Mandatory Mediation as a Means to Address the Medical Litigation Crisis in the South African Health Sector

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Declaration

I, Hlamatsi Jacob Moutlana, herewith declare that this research report titled

Mandatory Mediation as a Means to Address the Medical Litigation Crisis in the South African Health Sector

is my own, unaided work.

It is being submitted for the degree of Masters of Science in Medicine in Bioethics and Health Law, at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

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Signed

On this: 01 day of June 2021

Dedication

This project is dedicated to:

My wife Nhlanhla, for your countless support throughout this journey,

My children Thato and Bontle, for understanding when I needed time to lock myself up in the study for hours in order to focus on this project.

Acknowledgements

I would like to thank my supervisor, Prof Ames Dhai for her guidance, positive criticism and patience, throughout my limping journey while I endured this process. Your encouragement has made this journey bearable and you have actually inspired my love for bioethics and law.

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List of Acronyms

ADR	Alternative dispute resolution
CPR	Civil Procedure Rules
EU	European Union
HREC	Human Research Ethics Committee
MEC	Member of the Executive Council
MiM	Mediation in Motion
MPS	Medical Protection Society
NHA	National Health Act
NHS	National Health Service
SA	South Africa
SALC	South African Law Commission
SALRC	South African Law Reform Commission
SMC	Singapore Mediation Centre
UK	United Kingdom

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Chapter 1: Introduction to the research

1.1 Introduction

Medical litigation has been reported to be on the rise as far back as 1991 (Strauss, 1991) and has currently reached a crisis level in South Africa (SA) (Dhai, 2015, Claassen, 2016). This means that valuable time and other resources that should be dedicated to patient care are diverted to addressing this crisis. (Dhai, 2015) Several initiatives at national level, such as the medicolegal summit convened by then Minister of Health, Dr Aaron Motswaledi in 2015 (Department of Health, 2015), have been embarked upon in an attempt to address the issue. In addition to national initiatives, provincial and local governments have also embarked upon initiatives to address this issue, however, these have met with very little success.

Claims as a result of medical negligence is not only a South African problem, other countries globally face similar issues. In the United Kingdom (UK) clinical claims have also been on the rise over the past 10 years. (National Health Service, 2020) However, the proportion of cases settled without court proceedings in the UK has also been increasing over the years and the 2019/2020 annual report by the National Health Service (NHS) indicated that 71% of these claims are settled outside the courts. (National Health Service, 2020). A report by Crico Strategies showed a 27% drop in the frequency of medical negligence claims in the United States of America between 2007 and 2016. However, the value of indemnity payment increased by seven percent annually over the same period. Various factors such as improved patient safety and changes in the tort environment are cited as the likely contributors to the reduction in the frequency of medical negligence claims. (Crico Strategies, 2018). In this

chapter the background literature on medical litigation and the current crisis is analysed and critiqued, and the approach to research is outlined.

1.2 Background Literature Analysis and Critique

The doctor-patient relationship is governed by the law of contract. (Coetzee and Carstens, 2011) This means a patient who consults with a doctor or hospital enters into a contractual relationship with a doctor or hospital respectively and mere consensus between the parties renders the contract legally valid. The relationship is also governed by the law of delict (tort). (Coetzee and Carstens, 2011) Delict is defined by Neethling et al as an "act of a person that in a wrongful, and culpable way causes harm to another". (Neethling et al., 2017) A doctor or hospital is expected to ensure reasonable care to prevent harm to their patients. (Coetzee and Carstens, 2011) Liability for negligence may be incurred by the doctor or hospital should the patient suffer damages or injuries as a result of negligent conduct, intentional harm or breach of contract. (Dhai, 2015, Coetzee and Carstens, 2011).

In SA, according to the South African Law Reform Commission (SALRC), claims arising from possible medical negligence normally undergo the legal process, where the claimant sources legal representation for legal proceedings in the appropriate court to prove that he or she has suffered damages, as a result of negligence. (South African Law Reform Commission, 2017) The legal process referred to above is termed litigation. Alternative dispute resolution (ADR) mechanisms such as negotiation, mediation and arbitration can be utilised to resolve medical negligence disputes without resorting to litigation. (Patel, 2017, Amirthalingam, 2017).

