

Investigating the Reasons behind the Increase in Medical Negligence Claims

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Abstract

Medical negligence claims have increased significantly over the last number of years. The trend is still ongoing and concerns have been raised about the impact of this increase on the medical industry. Medical practitioners are increasingly practising defensive medicine in an attempt to limit the risk of medical negligence claims being instituted against them. Medical negligence claims are instituted for a number of reasons, such as lack of communication between doctor and patient. Birth-related claims are instituted most frequently.

This contribution investigates the possible reasons behind the increase in both the value and the number of medical negligence claims. The focus falls especially on the increase in the number of claims. The contribution considers a decline in the level of professionalism amongst medical practitioners as one reason behind the increase, followed by the possibility that lawyers may be responsible for the increase in claims. In addition, it is pointed out that patients are simply becoming more aware of their rights.

The contribution further focuses on patient-centred legislation and pronouncements by courts that bolster patient autonomy and place patients in an ever stronger position to enforce their rights. Relevant provisions of the *Constitution*, the *National Health Act*, the *Consumer Protection Act* and the *Children's Act* are singled out for discussion, followed by a brief discussion of case law in line with themes identified in the aforementioned legislation.

The contribution submits that the increase in medical negligence claims should not come as a surprise, considering the high regard that our courts had for patient autonomy even before the enactment of the 1996 *Constitution*. The *Constitution* and the above legislation now contain specific rights that patients, including child patients, can enforce. The best interests of the child principle embodied in both the *Constitution* and the *Children's Act* is very prominent in the medical context and impacts on the medical practitioner's responsibilities towards a child patient. The Constitutional Court relied on this principle in its recent judgment to the effect that claims for wrongful life (brought by a child with a disability), may possibly have a place in our law. If the claim for wrongful life is eventually confirmed, we will no doubt see a further increase in medical negligence claims.

Patient-centred legislation and pronouncements by our courts that constantly reiterate the importance of patient rights arguably create very fertile ground for medical negligence claims. These are, as the contribution concludes, merely contributing factors to the phenomenon under investigation.

Keywords:

Medical negligence; patient autonomy; increase in medical negligence claims; patient-centred legislation; patient.

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1 Introduction

The number and value of medical negligence claims in South Africa have increased rapidly in recent years.¹ The Gauteng Department of Health alone faced claims of R1.28-billion for the 2012/2013 financial year,² up from R573-million in the 2009/2010 financial year.³

The rising number of medical negligence claims affects both the private and public sector.⁴ The increase in both the number and value of claims has resulted in an increase in the cost of indemnity insurance for medical practitioners, so much so that it costs obstetricians R330 000 annually to be insured against medical negligence.⁵ An alarming consequence of the rise in indemnity insurance is simply that some practitioners may at some point no longer be able to afford the premium and will be forced to stop practising.⁶

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¹ Pepper and Slabbert 2011 *SAJBL* 29, where it is pointed out that there has been a 900% increase in claims of over R5 million, compared to approximately 10 years ago. Also see Bateman 2011 *SAMJ* 216. See further Oosthuizen and Carstens 2015 *THRHR* 269, where the trend in the rise in both the number and value of claims is confirmed.

² Anon 2014 <http://www.health24.com/News/SA-hospitals-face-billions-in-legal-claims-20140117>; Child 2014 <http://www.timeslive.co.za/news/2014/01/17/hospital-horrors-costing-sa-plenty>.

³ Pepper and Slabbert 2011 *SAJBL* 29. Also see Malherbe 2013 *SAMJ* 83. The Eastern Cape Department of Health faced claims amounting to R876 million in the 2012/2013 financial year. See Child 2014 <http://www.timeslive.co.za/news/2014/01/17/hospital-horrors-costing-sa-plenty>. See further Oosthuizen and Carstens 2015 *THRHR* 273-275 for the figures that the health departments of other provinces spend on medical negligence claims. Also see Coetzee and Carstens 2013 "Medical Malpractice" 432-434 for further information on the amounts claimed from provincial departments of health as well as from the practitioners involved in medical negligence cases, as reported by the Medical Protection Society.

⁴ Oosthuizen and Carstens 2015 *THRHR* 275.

⁵ Oosthuizen and Carstens 2015 *THRHR* 276. Also see Bateman 2011 *SAMJ* 216. Also see Pepper and Slabbert 2011 *SAJBL* 30, who explain that the 2011 MPS (Medical Protection Society) annual fee for obstetricians was R187 830, neurosurgeons had to pay R174 700 in that year, and gynaecologists, fertility specialists and plastic surgeons had to pay R101 030 in the year 2011. In 2012 these premiums went up and it cost obstetricians R220 700 per annum and neurosurgeons and spinal surgeons had to pay R209 470 per annum. Also see Anon 2012 <http://www.citypress.co.za/news/doctors-lose-patience-as-suits-spike-20120707/>.

⁶ See in general Oosthuizen and Carstens 2015 *THRHR* 269-284 for a discussion on further negative consequences that the increase in medical negligence cases can have on the health industry.

The increase in medical negligence claims is a strong impetus behind the trend developing in the medical industry to focus on "defensive medicine" rather than "compassion-centred care".⁷ Practising defensive medicine results in increased costs for the patient as it entails doing more tests to determine the exact cause of the patient's complaint. The risk of facing a medical negligence law suit could arguably ensure higher standards of care by the medical industry⁸ but it appears that this risk is being managed by practicing defensive medicine.⁹ The impact of the rapid increase in medical negligence claims, therefore, appears to have a negative impact, in one way or another, on medical practitioners and patients alike.

