement, who are in turn obligated to provide reports to the CESCR on how they are implementing these rights.[49]

## 2.3 Health service delivery by the South African health sector

The Constitution of South Africa is the cornerstone of the right to healthcare in South Africa and is tasked with dismantling the inequities of the two-tier healthcare system that was inherited as a result of the Apartheid[50] regime. The private sector, which served to provide world-class healthcare and facilities to the minority of the population, and the public sector which was responsible for the healthcare needs of the majority of the population. The Apartheid regime allowed unequal spending on healthcare services by prioritizing the health and well-being of the white population while neglecting non-white citizens. In 1987, the Apartheid government spent the following amounts to cater to the healthcare of the people according to race: R 597 per person for whites, R 356 for Indians, R 340 for Coloureds, and R 137 for Africans.[51] The inequity of spending on the healthcare of the population was in direct contrast to the needs of the general population at the time. In 1971, recorded deaths of black children from diarrhoea were a hundred times more prevalent than those amongst white children, and in 1978, infections of typhoid fever were 48 times more prevalent in the black community than the white community.[52]

Soon after the African National Congress (ANC) was elected into power, the new democratic government implemented a variety of pro-equity programmes and policies through the public sector, as part of the Reconstruction and Development Programme (RDP).[53] The RDP was implemented by the ANC in 1994 after consultations with the Congress of South African Trade Unions, civil society organizations, the South African Communist Party, and amongst the ANC itself.[54] It is a socio-economic policy framework aimed at mobilising the country's resources

[49] Ibid.
[50] Apartheid was a system of racial segregation that was in place in South Africa until the 1990s. This system benefited the white minority in that they socially, economically, and politically dominated the country, to the disadvantage of the majority black population. Development was directed towards the white minority spaces with the black majority and other non-white citizens receiving little to no development.
[51] Hassim, A et al, *Health & Democracy – A guide to human rights, health law and policy in post-apartheid South Africa*, Siberlnk, pp 2-29, 2010.
[52] Supra.
[53] The Reconstruction and Development Programme, A Policy Framework. Accessed on 20 November 2019. Available from: https://www.sahistory.org.za/sites/default/files/the_reconstruction_and_development_programm_1994.pdf
[54] Ibid.

towards finally eradicating Apartheid. The RDP oversaw advancements for the population regarding land reform, housing, electrification, clean water, public works and healthcare. The National Health Plan[55] was one of the first South African documents that outlined its belief in the right to healthcare being a fundamental right for all.[56]

The inequities in the provision of healthcare services to the population post-Apartheid were set to be addressed by the White Paper for the Transformation of the Health System in South Africa (White Paper),[57] which was endorsed by parliament in 1997. Whereas the Constitution had laid out fundamental human rights, of which the right to health was a part of these, Chapter One of the White Paper laid out the "mission, goals and objectives of the Health Sector". The White Paper contained specific guidelines regarding the health sector policy framework and strategies to be implemented with the goal of regulating the health sector and developing a one-tier unified health system. The government directed the national, provincial and district levels to unite in the promotion of equality and availing an integrated system of essential primary health care (PHC) services to the public at the first point of call. The PHC's approach was considered the most cost-effective and efficacious in improving the health of the population and was to be the responsibility of the unified health sector at the district level. Health authorities at district level were thus tasked with the supervision and allocation of budgets to public healthcare providers and the appropriation and purchase of services from private sources where necessary.[58]

Having recognized the gaps in healthcare service provided to the South African population, the White Paper's goal of forming a Unified National Health System was hindered by the limited resources as all the proposed actions were to be funded by government, which essentially meant that the people were major contributors via tax payments. Private health care had a major advantage in that the funding received from the individuals contributing was aimed solely towards healthcare with the expectations of receiving world-class health services in return, whereas the funding received by the Ministry of Health was a portion of the tax income collected from eligible citizens.[59]

[55] "A National Health Plan for South Africa", 1994. Accessed on 19 November 2019. Available from: https://www.sahistory.org.za/sites/default/files/a_national_health_plan_for_south_africa.pdf
[56] Ibid.
[57] Available from: https://www.gov.za/documents/transformation-health-system-white-paper
[58] Supra.
[59] McIntyre, D *et al*, "Health Expenditure and Finance in South Africa", Health Systems Trust and the World Bank. Accessed on 12 May 2020. Available from: https://www.hst.org.za/publications/HST%20Publications/hstefsa.pdf

## 2.4 Legislation and polices aimed at improving healthcare services

The recommendations of the White Paper were given effect through the NHA. The White Paper itself was informed by a detailed implementation strategy report, drafted by newly founded officials from the new provinces, and aimed at developing a decentralised and district-based healthcare system. This report was entitled 'A policy for the development of the district health system for South Africa'. The NHA determined policy-making structures as well as provisions that were aimed at health service co-ordination, outlining the boundaries of a uniform health system and makes provision for the responsibility to be shared by both the public and private health professionals within the district, provincial and national health plans context. The NHA is responsible for establishing the National Health Council which consisted of the Minister of Heath, their nominee who is tasked with acting as a chairperson, a deputy minister of health should one be nominated, a Director-General and his or her deputies of the national health department, one municipal councillor appointed by the national organisation who represents municipalities as envisioned in the Constitution and representing local government. Furthermore, pertinent provincial executive council members responsible for health, a department head for each of the provincial departments of health, the head of the South African Military Health Service, and one individual appointed and employed the national organisation which represents municipalities as envisioned in the Constitution. The NHA had the effect of establishing a legal environment for promoting equity and more importantly, protecting the rights of individuals who made use of the healthcare facilities.[60]

Fully implementing the NHA has not yet been realized years later.[61] One of the contributing factors is that even though public healthcare had been decentralized via the establishment of district health systems, most provinces have not been granted sufficient authority as the operational mandate is still centralised, thereby limiting its impact at the district level and as a whole.[62]

Although policy is not the law, it is in some cases based on law. It is a stage that occurs before a law is amended or made. An important new policy that was published in 1996 is the National

[60]Hassim, A *et al, The National Health Act 62 of 0f 2003, A Guide,* AIDS Law Project, 8 September 2008. Accessed on 12 May 2020. Available from: http://www.section27.org.za/wp-content/uploads/2010/03/national-health-act.pdf
[61] Ibid.
[62] Ibid.

Drug Policy (NDP).[63] It set out to "ensure the universal availability of high-quality, low-cost drugs",[64] and was aimed at rationalising usage of medicines through the creation of an Essential Drug List (EDL) of medicines which should be made available at all healthcare facilities. The policy also encouraged the use of affordable generic medicines as a cheaper alternative rather the more expensive patented medicines. The NDP was comprehensive by necessity as it had been developed by the post-apartheid Department of Health in response to the questions and challenges it had posed, and contained three main objectives in the health, economics, and national development domains. Primarily, the health objectives involved ensuring the 1) accessibility and 2) availability of essential medicines to the population, along with ensuring that the medicines were safe, efficacious and of 3) good quality. These three objectives are critical when assessing and ensuring the provision of health service delivery. The economic objectives primarily involved lowering the cost of medicines in both the public and private sector, promoting rational and cost-effective use of medicines, and building a partnership between the private pharmaceutical sector providers and government bodies. The national development objectives primarily involved supporting the development of local essential medicine production and the local pharmaceutical industry, and improving the management skills, efficiency and knowledge of the pharmaceutical staff.

The NDP was the result of previous commissions of enquiry which had been set up by previous governments to investigate the various aspects of the existing medicines policy. All the previously set up commissions had noted problems with the supply of medicines as supply was dependent on the overuse of branded medicines instead of the more affordable generic equivalents.[65] Under the "Drug pricing" chapter of the NDP, the aim to "promote the availability of safe and effective drugs at the lowest possible cost"[66] is clearly stated. However, the procedures and steps to realize this aim were not clearly defined. Instead, it was stated that the drug pricing aim would be realised through "monitoring and negotiating drug prices and by rationalising the drug pricing system in the public and private sectors, and by promoting the use of generic drugs". The significance and importance of the NDP is evident in that is was subsequently included in the White Paper as an appendix.[67]

[63] South African National Department of Health. National Drug Policy for South Africa. Pretoria: NDoH, 1996.
[64] Supra.
[65] A NDP Committee was appointed by the Minister of Health and tasked with developing strategies that were specific to the aim of increasing the use of generic drugs in South Africa as same was not widely used.
[66] Supra.
[67] Gray, A, Suleman, F, & Pharasi, B, "South Africa's National Drug Policy: 20 years and still going?". *SAHR*, pp 49-58, 2017.

The plan for the NDP was that it would be evaluated every three years; however, this has not been the case, apart from South African Drug Action Programme (SADAP) evaluations, whose reports were not made public.[68] The implementation of the NDP has therefore, not been as originally envisioned. However, a significant section of the policy, namely the drug pricing section, has had a far-reaching effect in ensuring accessibility of medicines and therefore, healthcare for the citizens of the county. There has been a marked increase in the use of more cost-effective generic drugs in both the public and private healthcare sector, with South Africa seeing an increase in usage to 56.3% between 2012 and 2017.[69]

The provision of adequate healthcare for all South Africans was hindered by the fact that the post-Apartheid government had to undo a lot of the socio-economic imbalances perpetuated by the Apartheid government, which saw Black South Africans relocated to the government created ethnic 'homelands' or Bantustans.[70] The creation of these homelands resulted in an increase in poverty and poverty-related diseases. The overused but under-resourced public health sector was negatively impacted while the private sector continued to thrive. In order to address this situation, parliament was tasked with introducing new laws aimed at regulating healthcare that would meet the needs of the South African people.[71] The Medical Schemes Act of 1998[72] was therefore promulgated. This Act was remarkable in that it changed the law that governed private medical schemes by re-establishing a principle of cross-subsidisation between the healthy and sick medical scheme members. The Medical Schemes Act had the effect of making it illegal for medical schemes to deny membership to persons on the basis of his or her "state of health". By making such actions illegal, the Medical Schemes Act ensured that citizens who were able to afford cover by a medical scheme were not discriminated against based on their health, further granting access to a variety of healthcare services.[73]

The Health Professions Act[74]came into effect during the Apartheid era, the aim of which was to establish a Health Professions Council of South Africa and other professional boards.

[68] Ibid.
[69] "Is the quality of generics above reproach?". Medical Academic, June 2018. Accessed on 23 April 2019. Available from: https://www.medicalacademic.co.za/news/quality-generics-reproach/
[70] Matanzima, K D, "The Homelands", South African History Online, 24 January 2019. Accessed on 12 May 2020. Available from: https://www.sahistory.org.za/article/homelands
[71] The purpose of the RDP policy framework was to address the existing socio-economic inequalities in South Africa including access to healthcare.
[72] Medical Schemes Act No. 131 of 1998.
[73] Ibid. Section 29 (n) provides that a person's past or present health shall not be used as a determining factor by medical aid schemes.
[74] Health Professions Act 56 of 1974. Formerly titled Medical, Dental and Supplementary Health Service Professions Act.