Negotiation is defined by Patton, as "back-and-forth communication designed to reach an agreement between two or more parties…..". (Patton, 2005) The parties work towards a mutually agreeable outcome to resolve the dispute, in a manner that is fair to everyone involved. (Dhai, 2016) Mediation is defined as "the process by which a mediator assists the parties in actual or potential litigation to resolve the dispute between them by facilitating discussions between the parties…….in an attempt to resolve the dispute" (Claassen, 2016) Arbitration involves the use of a neutral third-party to render a solution, through a binding process. (Cole and Blankley, 2005)

Litigation as a form of resolving disputes is expensive, time-consuming, emotionally draining and lengthy (Taylor et al., 2018). The cost of settling these claims have been on the rise. In 2009/2010 the Gauteng Provincial Health Department was facing medical negligence claims of R573 million (Malherbe, 2013). In 2016 Claasen reported that the same department had claims with a total quantum of approximately R3.5 billion instituted (Claassen, 2016). The Gauteng Provincial Health Department is reported to be facing medical negligence claims amounting R29 billion in 2019, according to a recent media report. (Mabuza, 2019)

In 2017 the South African National Department of Health incurred an amount in excess of R55 billion in contingent liabilities for alleged medical negligence (Taylor et al., 2018) The amount of medical negligence claims rose to about R80.4 billion 2017-2018 financial year. (Kahn, 2019) The national medical negligence claims against the nine provinces then increased by 30% in 2018/2019 financial year to R104.5 billion. (Medical Brief, 2020) These contingent liabilities as well as legal expenses take up a significant portion of the health budget, as the money used to pay these claims needs to be sourced from the provincial health budgets as they are not accounted for in the budget. (Malherbe, 2013)

In the private sector the rising costs of settling medical negligence claims is also alarming. In 2016, the Medical Protection Society (MPS), which is an indemnity insurance reported a rise of 550% in medical negligence claims against their members as compared to a decade ago. The quantum of claims exceeding R5 million rand also increased by 900%. (Claassen, 2016) The focus of the study is on the SA public health sector due to the fact that the majority of the SA population rely on the public health sector (Coetzee and Carstens, 2011), however the principles addressed will apply to both sectors.

The rising costs of medical negligence claims has reached crisis levels (Dhai, 2015, Claassen, 2016). This, coupled with the fact that the costs of managing these claims are drawn from the health budget in the public sector (Claassen, 2016), could result in a potential paralysis of service delivery. (Taylor et al., 2018). Consequently, this may result in compromising the provision of access to health care to patients as provided for in section 27 of the Constitution of the Republic of South Africa (Dhai, 2016, Claassen, 2016, Republic of South Africa, 1996). Inability to access health services may further infringe on the following constitutional rights: "section 10 (right to human dignity), section 11 (right to life), section 12 (2) (right to bodily and psychological integrity)" (Claassen, 2016, Republic of South Africa, 1996).

The right to human dignity and life are entirely non-derogable according to section 37 (5) of the Constitution of the Republic of South Africa (Republic of South Africa, 1996), therefore infringement of such rights is non-negotiable. Furthermore compromising the provision of access to health care will violate the rights to life and liberty, as proclaimed in the Universal Declaration of Human Rights (Boroi et al., 2015). Such a violation further infringes on section 39 (b) of the Constitution of the Republic of South Africa, which provides that when interpreting the Bill of Rights, international law must be considered. (Republic of South

Africa, 1996) Therefore, a violation of the Universal Declaration of Human Rights could be inferred to be an infringement of the Constitution.

The ethical concerns relating to litigation have brought about the need for a system that can address the rising costs of litigation and amounts paid as quantum for negligent acts, as well as fairly resolve the patient's disputes (Howarth and Hallinan, 2016). The counter-argument that will need to be addressed while considering the constitutional concerns related to litigation, is the issue of infringing the aggrieved patient's right to courts or independent and impartial tribunals or forums, as provided for in section 34 of the Constitution of the Republic of South Africa (Claassen, 2016, Republic of South Africa, 1996).