This contribution gives a very brief historical overview of medical negligence claims in ancient times and moves on to investigate some of the possible reasons behind the increase in medical negligence claims by exploring some of the reasons advanced in literature to date. This contribution explores in particular the roles that patient-centred legislation and pronouncements by courts on patients' rights play in arguably creating very fertile ground for the increase in medical negligence claims. Discussion of the relevant legislation and judicial pronouncements is focussed on selected themes relevant to the health care context.

2 The background to claims for medical negligence

Even though medical practitioners face astronomical damages claims for medical negligence today, much harsher measures were taken against medical practitioners in the past.

In ancient Greek times, for example, a medical practitioner was sentenced to death if a patient died under his care as a result of the use of unorthodox medical practices.¹⁰ If a patient lost the use of a limb after an operation, the medical practitioner's hands were often cut off.¹¹

⁷ Moore and Slabbert 2013 *SAJBL* 60. Also see Pepper and Slabbert 2011 *SAJBL* 32. See further Malherbe 2013 *SAMJ* 83.

⁸ Pepper and Slabbert 2011 *SAJBL* 30.

⁹ See further in general Oosthuizen and Carstens 2015 *THRHR* 278.

¹⁰ Carstens 2004 *Fundamina* 3, fn 13, where reference is made to Amundsen "Liability of the Physician".

¹¹ Ackerknecht *Short History of Medicine* 17. Also see Carstens 2004 *Fundamina* 3. Also see in general Zietsman 2007 *Akroterion* 87-98 for a detailed discussion of the provisions of the ancient codes relevant to medical negligence matters.

In Roman times, where a citizen suffered injury due to ignorant medical malpractice,¹² the *pater familias* could institute action against the medical practitioner with the *Actio Lex Aquiliae* for the citizen's loss of the ability to work and the medical expenses incurred.¹³

In the Germanic empire, medical negligence was governed by legislation that provided for a medical practitioner who caused the death of a patient to be handed to the family of the patient to do with him as they pleased. Where the patient survived but suffered injury, the medical practitioner had to pay a fine to the family.¹⁴ The position in Roman-Dutch law was fairly similar.¹⁵

Today, when medical negligence is suspected the patient or his/her family may choose to institute a civil claim to recover damages,¹⁶ and/or may file a criminal charge against the doctor and may further lodge a complaint with the Health Professions Council against the doctor involved for unprofessional conduct. The result of a finding of unprofessional conduct by the Health Professions Council may be that the doctor's name is removed from the register at the Health Professions Council.¹⁷ It is evident that a

¹² In Roman times, medical practitioners could be accused only of intentional, negligent or ignorant malpractice. See Berkhouwer and Vorstman *Aansprakelijkheid van de Medicus* 16 as referred to in Carstens 2004 *Fundamina* 7-8, where it is explained that intentional malpractice was identified in such cases as where a medical practitioner poisoned a person, for example, in which event he would be guilty of manslaughter, or where a medical practitioner convinced a patient to sell all his assets to him (the medical practitioner). The medical practitioner would be ordered to return the goods to the patient. Negligent malpractice referred to cases where intention was absent but gross negligence could be proved, whereas ignorant malpractice referred to cases where the medical practitioner was incompetent to perform the particular procedure.

¹³ No compensation for marks left on the body of the patient or for deformity could be claimed, because a Roman citizen was a "free man" and the body of a free man had no value, whereas the body of a slave had value, since a slave could be sold (Carstens 2004 *Fundamina* 9). Also see fn 47, where reference is made to the relevant part of the *Digesta* (D 9 3 7).

¹⁴ Berkhouwer and Vorstman *Aansprakelijkheid van de Medicus* 19 as referred to in Carstens 2004 *Fundamina* 11. Where the patient that died was a slave, the medical practitioner had to compensate the owner of the slave by replacing the deceased slave with a new slave.

¹⁵ Carstens 2004 *Fundamina* 12.

¹⁶ The claim can be based on contract or delict depending on the type of damages that is sought to be recovered. Since non-patrimonial damages cannot be recovered in contract, a delictual claim will have to be instituted to recover non-patrimonial damages. For a detailed discussion of the liability system in South Africa see Coetzee and Carstens 2013 "Medical Malpractice" 405. At 406 Coetzee and Carstens discuss vicarious liability of the state where the negligence took place in a state hospital, for example.

¹⁷ The consequence of the removal of a medical practitioner's name from the register at the Health Professions Council, is that such medical practitioner will not be allowed to practice medicine Coetzee and Carstens 2013 "Medical Malpractice" 406, 407, 408 explain the instances in which a medical practitioner could incur criminal liability and

medical mishap or a mere allegation of such, could lead to enormous consequences for a medical practitioner.¹⁸

The majority of medical negligence cases are brought against obstetricians and gynaecologists¹⁹ for birth-related claims. Plastic surgeons often face extremely high claims in value, although they are not sued as frequently as gynaecologists.²⁰

Medical negligence litigation is often the result of poor communication between the medical practitioner and the patient, pertaining to the risks involved in a procedure.²¹ There are, however, other factors that contribute to the significant rise in medical negligence claims, as discussed below.

3 Possible reasons for the rise in medical negligence claims today

Various reasons have been advanced for the increase in both the number and value of medical negligence claims. The most prominent of these will be canvassed below.

3.1 The rise in the value of claims

The rise in the value of medical negligence claims could perhaps, or at least in part, be ascribed to advances in medicine and technology. Advances in medicine enable people to live longer, increasing their life expectancy,²² which can be a factor for consideration when calculating an amount of damages in medical negligence claims. Advances in technology are pushing up the prices of assistive devices, such as wheelchairs, that have

explain the procedure of lodging a complaint of unprofessional conduct at the Health Professions Council of South Africa (at 398-401).