Furthermore, the Health Professions Act was aimed at providing "control over the education, training and registration for and practising of health professions registered under this Act; and to provide for matters incidental thereto." A significant and subsequent result of the promulgation of the Health Professions Act is that Section 2 (1)[75] of the act established the HPCSA, while Section 3 set out the objects and functions of the HPCSA. The Health Professions Act, therefore, governs the HPCSA regarding all its activities, the processes to be adhered to by the HPCSA in carrying out its mandate, and precisely lays out the scope of every profession that is mandated to register with the HPCSA.

The HPCSA as it stands is in part fulfilling the aim of the South African government to be in line with international regulations, Acts and conventions on human rights and healthcare, some of which the country is a signatory to and therefore bound by. The mandate of the HPCSA can be summed up as providing protection to the general public, all consumers of healthcare services, and provision of guidance regarding professional, ethical and educational issues to healthcare practitioners.[76] It is important to note that this statutory body makes provision for procedures of dealing with ethical issues arising in practice. Medical ethics practices are universally accepted and practiced worldwide.[77] In Western medical practice, medical ethics can be traced and linked to the ancient guidelines pertaining to the duty of physicians, as influenced by Christian teachings and the Hippocratic Oath.[78] Within the last century, medical ethics have been thrust in the spotlight and have had to become an integral part of medical practice and healthcare.[79] That is because advances in medicine have brought about discoveries and techniques that cannot be assumed to be acceptable to every individual that seeks medical intervention, such as organ transplants[80] and stem cell therapy. Stem cell therapy involves harvesting stem cells from sources such as an embryo, which is an organism in the early stages

[75]Ibid. Section 2 (1) specifically states that "There is hereby established a juristic person to be known as the Health Professions Council of South Africa and the first meeting of the council shall be convened by the registrar".

[76] This is per the founding Health Professions Act which provides a regulatory framework of the duties and aims of the HPCSA.

[77] Thalder, D *et al,* "An optimistic vision for biosciences in South Africa: A response to the ASSAf report on human genetics and genomics", *South African Journal of Science,* vol. 115, no. 7-8, pp 1-1, July 2019.

[78] The Hippocratic Oath, which requires new physicians to swear to uphold certain ethical practices and standards, is generally attributed to the Greek Hippocrates (460 – 370 BC), even though there is some doubt about whether he penned the Oath himself.

[79] Strode, A, Soni, S, "Pre-implantation diagnosis to create 'saviour siblings': a critical discussion of the current and future legal frameworks in South Africa", *SAMJ,* vol. 102, no. 1, pp 21-24, January 2012.

[80] According to the United Network for Organ Sharing, the first successful transplant was that of a kidney and was performed in 1954. Available from: https://unos.org/transplant/history/

of development from fertilisation to the beginning of the third month in human pregnancy,[81] to adult humans. Stem cells are defined as "undifferentiated cells because they have not yet committed to a developmental path to form specific organ tissue".[82] Another source of stem cells is the umbilical cord stem cells collected after the birth of a baby.[83] Ethical boundaries and rights as envisioned in the HPCSA and therefore in line with the Bill of Rights contained in the Constitution come to the fore and require separation in instances where they become entangled.

Another Act worth mentioning in the healthcare and health services discussion is the Consumer Protection Act[84] (CPA). Although not specifically geared towards the protection of the rights of patients, the CPA has become a useful tool in medical malpractice and medical negligence claims.[85] The CPA sets out the rights of consumers[86] as well as the duties and responsibilities of suppliers of goods and services.[87] The purpose of the CPA is to "promote and advance the social and economic welfare of consumers in South Africa". The connection to damages claims is established via the fact that the CPA applies to all transactions within the borders of South Africa that involve goods and services, except where an exemption applies. By aligning patients with consumers of goods and services in the medical sector, chapter 2 of the CPA entitles patients to a set of rights that notably include the right to disclosure and information and the right to good quality, fair value and safety. The consequence of regarding the patient as a consumer is that medical professionals may find themselves regarded as 'suppliers' and therefore potentially liable under the no-fault provision of the CPA.[88] As a supplier of medical goods and services to a patient who consumes and utilises such goods and services, the medical professional and patient transaction falls within the ambit of the CPA. Indeed, as a growing

[81] Shiel Jr, W C, "Medical Definition of Embryo", MedicineNet, 2019. Accessed on 20 June 2019. Available from: https://www.medicinenet.com/script/main/art.asp?articlekey=3225
[82] Ibid.
[83] Sheetal, K M *et al,* "Recent Stem Cell Advances: Cord Blood and Induced Pluripotent Stem Cell for Cardiac Regeneration – a Review", National Center for Biotechnology Information, May 2016. Accessed on 12 May 2020. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4961100/
[84] Consumer Protection Act 68 0f 2008.
[85] Section 61 of the CPA applies to all goods and services in South Africa and states that all producers, importers, distributors and retailers of goods are liable for any harm caused wholly or in part by the provision of goods and services. Section 49 (2)(c) specifically places a duty on a health care facility to point out to the patient the indemnity clause if such clause purports to exclude liability for any activity that may lead to death or serious injury of the patient.
[86] Chapter 2 Parts A – H of the CPA sets outs the specific rights of the consumer from the right to choose to the right to fair value, good quality and safety.
[87] Ibid. Chapter 2 also sets out instances where service and goods providers may be allowed to limiting provisions of goods where necessary. Chapter 2 Part I in particular deals with the supplier's accountability to the consumer.
[88] Section 54(1)(c), read together with Section 55(2) of the CPA.

number of the population become aware of their rights, provisions of the CPA have come into the spotlight in damages claims.[89]

## 2.5 The demand for healthcare in South Africa

The population of South Africa has increased from 50.72 million to 58.78 million within the last 10 years.[90] This growth in population and incidental growth in demand for healthcare is bound to put a strain on an already overburdened public healthcare system. Another significant change to the demand for healthcare is that brought about by the human immunodeficiency virus (HIV) and its opportunistic diseases.[91] South Africa currently has the largest antiretroviral therapy programme in the world, bigger than India, Zimbabwe, Kenya and Mozambique combined making up 20% of treatment worldwide.[92] This is related to the fact that South Africa currently has almost 20% of all the world population living with HIV living within its borders.[93] This seemingly overwhelming commitment in the battle against the spread of HIV by the government does not fare well under closer scrutiny, as the first recorded AIDS-related deaths in the country occurred in December of 1981 and January 1982.[94] Following this, the initial response to the emerging health threat was lacklustre at best. No significant research was directed towards the disease; instead, condoms were rolled out coupled with educational 'safe sex' teachings which failed to address the stigma, fear and social factors inherently associated with HIV at the time. More than two decades passed before a comprehensive programme and policies were implemented. This was involuntary on the part of the government and was brought about by the Constitutional Court judgment in the now-famous Treatment Action Campaign judgment.

[89] Slabbert, M N, Pepper, M S, "The Consumer Protection Act: No-fault liability of health care providers", *SAMJ,* vol. 101, no. 11, pp 800-801, November 2011.
[90] South African Population, Trading Economics, 2020. Accessed on 23 June 2019. Available from: https://tradingeconomics.com/south-africa/population
[91] Cleary, S *et al,* "The burden of HIV/AIDS in the public healthcare system", *SAJE*, vol. 76, issue s1, pp 3-14, May 2008.
[92] UNAIDS, "South Africa launches campaign to expand access to HIV treatment", 4 December 2018. Accessed on 12 May 2020. Available from: https://www.unaids.org/en/resources/presscentre/featurestories/2018/december/south-africa-access-hiv-treatment
[93] Ibid.
[94] Simelela N P, Venter W D F, "A brief history of South Africa's response to AIDS". *SAMJ*, Vol. 104, No.3, pp 249-251, January 2014.

It is estimated that there is one government-employed doctor for every 2 457 South African people not covered by medical aid and therefore reliant on public healthcare.[95] However, one doctor registered with a medical aid consults with between 429 and 571 patients.[96] Internationally, the top three countries with the most doctors per capita are: Qatar which has 77.4 doctors per 10 000 people, Monaco with 71.7 doctors per 10 000 people and Cuba with 67.2 doctors per 10 000 people.[97]

In terms of section 27 of the Bill of Rights as contained in the Constitution, the South African government must ensure that the population has access to healthcare, and nobody must be denied treatment. The government takes this responsibility seriously as was observed by the spending of nine percent of the Gross Domestic Product on healthcare in 2017, four percent higher than what is recommended by WHO for a country with South Africa's socioeconomic status.[98] Although such expenditure seems vast and should be making a noticeable difference in medical resources, this must be viewed in conjunction with the number of medical professionals in the country for a population over fifty million. A recent review of medical institutions and personnel place South Africa on a gradual incline when it comes to delivery of healthcare goods and services. Table 1 is a reflection of that increase.

[95] Skosana, I, "Does one SA doctor treat 4000 patients in public care, but fewer than 300 privately?", Africa Check, August 2018. Accessed on 25 June 2019. Available from: https://africacheck.org/reports/does-one-sa-doctor-treat-over-4000-patients-in-public-care-but-less-than-300-privately/

[96] Supra.

[97] World Atlas, Countries with the Most Doctors Per Capita. Available from: https://www.worldatlas.com/articles/countries-with-the-most-doctors-per-capita.html

[98] "Industry Insight: South Africa Healthcare Market Overview", 2019. Available from: https://www.africahealthexhibition.com/content/dam/Informa/africahealthexhibition/en/2019/pdf/AFH19_Industry_Insights-SA_MARKET_REPORT.pdf

| Healthcare Resources (South Africa 2012-2016) | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| Total Hospitals | 687 | 694 | 701 | 708 | 715 |
| Public Hospitals | 418 | 422 | 426 | 430 | 435 |
| Private Hospitals | 269 | 272 | 274 | 277 | 280 |
| Hospitals beds | 131,929 | 133,246 | 134,575 | 135,918 | 137,274 |

| Healthcare Personnel (South Africa 2012-2016) | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| Total Physicians | 38,444 | 39,445 | 41,132 | 42,323 | 43,425 |
| Total Dentists | 5,613 | 5,667 | 5,824 | 5,998 | 6,147 |
| Total Pharmacists | 12,998 | 13,401 | 13,364 | 13,479 | 13,878 |
| Total Nurses | 248,736 | 260,698 | 270,437 | 278,617 | 287,458 |

| Healthcare Activity (South Africa 2012-2016) | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| Public inpatient admissions, '000 | 4,861.40 | 4,987.70 | 5,117.28 | 5,250.23 | 5,386.63 |
| Hospitals, average length of stay, days | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Surgical procedures, '000 | 1,458.42 | 1,496.31 | 1,535.18 | 1,575.07 | 1,615.99 |
| Outpatient visits, '000 | 162,046.74 | 166,256.72 | 170,576.07 | 175,007.63 | 179,554.33 |

**Table 1**[99]

An important aspect of medical treatment is nursing care. The doctors are responsible for diagnosis, treatment procedures, and follow-up consultations, but it is the nursing staff that thereafter make up a significant portion of the recovery and treatment upkeep process. The nursing profession in South Africa is governed by the South African Nursing Council (SANC) which was established by the Nursing Act.[100] The SANC governs nursing standards, practice and education. When entering service the nurses take a Nurses' Pledge of Service[101] which in part states that they pledge to be of service to humanity and to practice with dignity and conscience, to treat the health of their patients as a priority and to have the utmost respect for human life. A shortage of nursing staff would, therefore, have a significant impact in patient care. In the past, trade unions have taken up the issue of a nursing shortage in South Africa that is caused by an increase in disease, which then places an even bigger burden on nurses and medical facilities. Trade union Solidarity's Research Institute stated that a nurse only has three minutes per hour to attend to the care of a patient's needs, conduct routine tasks and attend to

[99] Ibid.
[100] Nursing Act No. 45 of 1944.
[101] The Pledge specifically states the following: "I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity. I will maintain, by all the means in my power, the honour and noble tradition of my profession. The total health of my patients will be my first consideration. I will hold in confidence all personal matters coming to my knowledge. I will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient. I will maintain the utmost respect for human life. I make these promises solemnly, freely and upon my honour."

any emergencies that arise.[102] This is not adequate time in everyday medical treatment situations to live up to the values of the Nurses' Pledge of Service.