In order to benefit the healthcare system, healthcare providers and patients, there have been recommendations for the use of non-adversarial methods to handle medicolegal disputes outside the courts (Taylor et al., 2018). Mediation is reported as a far less costly process compared to litigation and other alternate dispute resolution mechanisms like arbitration. (Claassen, 2016). The success rate of mediation has been reported to be between 80 and 90%. (Claassen, 2016) Singapore implemented mediation years ago and had a success rate of 93% out of 3943 cases in the year 2000 (Claassen, 2016).

The advantages and benefits of mediation include the fact that it is voluntary, without prejudice, client based, private and confidential. (Claassen, 2016). A doctor-patient relationship is in most cases an ongoing relationship. Therefore, mediation is better suited than litigation to resolve medical negligence claims. (Amirthalingam, 2017) Mediation also assists in maintaining ongoing relationships. (Amirthalingam, 2017)

The fact that mediation addresses the ethical concerns brought about by litigation, makes a compelling argument that mediation as a dispute resolution mechanism is ethically justifiable. Furthermore, the ethical implications of instituting mandatory mediation as a first line of dispute resolution in the SA health sector, could be that the constitutional concerns brought about by litigation-related costs impact on the provision of health care services would possibly be addressed.

Addressing a counter-argument regarding as to whether it would be constitutional to institute mandatory mediation with specific reference to section 34 of the Constitution of the Republic of South Africa, access to courts, it can be argued that mediation is a form of an independent and impartial forum to resolve disputes, as provided for in the same section. (Republic of South Africa, 1996)

Countries like Singapore have adopted the mediation procedure which is conducted by the Singapore Mediation Centre (SMC), where parties seeking to mediate their dispute initiate the process by completing the request for mediation form to the SMC. The mediation process is governed by the Mediation Act 2017. (Singapore Mediation Centre, 2018) In England, mediation has also been adopted and the NHS provides practical steps to guide patients and healthcare workers to utilise mediation for their disputes. (Public Participation Team N.H.S, 2016)

In SA, the Rules of Voluntary Court-Annexed Mediation were approved by the Minister of Justice and came into operation on the 1st of December 2014. (Walters, 2014, Department of Justice and Constitutional Development, 2014) The rules allow for the referral of disputes for mediation at any given time during civil proceedings, provided that there is no judgement

already delivered. (Department of Justice and Constitutional Development, 2014) The amendment of section 41A of the rules regulating the conduct of courts in SA, which were promulgated early in 2020, requires for both the plaintiff and the defendant to indicate whether or not they agree for their dispute to be referred for mediation. The amendment also requires that if any party believes that the dispute is not capable of being mediated, they should provide clear and concise reasons in support of such belief. (Department of Justice and Constitutional Development, 2020)

Informed consent for medical treatment in SA is provided for in the National Health Act (NHA) 61 of 2003. (Parliament of the Republic of South Africa, 2003) Information about the patient's health status and treatment options, as well as the right to refuse hospital treatment is outlined on the informed consent. (The Health Care Professions Council of South Africa, 2016) The addition of an agreement to utilise mediation in case of arising medical negligence disputes, can be added to the informed consent document as an implementation of the amendment of section 41A of the rules regulating the conducts of court outlined in the previous paragraph.

1.3 Research Question

Would it be morally justified to use mandatory mediation as a means to address the medical litigation crisis the SA health sector?

1.4 Rationale for the study

The cost of settling medicolegal claims in the SA public health sector has spiraled out of control and it is an issue of great concern. (Dhai, 2015) While there are multiple ways of addressing the issue, for example the prevention of such claims, it is well known that the cost of litigation is the major contributor of the medical litigation crisis. (Dhai, 2015) Should the funds meant for the provision of actual health care services be used for litigation, a vicious circle ensues resulting in more claims.

The advantages and benefits of mediation as compared to litigation, includes: less costs compared to litigation, less time consuming, voluntary and without prejudice, suggesting that mediation would benefit state hospitals with malpractice cases. (Claassen, 2016) In 2016 there were been reports that the Minister of Justice would submit a policy framework to cabinet, making it necessary that all cases against the state are subjected to mediation first. (Claassen, 2016) This was realised in 2020, when the amendment of section 41A of the rules regulating the conduct of courts in SA, provided for parties to consider mediation prior to utilising the courts. (Department of Justice and Constitutional Development, 2020) Thus far studies looking at whether mandatory mediation would be morally justifiable could not be identified and therefore, a study focusing on mandatory mediation as a means to address the current medical litigation crisis in SA is imperative.