¹⁸ The negative emotional effect of medical negligence claims on medical practitioners has been highlighted by Moore and Slabbert 2013 *SAJBL* 60.

¹⁹ Pepper and Slabbert 2011 *SAJBL* 29, 30 point out that this is a global trend and that 70% of all obstetricians in the United States of America faced litigation at some point in their careers.

²⁰ Pepper and Slabbert 2011 *SAJBL* 29.

²¹ Hyman 2011 *Dispute Resolution Journal* 34. Also see *Castell v De Greef* 1994 4 SA 482 (C) (hereafter the *Castell* case) as examples of South African cases where the issue of risk disclosure was up for consideration by the court.

²² Bateman 2011 *SAMJ* 216 explains further that in a case of a child being injured at birth, for example, the cost of a claim could be based on lifelong care (thanks to the existence of new technology), whereas 10 to 15 years ago the child might not have survived due to a lack of this technology. Payment for the reasonable accommodation of a person that is living with a disability after an operation is made more expensive by the existence of more advanced technologies such as highly sophisticated wheelchairs.

to be factored in when calculating the appropriate amount of damages for the reasonable accommodation of a person that is living with a disability after an operation that was performed negligently.²³ These advances are positive, of course, as they enhance the quality of life of the person left with the disability after such procedure.

3.2 The rise in the number of claims

There are a number of factors to consider when it comes to investigating the reasons behind the increase in the number of claims.

Firstly, the possibility exists that medical negligence litigation is simply increasing because the standard of health care provided by medical practitioners has dropped. This possibility has been dismissed by some commentators.²⁴ The Health Professions Council of South Africa, however, labelled a "decline in professionalism among health care practitioners" as the motivation behind launching a campaign in 2012 to educate patients about their rights, should they fall victim to this decline in professionalism.²⁵ Even if we accept that there is a decline in the level of professionalism among health care practitioners,²⁶ which has yet to be established with certainty, this cannot be seen as the exclusive reason for the increase in medical negligence claims, but could at most possibly be seen as a factor²⁷ contributing to the phenomenon under investigation.

Secondly, the facts that lawyers litigating for aggrieved patients are advertising to represent maltreated patients,²⁸ and that these lawyers are becoming "smarter" have been suggested as possible reasons.²⁹ Lawyers have also recently been labelled as "greedy" and as preying on patients in

²³ See in general Malherbe 2013 *SAMJ* 83, 84. Also see Bateman 2011 *SAMJ* 216.

²⁴ Bateman 2011 *SAMJ* 216. Also see Malherbe 2013 *SAMJ* 83.

²⁵ Malherbe 2013 *SAMJ* 83, 84.

²⁶ Health care practitioners may sometimes find themselves having to perform their duties in less than favourable circumstances that are beyond their control. See Oosthuizen and Carstens 2015 *THRHR* 280, 281 for more information on this.

²⁷ Coetzee and Carstens 2013 "Medical Malpractice" 437, who share the view that the increase in medical negligence claims cannot be ascribed exclusively to a rise in the "incidence of negligence" in the health industry.

²⁸ Pepper and Slabbert 2011 *SAJBL* 30. Also see Moore and Slabbert 2013 *SAJBL* 60.

²⁹ Bateman 2011 *SAMJ* 218. Also see Malherbe 2013 *SAMJ* 83, who states that the changes in the law pertaining to motor vehicle accident claims from the Road Accident Fund might have been the impetus for lawyers to venture into medical negligence claims, as the RAF work is no longer as lucrative as it was. Also see Jordaan and Ismail 2014 *Without Prejudice* 24. Also see Oosthuizen and Carstens 2015 *THRHR* 282, 283, where the blame that has been placed on lawyers for the increase in medical negligence claims is discussed.

hospital who may have suffered at the hands of negligent medical staff.³⁰ What some may label as opportunism amongst legal practitioners specialising in medical negligence claims might otherwise be characterised merely as awareness of developments in the law³¹ which strengthen the patient's chances of success in litigation, provided the pleadings are drafted correctly. Even where cases are handled by skilled personal injury lawyers, there are obstacles to proving actual negligence.³² If we accept that the eagerness of lawyers to represent the victims of alleged medical negligence is a reason for the increase in the number of medical negligence claims, this alone is not sufficient to explain the extent of the increase in these types of claims. It could, at most, be considered to be a factor contributing to the phenomenon, since lawyers cannot fabricate medical negligence claims for litigation.

Thirdly, patients are becoming more aware of their rights and are enforcing their rights through litigation³³ - for which they need lawyers. It has been pointed out that this is a good development as it ensures that aggrieved patients, who have indeed suffered harm as a result of the failure of the health care system, are compensated.³⁴

Lastly, developments in legislation and case law have to be considered as two possible reasons behind the increase. There has been a shift in focus in both legislation and case law towards patient autonomy. Yet these developments have received little attention in the debate about the increase in medical negligence claims. It is submitted that patient-centred legislation

³⁰ Recent media reports state that the Minister of Health at a Medico-Legal symposium held on 9 and 10 March 2015 accused lawyers of being in cahoots with hospital management to ensure a flow of business to the lawyers of medical negligence cases, and thus accused the legal profession of the crisis relating to the rise in medical negligence claims. See for example Anon 2015 <http://www.citypress.co.za/news/motsoaledi-negligence-claims-affect-healthcare-hike-doctors-fees/>.