## 2.6 Requirements of good medical practice

To become a licenced medical professional in South Africa requires a qualification from an accredited institution. General medical professionals that the public encounter and has established relationships with are doctors and nurses. These two professionals form the backbone of healthcare and are the primary caregivers in the public and private sector. In order to qualify as a medical doctor, an individual requires a bachelor's degree in Medicine and Surgery and thereafter work as a clinical intern for two years. A nursing qualification is a bit more flexible as it requires a higher certificate in auxiliary nursing that takes one year, a three year diploma, a four year bachelor degree in nursing, and an additional one year post-graduate advanced diploma in midwifery and nursing over and above the diploma or degree.[103] After qualification, nurses and doctors are required to serve an internship for practical on the job training. This training is done under the supervision of an individual qualified in their field. The Department of Health has set up several accredited colleges that train student nurses.[104]

## 2.7 Conclusion

The South African government has done an exemplary job in drafting and enacting laws pertaining to human rights and the right to healthcare. The current healthcare laws are world-class even though South Africa is still a developing economy. However, when those same laws are not practiced to their full potential, a vacuum is created that allows for a breakdown of the integrity of those laws. There is also a clear shortage of an important part of the treatment process, which consists of human resources.[105] This then raises the question of whether strict adherence to the provisions of healthcare laws would have a significant impact on the quality of healthcare provided to patients. In Chapter 3, international and domestic laws and policies

[102] Bateman, C, "Legislating for nurse/patient ratios 'clumsy and costly' – experts", *SAMJ*, Vol, 99. No.8, p 565, August 2009.
[103] Maidment, H, "Nursing in South Africa", EduConnect, May 2018. Accessed on 22 September 2019. Available from: https://educonnect.co.za/nursing-in-south-africa/
[104] KwaZulu-Natal Department of Health. Accessed on 12 October 2019. Available from: http://www.kznhealth.gov.za/kzncn.htm
[105] Supra. It has been shown that a single doctor sees hundreds more patients in the public sector that one does in the private sector. This is still not in line with smaller countries such as Qatar whose doctors see less patients per doctor.

are examined more closely, specifically concerning human rights, the right to healthcare and protection of patient rights to safety and good healthcare services.

# CHAPTER 3

## 3.1 Introduction

In recent times the world has come together in attempting to establish global socio-economic and human rights. Declaration of these rights as well as the production of international treaties and establishment of organisations such as the WHO is testament to the goal of providing global harmony and equal rights for all. Many countries who then become signatories to these binding treaties are then bound to live up to them by ensuring that legislation is enacted in their individual countries to live up to the treaty they are bound by.[106] Human rights and the right to health are highlighted in so far as they pertain to healthcare and the resultant adverse effects that occur during the provision of healthcare.

## 3.2 International instruments defining the right to health and the committees requiring protection of the right to health

The right to health as a basic human right is a relatively new privilege in the history of humanity.[107] The UDHR[108] was one of the first international instruments to define and require protection of the right to health. The UDHR and its declarations of human rights were only adopted by the United Nations General Assembly in Paris on the 10th of December 1948 and were unanimously regarded as a set standard for all of humanity. The major contributing factor of why the UDHR came about was due to the atrocities and violations of human rights that were witnessed during World War II. The UDHR set out the fundamental rights of every human being in 30 articles, including the right to healthcare. After the UDHR was adopted by the United Nations General Assembly, it was subsequently adopted and followed by various countries and legal systems of the world, even though it was not legally binding. The UDHR was all-encompassing as it contained 30 'rights and freedoms' which included the right to be free from torture, the now universal freedom of speech, the right to education and the right to seek asylum. Of particular relevance to the right to health are the political and civil rights set

[106] Nnamuchi, O, Ortuanya, S, "The human right to health in Africa and its challenges: A critical analysis of Millennium Development Goal 8", *AHRLJ,* vol. 12, no. 1, pp 178-198, 2012.
[107] Yamin, A E, "The Right to Health Under International Law and Its Relevance to the United States", National Center for Biotechnology Information, July 2005. Accessed on 22 May 2020. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449334/
[108] Note 2.1 above.

out in the UDHR, which include the right to life.[109] The right to life for all individuals was further protected from various legal systems subjective interpretation by the strict provisions of article 2 of the UDHR.[110] Although South Africa was not one of the 48 of the 58 (at the time) United Nations member countries who voted in favour of the adoption of the UDHR, and was in fact one of the eight countries that abstained from adopting the UDHR with two not voting, the Bill of Rights contained in the South African Constitution comprises of equally comprehensive declarations and goals to protect the human rights of individuals. Post-Apartheid South African laws and legal systems pertaining to human rights are an adaptation of the UDHR and are therefore now in line with earlier international guidelines and principles.

The ICESCR[111] was a further international instrument that delved into human rights and the right to medical care.[112] Article 2 of the ICESCR, like the UDHR, also prohibits discrimination based on race, sex, religion and other grounds that have been used for discrimination purposes.[113] Although the ICESCR came into force in January 1976, South Africa was not a signatory to the legally binding treaty until the 3rd of October 1994. However, the ICESCR had a significant influence on the drafting of the South African Constitution. Article 2 of the ICESCR places an obligation on signatories, who are legally bound by the treaty, to bring about the realisation of the rights contained in the ICESCR within their available resources.[114] When adapting the protection and realisation of the rights contained in the ICESCR, the Constitution in the Bill of Rights places an obligation of the state to realise progression of these fundamental rights "within its available resources".

[109] Article 3.
[110] Article 2 states "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs. Whether it be independent, trust, non-self-governing or under any other limitation of sovereignty."
[111] Note 1.6 above.
[112] Chenwi, L, "Unpacking "progressive realisation", its relation to resources, minimum core and reasonableness, and some methodological considerations for assessing compliance", De Jure Law Journal 39, 2013. Accessed on 22 May 2020. Available from: http://www.saflii.org/za/journals/DEJURE/2013/39.html
[113] Article 2.2 states that "The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."
[114] Article 2.1 state that "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

On the African continent, human rights guidelines and principles were established in the African Charter on Human and Peoples' Rights[115] (African Charter), also known as the Banjul Charter. The African Charter came about as a result of a meeting of African heads of state who adopted a resolution that required the drafting of a human rights instrument similar to those in Europe that would apply to the African continent. The African Charter draft was approved in June 1981[116] and came into effect on the 21st of October 1986. Since the aim of the African Charter was to be similar to European treaties but for the African continent, it recognised rights that are widely regarded and accepted as civil and political rights under article 2 and 18,[117] as well as article 3[118] to name a few. The Article that bears relevance to the right to health is Article 16 as it bestows a right to health[119] and access to healthcare.[120] The obligation is placed on the member countries to protect and bring about realisation of these rights by Article 1,[121] which states that the freedoms, rights and duties contained in the African Charter shall be recognised and member countries are to "adopt legislative or other measures to give effect to them". The African Charter arguably did not bestow comprehensive rights to women as it upheld tradition over the specific rights of women. As a result of this lack of comprehensive protection of the rights of African women, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[122] (African Women's Protocol), also known

[115]African Charter on Human and Peoples' Rights, Organization of African Unity (OAU), 21 October 1986. Accessed on 20 November 2019. Available from: https://www.achpr.org/legalinstruments/detail?id=49

[116] Ibid.

[117] Article 2 states "Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or any status." Whereas article 18 (3) deals with discrimination and states "The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of women and the child as stipulated in international declarations and conventions."

[118] Article 3 deals with the right to equality and states that every induvial is equal before the law and shall be entitled to equal protection before the law.

[119] Purohit and Anor V Gambia (Communication No. 241/2001) [2003] ACHPR 49; (29 MAY 2003). In this matter it was alleged that the Lunatics Detention Act of Gambia was in contravention of Articles 2, 3, 5, 7 (1)(a) and (c), 13(1), 16 and 18(4) of the African Charter which deal the individual rights of persons. It was further alleged that such rights were being violated as there was overcrowding in the detention unit with no requirement of consent to treatment. It was held that Gambia was in contravention of the above sections of the African Charter and a repeal of the Lunatics Detention Act was strongly advised. Accessed on 22 May 2020. Available from: https://africanlii.org/afu/judgment/african-commission-human-and-peoples-rights/2003/49

[120] Article 16 states that every individual "shall have the right to enjoy the best attainable state of physical and mental health" and that signatories to the Charter "shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."

[121] Naldi, G J, "Observations on the Rules of the African Court on Human and Peoples' Rights", *AHRLJ* 20, vol. 2, chapter 4, pp 367-392, 2014.

[122] African Union, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 11 July 2013. Accessed on 24 November 2019. Available from: https://www.ohchr.org/Documents/Issues/Women/WG/ProtocolontheRightsofWomen.pdf

as the Maputo Protocol, came about and was adopted under Article 66 of the African Charter.[123] The adoption of the African Women's Protocol was aimed at supplementing the provisions of the African Charter regarding the rights of women. Article 14 of the African Women's Protocol guarantees women's right to health, which includes reproductive and sexual health. Article 14 (2) (b) places an obligation on states to bring about the realisation of these rights by taking the necessary measures to "establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding", which has a bearing on the medical malpractice and medical negligence cases involving births that have resulted in injury and/or damages. Article 14 (2) (c) provides for the protection of the reproductive rights of women "by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus." The African Women's Protocol prioritised and brought attention to the rights of African women who have a history of discrimination, violence, and oppression by aiding in the development of domestic law in Africa.[124]

The human rights guidelines and principles set out by international bodies both abroad and closer to South Africa have been adopted or provided significant inspiration when drafting South African law that related to human rights and the rights to health. There has been no notable discourse as domestic legislation governing human rights, the right to health and access to healthcare has sought to bring about realisation of the rights enshrined in treaties that South Africa is a signatory to and are therefore binding.