³¹ Both case law and legislation show a move towards patient autonomy, and will be discussed in more detail below.

³² The difficulties that legal professionals face in proving medical negligence due to the fact that they often have to rely on expert witnesses is still a major obstacle in medical negligence claims. The *res ipsa loquitur* doctrine could have been of great assistance in this regard, as the Plaintiff would then be required to show only that a situation presented itself which, upon the face of it, spells out negligence. This doctrine has never been applied in medical negligence cases. See *Van Wyk v Lewis* 1924 AD 438, where it was pointed out that this doctrine could find application only in cases where one works with absolutes. That is not the case in medical negligence matters. Also see Patel 2008 *SAJBL* 57-60 for a general discussion on the *res ipsa loquitur* doctrine in the South African medical negligence context. Also see *Goliath v Member of the Executive Council for Health, Eastern Cape* 2015 2 SA 97 (SCA).

³³ Bateman 2011 *SAMJ* 216. Also see Jordaan and Ismail 2014 *Without Prejudice* 24.

³⁴ Oosthuizen and Carstens 2015 *THRHR* 284.

and case law have a prominent role to play in explaining the increase in medical negligence claims.

The remainder of this contribution will show how legislation and case law have arguably paved the way for an increase in medical negligence claims.

4 Patient-centred legislation

A number of legislative provisions enacted over the last two decades³⁵ place emphasis on patients' rights, thereby, entitling patients to institute claims against medical practitioners and service providers to protect these rights. This contribution does not aim to discuss all of the relevant legislative provisions that may possibly empower a patient to institute a claim, but will focus on selected patient-centred pieces of legislation that have a significant impact on the health care context. A discussion of relevant provisions in the *Constitution*,³⁶ *National Health Act*,³⁷ *Consumer Protection Act*³⁸ and *Children's Act*³⁹ is therefore apt.

4.1 Constitution

The *Constitution* expressly protects the right to bodily integrity,⁴⁰ dignity,⁴¹ privacy,⁴² and access to health care.⁴³ These rights are of particular significance in the medical context as it is often the infringement of these rights that forms the basis of a medical negligence claim.⁴⁴ For instance,

³⁵ For example the *Constitution of the Republic of South Africa*, 1996, the *National Health Act* 61 of 2003, and more recently the *Consumer Protection Act* 68 of 2008 all contain provisions that aim to protect the user of services, including health services. The *Children's Act* 38 of 2005 empowers children to take independent decisions regarding their health, provided that certain requirements are met. The *Mental Health Care Act* 17 of 2002 contains a patient's charter that *inter alia* states that a patient is entitled to be informed of his/her rights. The new *Protection of Personal Information Act* 4 of 2013 may also impact on the way that health care providers do business.

³⁶ The *Constitution of the Republic of South Africa*, 1996 (hereafter referred to as the *Constitution*).

³⁷ The *National Health Act* 61 of 2003 (hereafter the *National Health Act*).

³⁸ The *Consumer Protection Act* 68 of 2008 (hereinafter referred to as the *Consumer Protection Act*).

³⁹ The *Children's Act* 38 of 2005 (hereafter the *Children's Act*).

⁴⁰ Section 12 of the *Constitution*.

⁴¹ Section 10 of the *Constitution*.

⁴² Section 14 of the *Constitution*.

⁴³ Section 27 of the *Constitution*.

⁴⁴ See for example *Jansen van Vuuren v Kruger* 1993 2 All SA 619 (A), where the privacy of the patient was at issue. The doctor disclosed the patient's HIV status without the patient's consent, in fact against the express wish of the patient. The court found that this behaviour by the medical practitioner constituted an unauthorised disclosure of the medical facts of the patient. After the enactment of the *Constitution*, the case of *Tshabalala-Msimang v Makhanya* 2008 1 All SA 509 (W) (hereafter the *Tshabalala-*

where a procedure is performed without a patient's informed consent, it could be argued that such a procedure constitutes an infringement of the patient's bodily integrity.⁴⁵ Where a patient's medical records are disclosed to the public without his/her consent, such a disclosure could be construed as a violation of a patient's right to privacy.⁴⁶ These rights are further strengthened by the provisions of the *National Health Act*.

4.2 *National Health Act*

The *National Health Act* sets out the rights and duties of patients.⁴⁷ It serves to emphasise the autonomy of the patient *inter alia* through the inclusion of the common law principle of informed consent.⁴⁸ Included in the right to informed consent is the express right to refuse treatment.⁴⁹ The patient's right to participate in his/her own health care decisions⁵⁰ further emphasises and bolsters patient autonomy.

The *National Health Act* emphasises the confidentiality of health care information,⁵¹ which may only be disclosed with the written consent of the patient, by order of court or where any other law authorises such disclosure,

Msimang case), confirmed the right to privacy of medical information as provided for in the *National Health Act*. Where an operation is done without informed consent, the patient's bodily integrity is infringed. See for example *McDonald v Wroe* 2006 3 All SA 565 (C).

⁴⁵ This would in particular violate s 12(2)(b), which provides that everyone will have the right to security and control over their bodies. If the decision to proceed with an intervention is taken by someone other than a competent patient in a situation where the patient was perfectly capable to take such a decision, such a patient was deprived of the right to have control over his/her body as provided for in s 12(2)(b) of the *Constitution*.

⁴⁶ See for example the *Tshabalala-Msimang* case.

⁴⁷ Sections 5-20 of the *National Health Act*. The duties placed on patients in this part of the Act relate to treating the health care provider with respect and signing a release of liability form in the event that the patient refuses the suggested treatment. The remainder of the provisions in this part of the Act focus on the rights of the patient.