## 3.3 Health service delivery

Establishing human rights and the socio-economic rights that followed led to the right to health and access to healthcare being regarded as a fundamental human right.[125] International laws and standards indicate that government must ultimately bear the burden of responsibility of its population's health. To this end, the WHO report of 2000[126] stated that "the ultimate responsibility for the overall performance of a country's health system lies with the

[123] Budoo, A, 'Analysing the monitoring mechanisms of the African Women's Protocol at the level of the African Union', *AHRLJ*, vol. 18, n1, pp 58-74, 2018.
[124] Rudman, A, "Women's access to regional justice as a fundamental element of the rule of law: The effect of the absence of a women's rights committee on the enforcement of the African Women's Protocol", *AHRLJ,* vol. 18, no. 1, pp 319-345, 2018.
[125] Vawda, Y A and Baker, B K, "Achieving social justice in the human rights/intellectual property debate: Realising the goal of access to medicines", *AHRLJ 4,* vol. 1, chapter 3, pp 55-81, 2013.
[126] WHO Report 2000 xiv.

government, which in turn should involve all sectors of society in its stewardship. The careful and responsible management of the well-being of the population is the very essence of good government. For every country, it means establishing the best and fairest health system possible with the available resources. The health of the people is always a national priority: government responsibility for it is continuous and permanent. Ministries of health must, therefore, take on a large part of the stewardship of health systems." The right to health and access to healthcare had at this time already been enshrined in the Constitution, which ensured its absolute protection. This has now become the highest law in the land in terms of Chapter 1(2) and forms the basis of the South African legal framework. When this was signed into law by President Nelson Mandela on 10 December 1996, the Constitution came into effect on 4 February 1997. The Constitution was adopted by the Constitutional Assembly who adopted the final amended text. The Bill of Rights, as found in Chapter 2 of The Constitution, enshrines the rights of people within the borders of South Africa. It binds the legislature, the executive, the judiciary and all organs of state. It applies to all law and laws passed must be in line with promoting the objectives found in The Constitution.

The WHO report of 2000 touched on the need for health ministries to be a driving force towards the stewardship of health systems. It so happens that subsequent to this report, the South African government passed the NHA.[127] The NHA is arguably one of the most crucial pieces of legislation enacted to ensure the realisation of the right of every individual to have access to healthcare services. Although is seems to coincide with the WHO 2000 report statements relating to governments bearing the burden of putting in place systems to support the right to healthcare, the NHA came about as a result of health policies dating back to 1994. The NHA reflects elements of the White Paper of 1997 regarding the decentralisation of healthcare services via the district health system, the necessity for human resource development and planning, the need for improved standards and quality of healthcare in the private and public sector, and an increase to access to healthcare services for every individual. The NHA was structured in such a way as to create a framework for the delivery of healthcare services to the population and to enable a district provincial and national healthcare system. The ambition of the NHA is limited, and its potential not fully utilised as a significant number of the provisions have not yet been brought into force, such as the Clinic and Community Health Centre Committees mentioned in section 42. Section 42 makes provision for the set-up of community and clinic health centre committees that must include members of the community. The NHA,

[127] Note 1.6 above.

however, does not specify the responsibilities and extent of the power of these committees but requires the scope of said committee functions to be outlined by provincial legislations. To date, many South African provinces do not have such provincial legislation that deals with community and clinic health centre committees as envisioned in the NHA. Of the nine South African provinces, only the Free State, Western and Eastern Cape, and KwaZulu Natal have made strides towards the fulfilment of section 42 by adopting policies or passing legislation on the regulation of community and clinic committees.[128] The NHA consists of many other provisions that have been promulgated but have not yet been implemented and await Regulations. According to Stats SA, seven out of ten households report that they utilise public hospitals, clinics, and other public institutions as their initial healthcare access point when they are in need of medical treatment. This contrasts with 27.4% of households who utilised private doctors and private institutions. These numbers show that South Africa has succeeded in its aim to provide healthcare services to the populations as stipulated in international and domestic law.

## 3.4 International standards of healthcare and service delivery in South Africa

The Constitution and ICESCR stipulate that the government must provide the best standard of healthcare within its available resources.[129] The legislation that has been put in place since the Constitution came into force has made significant strides towards the realisation of this obligation. Government clinics, hospitals and other institutions have been set up that provide readily available healthcare to the population from qualified medical professionals and medical specialists.[130] The safety and security of a patient go hand in hand with their human rights. Thus, patient safety is crucial while providing medical treatment. The International Patient Safety Goals[131] (IPSGs) came about as a measure of ensuring the realisation of the rights and obligations contained in international treaties as they pertain to individual human rights. The IPSGs contain six (6) goals as follows:

- Identify patients correctly

[128] The National Health Act Guide, Third Edition, 2019.
[129] Ngang, C C., "Judicial enforcement of socio-economic rights in South Africa and the separation of powers objection: The obligation to take 'other measures'", *AHRLJ* 32, vol.2, chapter 16, pp 655-680, 2014.
[130] Department of Health, "Strategic Plan 2014/15 – 2018/19", 2014. Accessed on 12 June 2020. Available from: https://health-e.org.za/wp-content/uploads/2014/08/SA-DoH-Strategic-Plan-2014-to-2019.pdf
[131] International Patient Safety Goals, Joint Commission International. Accessed on 20 February 2020. Available from: https://www.jointcommissioninternational.org/standards/international-patient-safety-goals/

- Improve effective communication
- Improve safety of high-alert medications
- Ensure safe surgery
- Reduce risk of health care-associated infections
- Reduce risk of patient harm resulting from falls

In a process aimed at identifying and limiting harm to patients, the international medical community has devised a means of monitoring adverse events through adverse events reporting. Adverse events (AE) are defined by the National Cancer Institute as "an unexpected medical problem that happens during treatment with a drug or other therapy. AE may be mild, moderate, or severe, and may be caused by something other than the drug or therapy being given. Also called "adverse effect",[132] AEs can occur during the ordinary course of medical treatment or during medical trials. All AEs must be reported regardless of where or when they occur. AEs are classed into five (5) grades varying in severity. Grade 1 is defined as Mild AE, Grade 2 Moderate AE, and Grade 3 Severe AE. Grade 4 Life-threatening or Disabling AE, and Grade 5 Death related AE.[133] There is, however, enough evidence to indicate that AEs are grossly underreported both in mandatory and voluntary reporting systems.[134] The lack of strict reporting may be as a result of fear of litigation as medical professionals have increasingly become subject to medical malpractice and medical negligence claims. AEs are also classed as study-related, not study-related or possibly study-related, serious or non-serious, and expected or unexpected.[135] It is believed that reporting AEs may results in a decrease in patient harm as reporting may raise areas of concern and where particular attention is needed to bring about change.

[132] National Cancer Institute, NCI Dictionary of Cancer Terms. Accessed on 20 February 2020. Available from: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/adverse-event
[133] Common Terminology Criteria for Adverse Events v3.0, August 2006. Accessed on 20 February 2020. Available from: https://ctep.cancer.gov/protocolDevelopment/electronic_applications/docs/ctcaev3.pdf
[134] Amalberti, R, Benhamou, D, Auroy, Y and Degos L. 'Adverse events in Medicine: Easy to count, complicated to understand, and complex to prevent.", Journal of Biomedical Informatics, Volume 44, Issue 3, June 2011.
[135] Ibid.

A further instrument of monitoring patient well-being and safety is the safety assessment code (SAC) which is a numerical score implemented to rate incidents that affect patients or security.[136] SAC is broken down into five categories:[137]

- Insignificant SAC 5: Where there is no increase in the level of care required, duration of stay and there is no injury to the patient. This category also includes incidents of near misses.
- Minor SAC 4: Where there is an increase in the level of care required which includes review, additional investigations, and a referral to another medical professional.
- Moderate SAC 3: Where there is a permanent reduction in bodily function that is not related to the initial illness and is different from the expected outcome of treatment. This involves an increase in duration of stay by 5-25 days or an additional procedure or surgery.
- Major SAC 2: Where there is major and permanent loss of a body function, unrelated to the natural progression of injury or illness and differs from the expected outcome of treatment. This also involves patient assault, increased duration of stay by 25-125 days and requires surgical intervention.

Extreme SAC 1: Regarded as a sentinel event[138] or death that is unrelated to the natural progression of injury or illness and differs from an expected outcome of medical treatment. This also involves an increase in the duration of stay of more than 125 days, an incident that has safety implications that are 'system-wide' and with system issues that are identified. This

[136] SA Health, Safety Assessment Code Matric, July 2019. Accessed on 20 February 2020. Available from: https://www.sahealth.sa.gov.au/wps/wcm/connect/29f2ff004e2bd4aca30cfbc09343dd7f/16037.4+-+PI+TOOL+2+SAC+Matrix+%28v7%29.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-29f2ff004e2bd4aca30cfbc09343dd7f-mN5yjOV

[137] Ibid.

[138] Ibid. Sentinel events are listed as: "Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death, surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death, wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death, unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death, haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death, suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward, medication error resulting in serious harm or death, use of physical or mechanical restraint resulting in serious harm or death (NEW in 2019), discharge or release of an infant or child to an unauthorised person, use of an incorrectly positioned oro or nasogastric tube resulting in serious harm or death (NEW in 2019)"

further involves incidents that may bring media attention, investigations and punitive measures or compensation.[139]

AE reporting and SAC have come about as a result of injury or harm suffered by patients while undergoing medical treatment.[140] It's estimated that up to 4 out of 10 patients suffer injury in ambulatory and primary care settings, with 134 million AEs per year occurring in hospitals in low and medium-income countries which contributes to 2.6 million deaths per year as a result of unsafe medical care, with medication errors costing an estimated 42 billion American dollars per year.[141] These figures revealed that although the WHO has made strides in attempting to ensure patient safety, more measures and adherence to the guidelines put in place is required in order to curtail AEs that compromise patient safety, particularly in hospitals and health facilities in low and medium-income countries.

## 3.5 South African stance on international patient safety standards

The WHO launched the World Alliance for Patient Safety in Washington, DC, on 27 October 2004 and as of May 2019 endorsed the establishment of the World Patient Safety observed annually on the 17th of September.[142] The objective of the meeting was to bring about the realisation of the "First do no harm" goal aimed at advancing patient safety. In 2005 the WHO World Alliance for Patient Safety drafted the first guidelines for AE reporting. The guidelines were intended for international adoption and application. To that end, the WHO sought to obtain external input for the drafting of the guidelines. The outcome of these interactions was that countries should attend to develop and implement sustainable and effective Patient Safety Incident Reporting and Learning Systems at a national level. The draft guidelines were updated to WHO Guidelines for Patient Safety Incident Reporting and Learning Systems.