⁴⁸ Sections 6 and 7 of the *National Health Act* confirm the patient's right to be informed.

⁴⁹ Section 6(1)(d) of the *National Health Act*. Patients are obliged to sign a release of liability form in the event that the patient refuses the suggested treatment. See ss 19(c) and (d) of the *National Health Act*. A health care practitioner who is not treated with the necessary respect in the sense that s/he is subjected to physical or verbal abuse or harassed sexually may refuse to treat the patient who is subjecting him/her to such disrespectful treatment. (S 20 of the Act).

⁵⁰ Section 8 of the *National Health Act*. This section even provides that, where the user is incapable of participating in decisions regarding his/her health care, s/he must be informed in accordance with s 6 of the risks and benefits involved in the relevant treatment once s/he is able to understand the relevant information. This information may be withheld only if it is in the best interest of the patient to do so. (S 8(4) of the Act).

⁵¹ This is information about the health status and treatment of a health care user. See ss 14 and 17 of the *National Health Act*.

or if non-disclosure would pose a threat to public health.⁵² It imposes corresponding duties on health care providers. Some of these duties did not form part of the common law, and are in addition to what was expected of medical practitioners prior to the promulgation of the *Act*.⁵³

It is evident from the above that a patient is now, after the enactment of the *National Health Act*, in a much stronger position to litigate against a health care practitioner than before, since the *Act* sets out express rights of the patient which the patient can enforce through litigation. A patient may, for example, decide to institute action where s/he was not granted the opportunity to participate in decisions regarding his/her health and may rely on the specific provision in the *Act* to this effect.⁵⁴ Previously, such a patient could rely on the more general protection of the right to bodily integrity as provided for in the *Constitution*.⁵⁵

4.3 Consumer Protection Act

The *Consumer Protection Act* adds to the new list of responsibilities that health care providers are tasked with.⁵⁶ It may have a significant impact on health care providers such as hospitals where an admission form, which usually contains an indemnity clause of some kind, is routinely signed by patients upon admission to the facility. The *Consumer Protection Act* now places a duty on the health care facility to draw the patient's attention to an indemnity clause where such a clause purports to exclude liability for any activity that could lead to serious injury to or the death of a consumer.⁵⁷ This changes the legal position, as it had been decided previously that there was no duty on a hospital admission clerk to draw a patient's attention to an indemnity clause to this effect.⁵⁸ Admission forms will have to be revised, as

⁵² Section 14 of the *National Health Act*.

⁵³ For example, the *National Health Act* requires a health care provider to inform a patient of all the diagnostic procedures available to the patient as well as the costs associated with each treatment option. (Ss 6(1)(b) and (c) of the *Act*). This duty did not rest on a medical practitioner in terms of our common law prior to the enactment of the *Act*.

⁵⁴ Section 8 of the *National Health Act*.

⁵⁵ Section 12 of the *Constitution*. More particularly, the right to have control over one's body, which could easily be interpreted as including the right to take informed decisions regarding medical procedures.

⁵⁶ The health care industry has not, as at the date of writing this article (March 2015), been exempt from the provisions of the *Consumer Protection Act*.

⁵⁷ Section 49(2)(c) of the *Consumer Protection Act*.

⁵⁸ It was decided in *Afrox Healthcare Bpk v Strydom* 2002 4 All SA 125 (SCA) that there is no duty on an admission clerk in a hospital to point out an indemnity clause to a patient, despite the apparent unequal bargaining power between the parties. The court found that there was no evidence of the bargaining power's being unequal. There was further no express prohibition against excluding liability for gross negligence in an

the *Consumer Protection Act* now prohibits the inclusion of an indemnity clause that aims to exclude liability for gross negligence.⁵⁹ These provisions seem to be aimed at placing the patient in a position of control over the decision as to the risks that they are willing to take. Such control bolsters patient autonomy.

4.4 *Children's Act*

The *Children's Act* places specific obligations on health care providers when treating children to ensure *inter alia* the protection of the child's right to bodily integrity.⁶⁰ The *Children's Act* emphasises the child's right to participate in decisions concerning him/her and states that the child's view should be taken into account in all matters that concerns him/her.⁶¹ This Act empowers the child to take independent decisions regarding his/her health care in certain instances.⁶²

The child's right to privacy, in particular with regard to contraceptives and HIV testing, has to be respected by the health care provider.⁶³ The best interests of the child principle as enshrined in the *Constitution* is echoed in the *Children's Act*, which states that the best interests of the child shall be paramount in all matters concerning the child.⁶⁴

The *Children's Act* changes the playing field for health care providers who provide health care services to children. They now have to obtain consent from the child, if the child is 12 years or older, before providing treatment, whereas in the past, they might only have been concerned with informing,

indemnity clause, although the court indicated that it might possibly not withstand opposition.

⁵⁹ Section 51(c)(i) of the *Consumer Protection Act*.

⁶⁰ Section 28(g)(i) of the *Constitution* specifically states that the rights of children as contained in s 28 of the *Constitution* shall be in addition to the rights that the child has in terms of s 12 of the *Constitution*. Also see Robinson 2003 PELJ 12, 16. See further *Bhe v Magistrate, Khayelitsha* 2005 1 SA 580 (CC) para 52, where this principle was confirmed by the Constitutional Court. Also see *Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development* 2014 2 SA 168 (CC) para 38.

⁶¹ Section 10 of the *Children's Act*. This could pose some challenges for the health care professional since different levels of maturity of children have to be considered in making the information understandable to the child – another obligation placed on the health care provider by the provision in the legislation that information must be made available to the patient having due regard to his/her level of literacy. See s 6(2) of the *National Health Act*.

⁶² Section 129 of the *Children's Act* sets out the circumstances under which a child may consent to his/her own medical treatment.

⁶³ Section 134 of the *Children's Act* guarantees a child confidentiality regarding contraceptives and s 133 guarantees the confidentiality of HIV test results.

⁶⁴ Section 9 of the *Children's Act*. Also see s 28(2) of the *Constitution*.

and obtaining consent from the parents for the treatment that the child has to undergo.⁶⁵

5 Patient-centred jurisprudence

The autonomy of the patient (including a child patient) is the one constant theme in all the legislative provisions discussed above, with the subthemes being informed consent, the confidentiality of medical information, and the paramountcy of the best interests of the child in all matters concerning the child.

As courts have to consider and apply the above legislative provisions in matters pertaining to medical negligence, it is appropriate to consider judgments which fall within the ambit of the above themes. This will serve to evaluate the court's approach to these issues in the context of medical negligence over the last couple of years.

The rise in medical negligence claims should come as no surprise as our courts have, even before the enactment of the *Constitution*, held patient autonomy, in particular, in very high regard.

5.1 Patient autonomy and informed consent

The court's approach to the autonomy of a patient is well illustrated by a case that was decided before the *Constitution* and before any of the above legislative provisions were enacted. This is the case of *Castell v De Greef*.⁶⁶ The court had to determine, inter alia determine if a patient had been properly informed of the risks involved in a particular procedure. Prior to the *Castell* case, the test that had been applied to determine if a medical practitioner had in fact been negligent in not disclosing a particular risk to a patient was the "reasonable doctor test".⁶⁷ The question was whether a

⁶⁵ The *Child Care Act* 74 of 1983, which was repealed by the *Children's Act*, provided in s 39 thereof that a child of 14 years or older might consent to medical treatment and a child of 18 might consent to a surgical operation. The position has changed in the *Children's Act*, in that a child of 12 years may now consent independently to medical treatment and may also consent to a surgical operation but must then be assisted by a parent. In the latter case, the medical practitioner would have to obtain the signatures of both parent and child to the performance of the procedure on the child if the child is over 12 years and of sufficient maturity to understand the risks and benefits relevant to the particular procedures. See s 129 of the *Children's Act*. When conducting an HIV test, a child under the age of 12 who is of sufficient maturity may consent independently to such a test. See s 130(2)(a)(ii) of the *Children's Act*.

⁶⁶ *Castell v De Greef* 1994 4 SA 408 (C) (the *Castell* case).

⁶⁷ *Richter v Estate Hamman* 1976 3 SA 226 (C). See, however, the *Castell* case 418H, 419C where the court rejected the notion that the "reasonable doctor test" had been

reasonable doctor would have disclosed the particular risk to a patient or not.⁶⁸ No consideration was given to the possibility that a particular patient might have considered a particular risk as significant.

In the *Castell* case the court moved away from the reasonable doctor test towards a doctrine of informed consent. This doctrine entails that a material risk test is used to determine which risks a medical practitioner should disclose to his/her patient.⁶⁹ The test has to be applied in two parts, the first comprising the objective inquiry and the second the subjective inquiry. Firstly, a risk would be material if "the reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it," and secondly, a risk would be material if "the doctor is or reasonably should have been aware, that the particular patient, if warned of the risk, would be likely to attach significance to it".⁷⁰ The formulation of this test is based on the fundamental right to self-determination and autonomy.⁷¹ The move towards autonomy turns its back on paternalism in the context of risk disclosure and introduces a subjective element to the inquiry into the question of whether or not a certain risk should be disclosed. The effect is that the best judge of what is reasonable in terms of disclosure is the patient and no longer the doctor. As Van Oosten puts it:

This shift in emphasis, from a profession-orientated test of disclosure, to a patient orientated test of disclosure, presents a radical departure from existing law and an important judicial innovation in the sphere of the doctor's duty to inform.⁷²

The court in the *Castell* case confirmed that this change in approach was in line with the "human rights culture" in South Africa and the "consumerism" ever present in "modern societies".⁷³ This statement in *Castell* was made prior to the enactment of the 1996 *Constitution*. One would imagine that the view expressed by the court in the *Castell* case is bolstered by the explicit right to bodily integrity now enshrined in the *Constitution*.⁷⁴

This material risk test was later confirmed in a further judgment in *Oldwage v Louwrens*,⁷⁵ after the enactment of the *Constitution*. The Supreme Court

well established in our law as stated in the first mentioned case. Also see Van Oosten 1995 *De Jure* 173.

⁶⁸ Van Oosten 1995 *De Jure* 170.

⁶⁹ *Castell* case 426F-H.

⁷⁰ *Castell* case 426F-H. Also see Van Oosten 1995 *De Jure* 174.

⁷¹ Van Oosten 1995 *De Jure* 174.

⁷² Van Oosten 1995 *De Jure* 176.

⁷³ *Castell* case 423H-I. Also see Van Oosten 1995 *De Jure* 176.

⁷⁴ Section 12 of the *Constitution*.