South Africa is a party to a significant number of international treaties relating to human rights and the right to health.[143] The country has also adopted international guidelines and principles

[139] Ibid.
[140] Williams, A. *Investigation into the factors contributing to malpractice litigation in nursing practice within the private healthcare sector of Gauteng* (unpublished Master of Nursing Science thesis, Stellenbosch University, 2018).
[141] World Health Organization, Patient safety, 2020. Accessed on 18 February 2020. Available from: https://www.who.int/patientsafety/en/
[142] World Health Organization, World Alliance for Patient Safety. Accessed on 18 February 2020. Available from: https://www.who.int/patientsafety/worldalliance/en/
[143] Although South Africa abstained from voting in favour of the UDHR in 1948, the South African Constitution shares similar values and principles as the UDHR. South Africa became a signatory to the ICESCR and the African Charter amongst others which are aimed at protecting human rights and the right to health.

aimed at reducing harm or injury to patients. An example of this is the Batho Pele principle which seeks to put the needs of the South African people first.[144] As a response to the WHO urging the implementation of effective Patient Safety Incident Reporting and Learning Systems, South Africa developed the National Guideline for Patient Safety Incident Reporting and Learning in the Public Health Sector of South Africa.[145] These guidelines make use of the term patient safety incidents (PSI), which are said to be "an event or circumstance that could have resulted, or did result in harm to a patient as a result of the healthcare services provided, and not due to the underlying health condition." PSI can be said to be similar if not like AE in as far as they relate to causing harm to a patient. The purpose of the guidelines is to prevent injury to patients by means of ensuring the management of PSI reporting and feedback, which will provide lessons going forward serving as a preventive measure. If the guidelines are carried out effectively they can be applied to any PSI that may occur within all South African health establishments and institutions and to clinical as well as non-clinical staff. The guidelines are comprehensive and establish definitive timeframes for PSI reporting and the reporting requirements thereof. The detail contained in the guidelines show a dedication by the South African government and the Department of Health to address and curtail the rising incidents of patient injury and damages claims.[146]

## 3.6 International codes of good practice – South Africa's progress

Canada has a similar legal system to that of South Africa and the United Kingdom.[147] The similarities arise because both South Africa and Canada are Commonwealth countries whose legal systems are based on English Common Law.[148] It is therefore prudent to assess the Canadian Code of Good Practice relating to medical treatment since the respect for fundamental human rights will not differ significantly. The only foreseeable difference would

[144] Batho Pele translates to people first and was introduced as a measure of bringing about transformation the South African system of service delivery. Accessed on 15 July 2020. Available from: http://www.kznhealth.gov.za/bathopele.htm

[145] National Guideline for Patient Safety Incident Reporting and Learning in the Public Health Sector of South Africa, April 2017. Available from: https://www.knowledgehub.org.za/system/files/elibdownloads/2019-07/National%2520%2520Guideline%2520for%2520Patient%2520Safety%2520Incident%2520Reporting%2520and%2520Learning%2520in%2520South%2520Africa%252022%2520May%25202017.pdf

[146] Gqaleni, T M & Bhengu, B R, "Analysis of Patient Safety Incident reporting system as an indicator of quality nursing in critical care units in KwaZulu-Natal, South Africa", Health SA Gesondheid, 31 March 2020. Accessed on 2 July 2020. Available from: https://hsag.co.za/index.php/hsag/article/view/1263/html

[147] The Canadian Superior Courts Judges Association, "The sources of our law", 2018. Accessed on 22 November 2019. Available from: http://www.cscja.ca/justice-system/the-sources-of-our-law/

[148] Ibid.

be in implementation and delivery since Canada is a first world country with available resources while South Africa is still a developing country which still faces a shortage of resources, particularly when it comes to service delivery.

The Canadian medical profession is governed by the Canadian Medical Association Code of Ethics and Professionalism.[149] The guidelines urge physicians to uphold the virtues of compassion, honesty, humility, integrity, and prudence in their interactions with patients.[150] The guidelines also list the Canadian medical profession's fundamental commitments as a commitment to the well-being of the patient, respect for persons, justice, professional integrity and competence, professional excellence, self-care and peer support, and inquiry and reflection.[151] Additionally, the guidelines state that a physician should maintain patient privacy and confidentiality and minimize and manage conflicts of interest during the practice of medicine. On the face of it, these guidelines are not substantially different from those contained in the HPSCA and which govern South African medical professionals generally. Hence, South Africa can be said to have put adequate systems in place to ensure good practice.

Canada has a good medical system in place that respects patients and aims to prevent injury. However, since medical malpractice and medical negligence claims are a global issue, Canada has also had to deal with damages claims resulting from negligent medical treatment. The Canadian courts have, however, found a way to enable settlement payments to be paid in instalments. The Ontario Court of Justice Act under section 116 (1)[152] states that in court proceedings where damages are claimed, and where the parties involved consent, the court may order the defendant to make payment of part or all the damages awarded. Where partial losses are to be paid, the court will specify the terms of such payment that it deems just. Section 116 (1) has now been amended by 2006, chapter 21, Schedule A, section 17 to the Act to reflect that "Despite section 116, in a medical malpractice action where the court determines that the award for the future care costs of the 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,

[149] Canadian Medical Association Code of Ethics and Professionalism, December 2018. Accessed on 22 November 2019. Available from: https://policybase.cma.ca/documents/policypdf/PD19-03.pdf
[150] Ibid.
[151] Ibid.
[152] Courts of Justice Act, R.S.O. 1990 CHAPTER C 43. Available from: https://www.ontario.ca/laws/statute/90c43#BK149

order that the damages for the future care costs of the plaintiff be satisfied by way of periodic payments."[153]

Canada has also placed a limit of 360 000 Canadian dollars in a general non-pecuniary loss payable in a medical malpractice claim.[154] Deviation from this limitation is permissible in extreme cases but rarely occurs.[155]

The United Kingdom also has a similar legal system and regard for patient rights and treatment as South Africa and Canada and has many medical malpractice and medical negligence claims. A 9-year old girl who was born with severe jaundice which subsequently resulted in her suffering from a brain injury was recently awarded what could amount to 19 million pounds.[156] Unlike in Canada where the number of malpractice claims is said to be on a decrease, the United Kingdom is facing an increase in claims. This may be due to the fact that Canadian doctors are generally in private practice and are not employed by the state, whereas the United Kingdom, like South Africa, has a state-funded medical institution in the National Health Service. As a means of curtailing the rise of malpractice claims, the United Kingdom launched a mediation service in December 2016 due to the success of a pilot scheme that managed to settle most of the claims without the need to approach the court.[157]

The United Kingdom's medical profession is governed by the General Medical Council, which also subscribes to principles of good medical practice. A good medical practice requires doctors to meet the standards of competence, knowledge and skills, maintenance of trust, quality and safety, working in partnership with patients, communication within the partnership and teamwork.[158] UK legislation has also in recent times had court intervention when it comes to medical malpractice claims. The Damages Act of 1996[159] established the payment of pecuniary loss in instalments. Section 2 of the Act states that when awarding personal injury damages, a

[153] Amendment to the Ontario Court of Justice Act. Accessed on 23 November 2019. Available from: https://www.ontario.ca/laws/statute/90c43#BK149
[154] "Medical Malpractice Cases in Canada Are Dropping", Cuming & Gillespie, April 2019. Accessed on 12 February 2020. Available from: https://www.cuminggillespie.com/news/serious-personal-injury/medical-malpractice-cases-in-canada-are-dropping/
[155] Ibid.
[156] "Medical negligence: there are no winners", The Lancet, vol. 391, May 2018. Accessed on 20 February 2020. Available from: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)31119-X.pdf
[157] Ibid.
[158] General Medical Council Good medical practice. Available from: https://www.gmc-uk.org/-media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf?la=en&hash=DA1263358CCA88F298785FE2BD7610EB4EE9A530
[159] Damages Act 1996, 1996 CHAPTER 48. Available from: http://www.legislation.gov.uk/ukpga/1996/48/contents

court may, with the consent of the parties involved, "order that the damages are wholly or partly to take the form of periodical payments." Such an order will not be made unless the court is satisfied that continued payment as per the order is guaranteed.

Canadian and UK medical systems hold complimentary views and principles to the current South African one. The country's approach to the treatment of patients seeks to ensure patient safety and measures have been put in place to guide the process. South Africa lacks the financial resources which the other two countries have. With respect to medical rules and principles, South African is not found wanting and therefore does not require adapting to a system of treatment of the other two countries. Where South Africa can improve is by adopting the Canadian and the UK's approach to personal injury damages claims and their settlement. Currently, the only court award that is permitted to be paid in some form of an instalment is the Section 17 (4) (a) Road Accident Fund Undertaking for future medical costs payable as the need for treatment arises. The prospects of settlement claims being paid out in instalments would benefit the Department of Health, who are required to pay lump sums which are growing in number and compensation size.

## 3.7 Conclusion

Human rights and the right to health were declared by the UDHR, and the spirit and values enshrined therein were made binding to signatory countries through the ICESCR.[160] The socio-economic rights protected by the ICESCR were broadly introduced into the African continent as a whole through the African Charter and for women in particular, through the African Women's Protocol. The effect of the identification of these human and health rights led to the provision of healthcare facilities and systems that catered to the population. Such healthcare has not been without its drawbacks as countries such as Canada, the United Kingdom, and South Africa[161] have had to deal with claims against medical professionals due to alleged medical negligence and medical malpractice.

In the next chapter, I turn my attention to medical negligence, medical malpractice and the circumstances that medical professionals have been found lacking in the provision of healthcare services.

[160] Par 3.2.
[161] Par 3.6.

# CHAPTER 4

## 4.1 General

Increased access to healthcare and healthcare services has had a positive effect on the population of South Africa. However, with the increased demand for healthcare professionals and the healthcare system has come to a further drain in the form of medical negligence and medical malpractice litigation.

## 4.2 Medical malpractice

Medical malpractice is a cause of action found in law and occurs when there is a deviation from the set standards of practice by a medical or healthcare professional, which subsequently causes harm or injury to the patient. The medical or healthcare professional is therefore held liable for such harm. In common law, medical malpractice liability is based on the law of negligence and must be grounded in delict and/or contract. Medical malpractice cannot be assumed to have occurred, and therefore in order to prove liability, certain criteria need to be met. The accuser must show: (1) there existed a legal duty (2) there was a breach of such duty (3) injury must have been caused by the breach and (4) the breach must have resulted in damages.[162] In addition, medical malpractice liability may be incurred in cases where there is alleged assault as a result of lack of informed consent,[163] invasion of privacy due to disclosure of a patient's medical information without consent, performance of a procedure that is deemed unnecessary, and when medical service providers fail to perform an agreed-upon service resulting in a breach of contract.[164]

Medical malpractice requires a deviation from set standards of practice and consequently, the deviation results in a medical error. Such an error could be any of the following:

- Surgical errors, unnecessary surgery or surgical procedures at the wrong site on the body;

[162] Supra.
[163] Informed consent is a more comprehensive form of consent in that it requires permission to be granted with the full knowledge of any possible risks, benefits and consequences.
[164] Oosthuizen W T and Carstens, P A, "Medical Malpractice: The extent, consequences and causes of the problem", (78) *THRHR*, pp 269-284, 2015.