⁷⁵ *Oldwage v Louwrens* 2004 1 All SA 532 (C) (hereafter the *Oldwage* case).

of Appeal has yet to confirm the correctness of the material risk test.⁷⁶ In the meantime, traces of the material risk test have been incorporated into the *National Health Act*.⁷⁷

Our courts have for some time now followed the approach that a patient has to give informed consent to a medical intervention (barring certain exceptions such as an emergency).⁷⁸ Through taking this approach, patient autonomy is recognised and protected. The move away from paternalism in our jurisprudence strengthens the possibility that a patient is now more likely to sue a doctor for not disclosing information that the doctor might not have considered significant, but that the patient would have wanted to know in order to take an informed decision about a procedure.⁷⁹ A doctor may rely on therapeutic privilege⁸⁰ to justify non-disclosure of certain information to a patient, but this possible defence obviously does not bar an aggrieved patient from instituting an action against a doctor.

One must not lose sight of the fact that the doctor has the medical knowledge to best advise the patient on the appropriate treatment and the risks involved in a particular procedure. Failure by the doctor to disclose relevant risks could expose him/her to liability, as such a failure deprives the patient of the opportunity to consider the risks in the process of making an informed decision about the relevant medical procedure. The ultimate decision to take the disclosed risks rests with the patient.⁸¹

⁷⁶ The *Oldwage* case went on appeal to the Supreme Court of Appeal, where the appeal was upheld. The Supreme Court of Appeal, however, did not expressly confirm the correctness of the material risk test in this judgment.

⁷⁷ Sections 6 and 7 of the *National Health Act*.

⁷⁸ Van Oosten 1995 *De Jure* 167.

⁷⁹ This is of course not a blanket rule as the doctor may be justified in not disclosing a particular risk if the withholding of the information is in the best interest of the patient. The doctor would in this instance rely on therapeutic privilege. See the *Castell* case 427, where the court mentions in an *obiter dictum* that the duty to disclose has to be considered with due regard to therapeutic privilege. Also see in general Coetzee 2003 *CILSA* 268-288, where therapeutic privilege is analysed in detail.

⁸⁰ This entails that the doctor withholds information from the patient, believing that it would be in the best interest of the patient to not know of a particular risk. This is mostly relevant where a patient is diagnosed with cancer, for example, but the doctor withholds this information from the patient out of fear that the patient will refuse treatment. Coetzee 2003 *CILSA* 271. Also see Van den Heever 2005 *SAMJ* 420, 421, where it is stated that the defence lends itself to abuse by doctors for an excuse as to why they did not inform a patient of a particular fact.

⁸¹ This could be seen as the aim of the material risk test as introduced in the *Castell* case.

5.2 Privacy of health information

The Constitutional Court emphasised the importance of protecting confidential medical information such as a person's HIV status.⁸² Subsequent to this judgment, the *National Health Act* was promulgated. It expressly provides for the confidentiality of a person's health status, which could include the person's HIV status.⁸³

The High Court applied the provisions of the *National Health Act* to order the return of health records containing information about a patient's health status in the case of *Tshabalala-Msimang v Makhanya*.⁸⁴ The Sunday Times newspaper was in possession of information about Ms Tshabalala-Msimang's treatment in a private health facility, and the information was published in the newspaper.⁸⁵ She relied on the provisions of the *National Health Act*⁸⁶ to request the court to order the return of the records, as she had not consented to the disclosure. She succeeded with this plea.⁸⁷ The court held that an individual's medical information is worth protecting as part of a person's autonomy and dignity, as provided for in both the *Constitution* and the *National Health Act*.⁸⁸

She further requested the court to order that no further information about her treatment be published. The court was not willing to make this order and stated that her right to privacy had to be weighed up against the public's right to know, since she was a public figure at the time.⁸⁹

This case illustrates that the right to privacy in the health care context is not absolute and will have to be weighed up against other rights. It also illustrates the importance of the protection of medical information as a component of patient autonomy.

⁸² *NM v Smith* 2007 5 SA 250 (CC). In this case, the names and HIV status of three applicants had been published without their consent. The court found that there was a strong need to protect autonomy and foster respect for private medical information. The court found that the disclosure of the identities of the applicants and their HIV status in this particular instance was unreasonable. Damages were awarded to the applicants.

⁸³ Section 14(1) of the *National Health Act* states that all information about a user, including his/her health status, is confidential. The Act does not define "health status" and this term therefore probably includes any diagnosis, including the HIV status of a patient.

⁸⁴ *Tshabalala-Msimang v Makhanya* 2008 1 All SA 509 (W).

⁸⁵ *Tshabalala-Msimang* case para 7.

⁸⁶ More specifically ss 14 and 17 of the *National Health Act*.

⁸⁷ *Tshabalala-Msimang* case para 61.1.

⁸⁸ *Tshabalala-Msimang* case para 27.

⁸⁹ *Tshabalala-Msimang* case para 45.

5.3 *Best interests of the child in the medical context*

As noted earlier, the majority of medical negligence claims are instituted against obstetricians and gynaecologists. Notably, claims for wrongful pregnancy⁹⁰ and wrongful birth⁹¹ are brought against these practitioners. Claims for wrongful life⁹² have been instituted in our courts but are not recognised in our law, as such recognition is regarded as against public policy.⁹³ Establishing the amount of damages to be awarded in wrongful life cases poses challenges. In fact, a more fundamental question has to be asked in these cases, namely, were damages suffered at all? The court is asked to determine if the child with disabilities should have been born at all.⁹⁴

Recently, however, the Constitutional Court in *H v Fetal Assessment Centre*⁹⁵ did not concern itself in the first instance with whether or not the child should have been born. "The legal issue," the court found, "is not the 'wrongful life' of the child, but whether the law should allow a child to claim compensation for a life with disability".⁹⁶ The Constitutional Court found that a claim by a child born with a disability, known as a "wrongful life" claim, "may potentially be found to exist,"⁹⁷ and found that the dismissal of the wrongful life claim by the High Court in this particular case was

⁹⁰ A claim where the parents of a healthy but unwanted child institute a claim against the medical practitioner who failed to perform a contraceptive procedure properly or at all, or who gave incorrect or incomplete contraceptive advice. These claims succeeded in the cases of *Administrator Natal v Edouard* 1990 3 SA 581 (A) and *Mukheiber v Raath* 1999 3 SA 1065 (SCA).