- Prescribing improper medication or prescribing the wrong dosage;
- Mistreating/ignoring laboratory results;
- Misdiagnosis or failure to diagnose a medical condition;
- Premature discharge of a patient;
- Poor follow-up/aftercare of a patient.[165]

Medical procedures involve medical treatments or operations.[166] Medical procedures are inherently risky in nature as many medical treatments have side-effects and operations involve necessary incisions into the human body.[167] A medical professional is, therefore not liable for all the harm experienced by a patient.[168] They are, however legally responsible for any pain or injury suffered by a patient as a result of deviating from the practices normally expected for quality healthcare. Damage or injury to a patient can take on the form of pain and suffering, loss/limitation of a body function or enduring hardship, disfigurement, loss of income, and disability.[169] Where a patient is dissatisfied with the outcome of treatment received, they cannot imply that there was medical malpractice involved as there would be no resultant harm or injury from the medical treatment received. In cases where the medical professional is found guilty of medical malpractice, the patient will be awarded damages for the injury suffered. The damages can either be compensatory in nature for the economic and functional loss suffered, or punitive in nature if the medical professional is found to have acted maliciously or with wilful misconduct.[170]

The highest medical malpractice settlement in South Africa was settled out of court in the amount of R25 million.[171] A neurosurgeon was found to be liable for the brain damage suffered by an 11-year old girl after numerous brain surgeries performed by Dr Minette du Preez. The patient had been born with a brain bleed which required a shunt to be inserted at the age of five

[165] In *M M v Dr S Vallabh* this standard of practice was discussed with regard to improper after discharge care and general handling of the patient whose surgery wound subsequently became necrotic and required extensive debridement. Accessed on 12 May 2020. Available from: http://www.saflii.org.za/za/cases/ZAGPJHC/2017/397.pdf
[166] Collins dictionary, 2019.
[167] Brazier, Y, "All about side effects", Medical News Today, 31 March 2017. Accessed on 12 May 2020. Available from: https://www.medicalnewstoday.com/articles/196135
[168] Pandit, M S, Pandit, S, "Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defense - A legal perspective", Indian Journal of Urology, vol. 25, issue 3, page 372 – 378, 2009. Accessed on 12 May 2020. Available from: http://www.indianjurol.com/article.asp?issn=0970-1591;year=2009;volume=25;issue=3;spage=372;epage=378;aulast=Pandit
[169] Neethling, J *et al, Law of Delict,* LexisNexis, 7th Edition, 2015, pages 221 – 226.
[170] Ibid.
[171] "R25m awarded in medical malpractice suit", news24, 2013. Accessed on 12 October 2019. Available from: https://www.news24.com/southafrica/news/r25m-awarded-in-medical-malpractice-suit-20130616

to drain excess fluid from the brain. In 2009, Dr du Preez advised the patient's parents that a new shunt would need to be inserted to relieve the patient's headaches. The operation that followed was unsuccessful and necessitated a further three operations to attempt to place the shunt in the correct position. During investigations, it was discovered that the first two operations had caused brain damage to the patient. The claim was settled out of court.

## 4.3 Medical negligence

Medical negligence refers to an adverse consequence of medical treatment suffered by a patient that should and could have been prevented by having the medical practitioner practice due diligence.[172] The test for medical negligence differs from that of negligence in delictual claims. In the case of *Mitchell v Dixon*[173] it was stated 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 he is liable for the consequences if he does not." The elements of medical negligence are the same as those found in medical malpractice in that there must have been: (1) a duty to act (2) breach of said duty (3) breach must have caused harm and (4) damages must have been suffered as a result.[174] Medical negligence liability can also be incurred by a 'failure to act' by a medical professional. The standard by which negligence is measured is that of the "reasonable man" test, which is then applied to medical practice as a reasonable medical professional in a similar situation.[175]

In the case of *H N v MEC for Health, KZN*,[176] the defendant's employees were found to have been negligent by virtue of a 'failure to act' in that they failed to monitor the heart rate of the foetus every half hour. The necessary C-section was also not performed timeously, resulting in foetal distress that in turn resulted in the baby being born with cerebral palsy.

A classic test for negligence was set out in *Kruger v Coetzee,*[177]where the court stated that liability for negligence arises if a reasonable person, in the position of the defendant, would

[172] Carstens, P A, Pearmain, D, *Foundational Principles of South African Medical Law,* LexisNexis, 2007.
[173] *Mitchell v Dixon* 1914 AD 519 at 525.
[174] Supra.
[175] Supra. Carstens and Pearmain state that the test for legal liability whether the omission was "objectively unreasonable or contrary to public policy with regard to what might or might not be expected of healthcare providers in the same circumstances."
[176] Supra.
[177] *Kruger v Coetzee* 1966 (2) SA 428 (A).

foresee the reasonable possibility of his conduct injuring another person and take reasonable steps to prevent such occurrence, which he failed to do.

## 4.4 Medical malpractice versus medical negligence

Medical malpractice can be defined as medical treatment provided by a medical professional who is deemed to be below the acceptable standard of care expected from a medical professional.[178] Medical negligence has an element of omission or 'failure to act'. However, it is important to note that not every undesirable outcome in medical practice can be deemed to be medical malpractice as medical professionals can only do so much in any given situation.[179] In some instances, they may not be able to prevent an undesirable outcome or to save a patient's life. Medical malpractice has an element of intent as opposed to medical negligence which lacks intent. An example of medical malpractice would be a surgeon performing an operation they are not adequately qualified to perform.[180] Although the act of performing the surgery was not intended to be harmful or cause harm, it has an element of intent in that he/she would have known that performing a procedure he is not adequately qualified to perform carried with it a risk that may result in harm. On the other hand, medical negligence applies where a mistake or omission occurs during the process of treating a patient which results in harm. The error or failure could be leaving a surgical object inside a patient.[181] The medical professional in that instance would not have had the intention to cause harm nor had the knowledge that the act would result in harm since the action would have been committed negligently. Where a patient then wishes to pursue legal action as a result of adverse consequences from medical treatment, an attorney would need to evaluate the facts of each case individually in order to determine whether to proceed based on medical malpractice or medical negligence.

[178] Meyer, E.C. *An Analysis of the Duty of Care Concept from a Pragmatic Medical Malpractice Perspective* (unpublished Medical Law and Ethics thesis, University of Pretoria, 2017).
[179] Steinhausen, S *et al,* " Short- and long-term subjective medical treatment outcome of trauma surgery patients: the importance of physician empathy", Dove Press, 18 September 2014. Accessed on 12 May 2020. Available from: https://www.dovepress.com/short--and-long-term-subjective-medical-treatment-outcome-of-trauma-su-peer-reviewed-fulltext-article-PPA#
[180] Supra.
[181] In *Daleen Els v MEC: Department of Health, Northern Cape*, the court ruled in the plaintiff's favour when a tip of a needle/alternatively a foreign object was left behind after an operation to the breast resulting in harm. Accessed on 21 May 2020. Available from: http://www.saflii.org/za/cases/ZANCHC/2017/7.pdf

Medical malpractice and medical negligence are often used interchangeably in discussions and in some claims processes as the critical elements for incurring lability are essentially the same. However, the critical difference lies in the medical professional's 'intent' while carrying out the medical treatment in question. The intent factor would call into question whether the medical professional had performed a procedure outside of his/her scope of practice or training, or whether factors such as lack of adequate resources and deviation from normal, expected standards of practice had played a role.

## 4.5 Liability for medical malpractice and medical negligence

In successful claims against the actions or lack thereof of a medical professional, the claimant is awarded damages for the injury suffered. South Africa does not have a specific law that deals with medical malpractice and medical negligence claims.[182] The common law is utilised to prove damages and liability in such claims. Where a medical professional is found to be liable for the damages suffered, he or she will be personally responsible for the compensation due to the claimant.[183] In cases where the medical professional was employed by an organization when the treatment occurred, the employer will be liable to pay compensation to the claimant.[184] Employer liability for an employee's actions or lack thereof is made possible by the doctrine of vicarious liability. For vicarious liability to be invoked, three requirements need to be fulfilled: (1) there must exist an employment relationship, (2) there must be commission of a delict, which is a violation of the law, and (3) the delict must have been committed during the course and scope of employment.[185] The question of what circumstances constitute course and scope of employment has been the subject of discussion and scrutiny in many a common law country.[186] In the United Kingdom and other commonwealth countries like Australia and Canada, which have similar legal systems to South Africa, the courts have departed from a

[182] Van Dokkum, N, "The Evolution of Medical Malpractice Law in South Africa", *Journal of African Law,* vol. 41, no. 2, pages 175 -191, 1997.
[183] Supra. In the matter against Dr Vallabh, he was ordered to pay 100% of the claimant's proven damages as a result of damages suffered by the claimant in his care.
[184] McQuoid-Mason, D, "Establishing liability for harm caused to patients in a resource-deficient environment", *SAMJ,* vol. 100, n. 9, September 2010. Accessed on 20 May 2020. Available from: http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742010000900013
[185] *Mkize v Martens* 1914 AD 382 390
[186] Millard, D, Bascerano, E G, "Employers' Statutory Vicarious Liability in Terms of the Protection of Personal Information Act", *PER/PELJ* 2016(19). Accessed on 21 May2020. Available from: http://www.saflii.org/za/journals/PER/2016/12.html

strict interpretation of what constitutes a scope of employment. In doing so, they have applied the 'close connection' test.[187]

The close connection test questions whether the relationship between the defendant and person who commits a wrongful act or infringement can rise to the occasion of vicarious liability, and whether the wrongful act or infringement is closely linked to such a relationship as to make it just and fair to hold the defendant liable. In *Lister and Others (AP) v Hesley Hall Limited*,[188] the question raised was,

> Whether as a matter of legal principle the employers of the warden of a school boarding house, who sexually abused boys in his care, may depending on the particular circumstances be vicariously liable for the torts of their employee.

It was held that the school was vicariously liable for the warden's assaults and that the employer could be held liable where "the unauthorised acts of the employee are so connected with acts which the employer has authorised that they may properly be regarded as being within the scope of his employment."[189] The application of the close connection test has been followed by South African law in the highest court in the land. In the *N K v Minister of Safety and Security*[190] case, the Constitutional Court adopted the close connection test to be in line with constitutional values, of which the right to health is enshrined as a fundamental right. The N K case involved a woman who was stranded in the early hours of the morning without transportation. She was attempting to get her mother to pick her up when three policemen in a marked vehicle, full uniform and on duty at the time offered to drive her home. She accepted and, on the way home, the policemen took a wrong turn, and all three of them raped her. She subsequently sued the Minister of Safety and Security for damages. The case was dismissed in both the High Court and Supreme Court of Appeal. When the matter was before the Constitutional Court for adjudication, it was held that sufficient neglect of duty as a result of deviation from authorised duties could in certain circumstances be regarded as closely connected to employment.[191]

Personal injury claims generate a lot of revenue for attorneys in practice. When the Road Accident Fund introduced strict guidelines for compensation due to personal injury,[192] it was

[187] *Lister and Others (AP) v Hesley Hall* [2001] *UKHL* 22 para 25
[188] Ibid.
[189] Ibid.
[190] *N K v Minister of Safety and Security* 2005 26 *ILJ* 1205 CC
[191] Ibid. Paragraph 56 of the judgment.
[192] The Road Accident Fund Amendment Act 19 of 2005 further brought about regulation of the Fund's obligation to compensate third parties and limited the compensation paid out for general damages brought

inevitable that personal injury attorneys would seek another avenue for making money through a personal injury. Personal injury attorneys have thus been delving more frequently into medical malpractice and medical negligence claims.[193] This has resulted in a steady increase in complaints against medical professionals and medical institutions. Personal injury claims arising as a result of medical treatment have generally favoured medical negligence as a cause of action since there is typically no ill 'intent' when a healthcare worker treats a patient. This approach is regarded as more favourable and easier to prove as most incidents that occur during medical treatment are as a result of negligence or a failure to perform an action. Medical professionals do not, as a rule, set out to intentionally cause harm to a patient.[194] The element of general, specific and constructive intent would, therefore, occur less frequently than omission and would be harder to prove in a court of law.