⁹¹ A claim brought by the parents of a child living with a disability against the party who is allegedly responsible for failing to prevent the birth of the child. The plaintiff must prove that she would have aborted the foetus, had she been aware of the fact that the foetus had a disability. The doctor thus breached his duty of care towards the patient in either not performing the tests to detect a disability properly or at all, or he conducted the tests but failed to inform the plaintiff of the results. The parents would claim for the costs of maintaining and rearing a child with special needs, which might include a claim for special schooling and medical expenses that might have to be incurred to manage the disability of the child. This claim was successful in *Friedman v Glicksman* 1996 1 SA 1134 (W) (hereafter the *Friedman* case).

⁹² A claim brought by a child living with a disability against a medical practitioner for allowing him/her to be born. In these cases, the harm suffered is alleged to be the life of the child. See the *Friedman* case and *Stewart v Botha* 2007 6 SA 247 (C) (hereafter the *Stewart* case) for reasons why these claims are not recognised in our law.

⁹³ See in general the *Friedman* case and the *Stewart* case.

⁹⁴ *Stewart v Botha* 2008 6 SA 310 (SCA) para 20, where Snyders J stated that the question if a child should have been born at all "...goes so deeply to the heart of what it is to be human that it should not even be asked of the law".

⁹⁵ *H v Fetal Assessment Centre* 2015 2 SA 193 (CC).

⁹⁶ *H v Fetal Assessment Centre* 2015 2 SA 193 (CC) para 19.

⁹⁷ *H v Fetal Assessment Centre* 2015 2 SA 193 (CC) para 81.

unwarranted.⁹⁸ The matter was referred back to the High Court for consideration.⁹⁹

It was emphasised in this judgment that the constitutional rights and values at the forefront of this enquiry into the existence of the claim for wrongful life are equality and dignity,¹⁰⁰ and the right of all children to have their best interests considered to be of paramount importance in all matters concerning them.¹⁰¹

If it is eventually decided that there is a place in our law for an action for wrongful life based on the best interests principle, we will most definitely see yet a further increase in medical negligence claims.

6 Conclusion

The increase in medical negligence claims cannot be ascribed to one single reason. It is rather a combination of developments in the medical industry and the law that creates fertile ground for making such claims.¹⁰²

The progressive patient-centred legislation that saw the light after the enactment of the *Constitution* will continue to raise awareness in patients of their rights, and may encourage them to institute claims where they might not have done so before.

It is clear that our courts hold patient autonomy and the confidentiality of medical information in very high regard. The principle of the best interests of the child as the paramount consideration in all matters concerning a child has been re-emphasised by the Constitutional Court's judgment in the *H v Fetal Assessment Centre* case *supra*. The court's approach to these matters, as illustrated by the above decisions, together with the patient-

⁹⁸ *H v Fetal Assessment Centre* 2015 2 SA 193 (CC) para 79.

⁹⁹ The plaintiff is granted leave to amend the particulars of claim in order for the matter to be considered by the High Court. See *H v Fetal Assessment Centre* 2015 2 SA 193 (CC) para 79 and the relief granted at para 83.

¹⁰⁰ Presumably, in the context of the facts under consideration, this refers in particular to the right to dignity and equality of children and persons living with disabilities.

¹⁰¹ *H v Fetal Assessment Centre* 2015 2 SA 39 (CC) para 49. Froneman J stated that: "Our law, including our common law, must conform to the values of the Constitution and that its development must promote the 'spirit, purport and objects of the Bill of Rights' is the given starting point for determining the viability of the child's claim in the circumstances of this case. The particular values and rights that are at the forefront are those of equality, dignity, and the right of children to have their best interests considered of paramount importance in every matter concerning them."

¹⁰² Coetzee and Carstens 2013 "Medical Malpractice" 437. They add that the less personal relationship that exists these days between doctors and patients could be another reason for the rise in negligence claims.

centred legislation discussed above, seems to further create fertile ground for an increase in medical negligence claims in South Africa. The success of a medical negligence claim is not guaranteed, however. There are many examples of cases where patients were unsuccessful.¹⁰³

It could possibly be argued that the joint effect of patient-centred legislation and jurisprudence is that the scale has tipped ever so slightly and no doubt unintentionally in favour of the patient, and that this has made it increasingly difficult (and expensive) for a medical practitioner to defend a medical negligence claim brought against him/her.

There have been many suggestions as to how to curb the increase in medical negligence claims, but they are not considered here. The focus of this contribution is to consider the possible reasons behind this increase. Since this contribution suggests that legislation is at the very least a contributing factor to the increase in medical negligence claims, it seems appropriate to suggest that solutions to curbing the increase in these claims, too, should perhaps be introduced through legislation. The viability of such legislation and the possible ambit thereof merit further investigation.

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List of Abbreviations

CILSA	Comparative and International Law Journal of Southern Africa
MPS	Medical Protection Society
PELJ	Potchefstroom Electronic Law Journal
SAJBL	South African Journal of Biotechnology and Law
SALJ	South African Law Journal
SAMJ	South African Medical Journal
THRHR	Tydskrif vir Hedendaagse Romeins-Hollandse Reg