The medical negligence approach, though generally favoured, is by no means easy to prove or a foregone conclusion in incidents where medical treatment has resulted in adverse outcomes.[195] In the matter of *Goliath v MEC, Eastern Cape*,[196] a medical negligence claim was unsuccessful. The case involved a plaintiff who alleged medical negligence by the medical professionals involved in her routine hysterectomy. The surgical wound was closed without removing all the surgical swabs from her abdomen. The plaintiff subsequently suffered from complications caused by sepsis in the wound and abdomen. The surgical swab was consequently later surgically removed. The basis of the plaintiff's claim was that medical staff failed in their duty of care by negligently allowing the wound to be closed before all swabs were removed. It was held that there was nothing before the judge "relevant to what occurred in the operating theatre or of the circumstances surrounding the alleged negligence whatsoever."[197] The plaintiff's claim was dismissed as they failed to show enough factual evidence to prove negligence and therefore satisfy the negligence test. It was also found that the principle of *res ipsa loquitur* did not apply to the case. The *res ipsa loquitur* principle states

about by personal injury. The Act also abolished certain common law claims thereby restricting the compensation payable.

[193] Supra.

[194] Klaas, P B, *et al,* "When Patients Are Harmed, But Are Not Wronged: Ethics, Law, and History", Mayo Clinic, September 2014. Accessed on 22 May 2020. Available from: https://www.mayoclinicproceedings.org/article/S0025-6196(14)00434-0/pdf

[195] *MEC for Health, Western Cape v Q* (928/2017) [2018] ZASCA 132 (28 September 2018). In this matter the MEC for health appealed a judgment which had found that the medical professionals acted negligently in the treatment of the then pregnant patient resulting in the child being born with brain damage. It was held that the cause of the damage as well as the timing could not be identified.

[196] *Goliath v MEC for Health in the Province of Eastern Cape* (1084/2012) [2013] ZAECGHC 72

[197] Ibid. Paragraph 110.

that the mere occurrence of certain kinds of accidents would be enough to imply negligence.[198] The judgment, in this case, was the opposite of the successes of the *N H v MEC for Health, KZN* and *Lushaba v MEC for Health, Gauteng* cases where the medical professionals were found to have acted negligently and therefore were liable for any damages suffered due to a causal link and failure to act being established.

A true and specific reflection of the costs of medical malpractice and medical negligence claims against the private medical sector is not known as most of these claims are settled out of court, while claims against medical professionals employed by the Department of Health cite the relevant provincial Department of Health as a defendant or one of the defendants. The implication of this action is that if the claim is successful, the Department of Health of that province becomes liable to the outright payment of the judgment amount. The Department of Health or state is liable in terms of the State Liability Act,[199] as amended by the State Liability Amendment Act.[200] The State Liability Act aimed to consolidate law that related to State liability with regard to actions of its employees. Section 1 of the State Liability Act states that any claim instituted in a court of law against the State:

> [s]hall be cognizable by such court, whether the claim arises out of any contract lawfully entered into on behalf of the State or out of any wrong committed by any servant of the State acting in his capacity and within the scope of his authority as such servant.[201]

The State Liability Amendment Act amended section 2 of the State Liability Act by substituting the word "may" with "must" when stating that in proceedings against the State in terms of section 1, the Minister concerned must be cited in initiation documents as a nominal defendant. The State Liability Amendment Act also amended section 4 of the State Liability Act with regard to liability and provision of specified periods by now stipulating that an order against the State must be satisfied with thirty days of such order or satisfied within a time frame as agreed by the "judgment creditor and the accounting officer" of the department in question.

## 4.6 South African patient care in health institutions

South African health professionals are legally required to register with the HPCSA in order to practice. Chiropractors, homeopaths, pharmacists, dental technicians, nurses and health institutions are, however, not registered with the HPCSA. Nevertheless, they are also required

[198] Patel, B, "Medical negligence and res ipsa loquitur in South Africa", *SAJBL,* vol. 1, no. 2, December 2008.
[199] State Liability Act 20 of 1957.
[200] State Liability Amendment Act 14 of 2011.
[201] Ibid.

to register with their individual statutory bodies which govern and maintain their standards and practice.[202] One of the things these statutory bodies have in common is the respect for patient's right and a Code of Ethics the individuals must abide by when performing their duties. The central ethical values and standards of care that are required of medical professionals include and expand on the four principles of bioethics and are as follows:

- **Autonomy**: This involves respect for a patient's right to self-rule or self-determination and allowing the patient to make their own decisions.[203]
- **Beneficence:** Medical professionals should act in the best interest of the patients and for their benefit, regardless of conflict or their own self-interest.
- **Non-maleficence:** This is in line with the 'do no harm' principle and involves not causing harm to the patient or acting against their interests.
- **Justice:** This involves giving each patient fair consideration and impartial treatment.
- **Respect for persons:** Treating patients with respect and acknowledging their right to dignity.
- **Human rights:** Requires medical professionals to recognize the human rights of all patients.
- **Integrity:** The ethical values should be incorporated as the foundation of the medical professional's practice and character as a responsible medical professional.
- **Truthfulness:** This should be the basis of trust in relationships between patient and medical professional as the truth should be shared in all circumstances.
- **Compassion:** Medical professionals are required to be sensitive to and compassionate towards the needs of patients. They should further attempt to provide comfort where possible.

[202] Krebs, M, "The regulation of healthcare providers and professionals in South Africa", Lexology, 12 September 2019. Accessed on 23 May 2020. Available from: https://www.lexology.com/library/detail.aspx?g=1938fdd7-df35-4171-ba73-0a2dd2387234#:~:text=The%20relevant%20regulatory%20authorities%20include,South%20African%20Dental%20Technicians%20Council.

[203] Van der Reyden, D, "The right to respect for autonomy Part 1 — What is autonomy all about?", *South African Journal of Occupational Therapy*, vol. 38, n. 1, 2008.

- **Confidentiality:** Patient information should be treated as private and confidential, unless there are overriding legal and moral reasons that warrant disclosure of information.
- **Tolerance:** Medical professionals should be tolerant of and respect the right of patients to have different beliefs and ethical values.
- **Community:** Medical professionals must aim to uplift and contribute to the betterment of the community they serve.
- **Competence and professional self-improvement:** Medical professionals must aim to continually obtain skills and knowledge as required by their area of practice.[204]

The aim of medical institutions and medical professions is to attend to the ailing and those needing medical attention in order to improve their conditions. Strict guidelines have been put in place to ensure positive outcomes. However, South Africa is still left wanting when it comes to medical treatment of patients and this has given rise to a steady increase in medical malpractice and medical negligence claims as patients have become more aware of their rights.[205] The treatment and negligence that is endured is significant enough to warrant compensation in several cases. The recent incident that has created public shock and becomes synonymous with public healthcare in recent times is that of a Durban man who died after he was discovered with maggots in his mouth at R K Khan Hospital in Chatsworth.[206] The patient, Mr Ebrahim, had initially been taken to hospital on 14 May 2019 for treatment of a wound near his ankle that had maggots inside. Upon arrival, there was a wait of approximately eight and a half hours before he was treated and subsequently sent home and assured everything was fine. Mr Ebrahim was returned to the hospital on 19 June 2019 as his leg had become black from infection and required surgery. When Mr Ebrahim's son, Azaad, visited him after the surgery on 23 June 2019, he noticed that his upper lip was swollen while attempting to feed him. It was when Azaad looked inside Mr Ebrahim's mouth that he discovered the maggot infestation that had gone unchecked. After alerting hospital staff, Azaad removed himself from his father's bedside for a period of approximately thirty minutes in order to calm himself down. Upon his

[204] HPCSA, *Ethical guidelines for good practice in the health care professions*. Accessed on 22 May 2020. Available from: https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf
[205] Moore, W, "Medical information therapy and medical malpractice litigation in South Africa", *SAJBL,* vol. 6, no. 2, pp 60-63, 2013.
[206] Singh, O, 'Durban man dies after maggot infestation in mouth', Times Live, July 2019. Accessed on 20 November 2019.Available from: https://www.timeslive.co.za/news/south-africa/2019-07-05-watch-durban-man-dies-after-maggot-infestation-in-mouth/

return, his father had still not been attended to and cleaned in his absence. During a meeting with the hospital CEO, Azaad was not provided with an explanation of how the maggots went undetected. Mr Ebrahim later died.

In another incident that made international news and again involved R K Khan Hospital, monkeys were filmed upsetting patients and having free reign of the hospital ward containing sick patients.[207] In video footage of one incident, an audibly disturbed patient can be heard attempting to shoo the monkey away, while another screams in fright. In all the videos linked to the articles, there is no intervention from medical professionals as patients are left to their own devices.

## 4.7 Consequences of the breach of professional duty

A breach of a duty of care has negative consequences for both the patient and medical professional. Where an allegation of medical malpractice or medical negligence has been alleged against a medical professional, a disciplinary inquiry may be initiated in terms of the Health Professions Act. If the inquiry results in findings against the medical professional, this may result in the medical professional being suspended or struck off. Where there has been death of a patient as a result of medical treatment, an investigation in the form of an inquest will be held to determine the cause of death. The most extreme outcome of a medical malpractice or medical negligence claim would be a criminal charge of culpable homicide, which is negligently causing the death of another human being.

In cases where the plaintiff wins a case against the medical professional and/or their employer, monetary compensation is paid out.[208] A medical professional who has had to settle medical malpractice or medical negligence claim would see their indemnity cover premiums affected. This consequence has understandably led to medical doctors practising 'safe medicine' in an attempt to fend off damages claims. Another consequence of the prominence of malpractice claims is that it inhibits medical doctors from branching out as indemnity premiums rise annually due to the increase in malpractice claims. According to the Medical Protection Society SA, there has been a 35% increase in claims against medical professionals between 2011 and

[207] Pyatt, J, 'Monkeys terrorise South African hospital for three months as they run riot through wards and kitchens to steal food while patients cower under their blankets', Mail Online, March 2019. Available from: https://www.dailymail.co.uk/news/article-6863941/Monkeys-terrorise-South-African-hospital-stealing-food-patients.html

[208] Coetzee, L C & Carstens, P, "Medical Malpractice and Compensation in South Africa", Chicago-Kent Law Review, vol. 86, issue 3, 1263, June 2011.

2016, with claims over one million rands seeing nearly a 550% increase compared to ten years before.[209] Claims over five million seen an increase of 900% from 2008 to 2013.[210]

The rise in claims against medical professionals has also had the effect of increasing medical indemnity cover, which has, in turn, put medical professionals on the defensive. One of the most affected areas of medicine is the obstetrics sector. Obstetricians saw an increase from R250 000 per annum increase up to approximately R 900 000 per annum.[211]

When one considers that the right to health is a fundamental right and that medical professionals have a legal and ethical duty of care, yet there are still cases of obvious medical malpractice and medical negligence which are not given their due urgency at the time, it is not surprising that medical malpractice claims are on the rise. When those affected are not given satisfactory reasons and information as to what led to an incident of medical malpractice or medical negligence as in Mr Ebrahim's case, the relationship of trust is broken, and this often leads to the affected seeking compensation via the courts, thus contributing to a rise in malpractice claims.

## 4.8 Conclusion

The one notable difference between medical negligence and malpractice is that of 'intent'.[212] Cases, where medical negligence and/or medical malpractice has been proven however, goes shows there is a disconnect between the laws and policies put in place to ensure professional conduct and the actions of the medical professionals entrusted with proper patient care. Questionable actions while providing medical care is not unique to South Africa and have seen countries such as Canada and the United Kingdom find alternate means of attempting to curb the rise of medical negligence and medical malpractice claims. As South Africa cannot afford to allow a situation where these claims continue to rise, changes need to be looked into and such possible changes are explored in the following chapter.

[209] "Malpractice claims on the rise", Bizcommunity, April 2018. Accessed on 22 November 2019. Available from: https://www.bizcommunity.com/Article/196/334/176029.html
[210] Ibid.
[211] Mashego, P, 'Insurance cost puts doctors on defensive', Sunday Times, September 2018. Accessed on 22 November 2019. Available from: https://www.pressreader.com/south-africa/sunday-times-1107/20180923/282565904060020
[212] Par 4.4.

# CHAPTER 5

## 5.1 General

Medical negligence and malpractice claims are arguably an inevitable part of medical practice and healthcare. This inevitability can be due to innocent error or general dissatisfaction with the healthcare service received. Guidelines and ethical principles have been put in place by medical professional governing bodies and legislation to protect patient rights and ensure that medical professionals carry out their duties in line with acceptable standards of practice. Patient care guidelines, policies and laws are in place both on the international and domestic stage.

## 5.2 International and domestic healthcare law and policies

South Africa is party to international treaties that establish and uphold the right to healthcare and a safe environment while also placing an obligation on signatories to ensure a realisation of rights at the state level. The South African government has also adopted international guidelines geared toward patient safety in the medical treatment process.[213] The post-Apartheid government has complied with international standards and regulations by ensuring compliance where there was a violation of human rights in the form of unfair and unequal treatment. The Constitution and White Paper have resulted in the enactment of public health laws that ensure the best standard of healthcare and access to healthcare within South Africa's available resources as a developing country. This means that from a legal framework point of view, South Africa has enacted ambitious and comprehensive legislation which the government may not be able to live up to as envisioned.[214] The drawback from this is that not all the provisions of the relevant acts have been implemented which creates a gap in implementation and intended output.[215] Legislation relating to healthcare is not a notable factor contributing to medical malpractice and medical negligence claims.[216]

[213] The introduction of methods to report and monitor adverse events suffered buy patients in South African healthcare is one of the examples of this aim of being in line with international standards of healthcare.
[214] Dhai, A & Mahomed, S, "Healthcare in crisis: A shameful disrespect of our Constitution", *SAJBL,* vol. 11, no. 1, pp 8-10, 2018.
[215] Ibid.
[216] Maphumulo, W T & Bhengu, B R, "Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review", Curationis, vol. 42, no. 1, 29 May 2019. Accessed on 02 July 2020. Available from: https://curationis.org.za/index.php/curationis/article/view/1901/2489

## 5.3 Ethics, training and good medical practice

Medical professionals must obtain the relevant qualifications in order to practice legally and be recognized by their relevant statutory governing bodies. Upon registration with their governing bodies, a pledge or oath to act professionally and with integrity is sworn. These medical governing bodies also require members to abide by a set of ethical standards in practice. In order to ensure that patients are not harmed during treatment, set processes and procedures are put in place such as AE and PSI[217] reporting. Work competence is safe guarded by the requirement of accredited qualifications and initial on the job training under qualified supervision to develop skills. An environment conducive to patient safety has therefore been cultivated via ethical, skilful, and work practice means. This then leaves the area of resources and individual decision-making as the contributing factor in personal injury claims. When adequate theoretical training has been provided and there is set procedures when providing treatment, it stands to reason that the human factor is questioned. In the case law analysed in previous chapters, it was either the doctor, surgeon or nursing staff who deviated from protocol by either performing brain surgery incompetently, delaying medical attention in a medical emergency known to be critical, or leaving foreign objects in the patient after surgery. The same medical professionals that make these types of decisions, some not reported, are then responsible for training the next generation medical professionals. Stricter rules need to be applied to the individuals providing supervision. Therefore, in as much as lack of resources such as a shortage of staff is a factor,[218] the decisions of medical professionals have led to the institution of medical malpractice and medical negligence contributing to an increase in personal injury claims.

The individual and collective decision-making process that leads to the harm or death of a patient has come into the spotlight with the death of a patient who was allegedly not provided with food for two days.[219] The patient, Mr Mkhize, died five days after a plea via social media to the Minister of Health stating that he was not provided with food. The reason given for the patient not being given any food is alleged to be fear by the medical staff at Tembisa Hospital

[217] Note 3.4 and 3.5 above.

[218] Green, A, "Health staff shortages make NHI a 'pipe dream'", IOL, 12 December 2018. Accessed on 02 July, 2020. Available from: https://www.iol.co.za/news/south-africa/health-staff-shortages-make-nhi-a-pipe-dream-18480817

[219] Tlou, G, "Businessman fighting Covid-19 dies after complaining of not being fed for two days", IOL, 2 July 2020. Accessed on 02 July 2020. Available from: https://www.iol.co.za/the-star/news/businessman-fighting-covid-19-dies-after-complaining-of-not-being-fed-for-two-days-50284953

in Ekurhuleni that they would contract the deadly virus that had infected the patient.[220] Neglect of the patient's needs reflects a violation of the ethical principles of medical practice as well as the opposite of what is envisioned in the concept of good medical practice.[221]

## 5.4 Legislative responses

Legislation to establish a medical infrastructure needs to be amended to reflect the current and/or foreseeable economic state of the country. Elaborate acts such as the NHA[222] are a comprehensively drafted legal instrument in line with first world countries in their aims and objectives but have yet to fully realize their potential as not all the provisions have been implemented. Legislation that is precise and with an end goal contained in the provisions will narrow down the spread of resources. More importantly, the State Liability Act needs to be amended with regard to payment of settlements by the state. Adopting the 'periodic payment' approach adopted by the Canadian and United Kingdom courts will make a significant difference to the budget of the Department of Health who are ordered to pay large settlements in a matter of days. Legislation capping the amount payable in general damages claims, as per the Canadian system, is recommended. This should have the effect of making the claim process easier, thereby reducing the need for attorneys who increase costs. Furthermore, medical malpractice claims may be seen as less of a money-making scheme by attorneys and therefore less sought after.

## 5.5 Human resources and the medical system

Medical malpractice and negligence claims have an element of human error or action involved. The medical professionals responsible for the training and supervision of new staff should themselves be the subject of rigorous scrutiny and control with checks and balances in place. Periodic training on crisis management and decision-making under pressure should be the norm in order to be effective in an under-resourced environment. Training on the consequences of deviation from the expected standards of practice should be provided on a regular basis. Skills upgrade courses, where possible, should be further encouraged.

Upon discharge, the same attention should be paid to detail as on admission. Providing closely monitored satisfaction questionnaires and following up promptly to complaints will go a long

[220] Ibid. The patient in this case had contracted COVID-19, a virus of pandemic proportions which was discovered in 2019 and had global implications by the year 2020.
[221] Seggie, J, "Revitalising professionalism", *SAMJ*, vol. 101, no. 8, pp 508-509, 2011.
[222] Refer to 1.6 above.

way towards minimizing claims and consequences of harm or injury. A situation like the one involving Mr Ebrahim should never become the norm, where both the general staff and hospital CEO are unable to deescalate a situation. Launching a mediation service like the one that was successful in the United Kingdom will strengthen relations between medical service providers and patients, while further contributing to a reduction in medical malpractice and medical negligence claims.

## 5.6 Conclusion

Access to healthcare for the South African population, in general, has seen a marked improvement post-Apartheid. Similarly, medical negligence and malpractice claims have also grown in number and amounts claimed and paid in compensation. International law and healthcare policies have provided a strong basis for domestic patient rights. As an emerging market, South Africa cannot maintain nor keep up with the current growing trend of litigation in the medical sector and change is required to curb this trend, as failure to do so will adversely affect the healthcare system.

# CHAPTER 6

## 6.1 Introduction

The purpose of the study was to investigate the factors that contribute to and in some cases, give rise to medical malpractice and medical negligence claims in the private and public health sector. This was undertaken to re-evaluate the often-visited notion that there is a link between medical professional training in South Africa and professional ethics, with the aim of identifying effective solutions. This chapter will present conclusions and observations based on the results analysed in the previous chapters as well as recommendations informed by the analyses conducted.

## 6.2 Recommendations

The following recommendations are based on the research study results and are aimed at enhancing clinical practices in the healthcare sector to reduce incidents that lead to medical negligence and malpractice claims:

- Amendment of current damages legislation regarding payment of compensation. Capital payments when a court case is won should be made in instalments where agreeable as is the practice in Canada and the United Kingdom. Alternatively, lump-sum payment of non-pecuniary damages should be capped and deviated from in exceptional circumstances. This practice has seen a noticeable reduction in litigating medical negligence matters in other countries. The concept is not foreign to South Africa as demonstrated by the RABS proposal.
- Continuous skills development training and policy education should be a requirement in the medical field with a skills/practice grading system that starts at an entry-level to master level and necessitates a downgrade where the medical professional has been found in contravention of bioethical principles and the ethical codes of good practice. This will introduce an element of personal and professional liability even when the incident does not lead to litigation.
- The hiring of more medical professionals, especially in the public sector since the public sector medical professionals see more patients per staff member than those in the private sector, as shown above. More team members will lead to less strain on

medical professionals. Simultaneously, medical institutions should be properly equipped with all the necessary equipment to carry out adequate healthcare.

- Address issues of medical professionals who behave in an unacceptable and inappropriate manner towards patients. The indefensible actions or lack thereof of medical professionals towards Mr Ebrahim and Mr Mkhize while under their care and the incident on monkeys having unrestricted access to hospital wards show a lack of patient care urgency at an individual and state level.

## 6.3 Conclusion

The one constant in a dynamic environment is constant change. The research question of whether there is a direct link between malpractice claims and the training provided to health professionals in South Africa has been addressed and it's established that South Africa has drawn inspiration from international standards when it comes to qualifications and the training of medical professionals. Therefore, the training provided to healthcare professionals is not a direct cause of malpractice claims. Adequate training is in place to facilitate an excellent quality healthcare service. Furthermore, medical professional governing bodies and South African health legislation have in place laws and policies that require adherence to acceptable bioethical standards. It has been highlighted that although a lack of resources is a contributing factor to medical negligence and medical malpractice claims, the major contributing factor is the breakdown of the clinical management of patients through lack of adherence to known policies and protocols. Medical negligence can be prevented in South African hospitals by addressing the lack of strict adherence to policies, protocols and health regulations. The rise of malpractice claims is having a negative impact on realizing the right to health to the fullest and is a crisis that requires urgent intervention.

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UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

Miss Zakithi Charity Zondo (200001217)
School Of Law
Howard College

Dear Miss Zakithi Charity Zondo,

**Protocol reference number:** 00006950
**Project title:** Reopening the Debate on Medical Malpractice Claims in South Africa: Examining the intersection between quality Health Professional Training and Bioethics

## Exemption from Ethics Review

In response to your application received on 03/08/2020, 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 Phungula**
**Research and Higher Degrees Committee**
**School of Law**

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