1.5 Thesis Statement

I argue that mediation should be instituted as a mandatory step prior to litigation in the SA health sector.

1.6 Research Aim

This research report aims to normatively assess whether mediation ought to be a mandatory process when disputes with potential for litigation with regards to matters involving medical negligence/ malpractice arise in the SA health sector.

1.7 Research Objectives

In this research there are three research objectives:

- To discuss the current medicolegal climate in South Africa.
- To describe the different forms of alternate dispute resolution mechanisms.
- To normatively articulate and defend factors justifying the use of mandatory mediation as a form of dispute resolution prior to litigation in the SA health sector.

1.8 Research Design

The research follows a normative research design, where methods applicable to philosophical research are employed. Normative research as described by Daniel P Sulmasy and Jeremy Sugarman (Sugarman and Sulmasy, 2010), "is the branch of philosophical or theological enquiry that sets out to give answers to the following questions: What ought to be done? What ought not to be done? What kinds of persons ought we strive to become?". It involves interpretation and critical analysis of the study context, as well as the defense of new arguments, in a systematic and critical fashion while justifying answers that are offered (Sugarman and Sulmasy, 2010). In this research, the normative questions asked are: "Ought we address the constitutional concerns brought about by the current medical litigation crisis?"

and “Ought mediation be a mandatory process when disputes with potential for medical litigation arise in the SA health sector?”.

1.9 Research Methods

The study is based on desktop and library-based research. No new data is collected or analysed and the research involves no human participants. The typical research methods and standards applicable to philosophical research are employed. The discussions involve the ethical analysis of findings from the literature. The research primarily involves the interpretation and critical analysis of the most important texts, postings and relevant government legislation in order to answer the research questions.

The analysis of the relevant texts includes the definition and clarification of concepts, as well as the identification and criticisms of assumptions. The theoretical frameworks are clarified and evaluated, and the most reasonable interpretation of significant concepts found in the sources are articulated. The sources of literature include, but not limited to, research articles, books, google scholar, PubMed, Government legislation and other academic search engines for gathering the research data.

1.9.1 Argumentative Strategy

The deontological and consequentialist moral theories are used to argue that it would be morally justified to use mandatory mediation as a means to address the medical litigation crisis the SA health sector.

With the use of the theory of Deontology it is argued that there is a categorical imperative (Dhai et al., 2011) to ensure access to health care, life and dignity; and that the current medicolegal climate impedes this access. The diversion of the budget meant for provision of health care services towards settling medicolegal claims which are not provided for in the budget, impedes the access to health care. For example, if medicolegal claims are settled for a certain amount in a particular financial year, the would be less funds available for the provision of certain medical services, which could impact on the access to health care. (Claassen, 2016) The arguments will be substantiated by a critical appraisal of the impact of litigation and rising legal costs infringing on the following rights of other patients: section 10 of the Constitution of the Republic of South Africa, provides for the right to human dignity, section 11: right to life, section 27: right to health care services, right not to be refused emergency medical treatment, section 28: children rights to basic health care services, protection from maltreatment, neglect, abuse or degradation. (Republic of South Africa, 1996).

Section 34 of the Constitution of the Republic of South Africa affirms that "everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum." (Republic of South Africa, 1996) It will be argued that mediation would be a constitutionally appropriate forum because the process involves the appointment of an independent and neutral mediator to facilitate the process. (Claassen, 2016, Kovach, 2005)

Using the justice principle, it will also be argued that the aggrieved patient's right to have a dispute resolved, will still be realised as mediation in itself is a tool towards attaining justice. The fact that mediation is without prejudice (Claassen, 2016, Kovach, 2005, Brand et al.,

2016), means that the aggrieved patient may still decide to utilise other judicial avenues should mandatory mediation not yield the desired results.

With the use of the consequentialist set of theories (Dhai et al., 2011) it will be argued that there are overwhelming advantages of mediation as compared to litigation thereby bringing about greater good to society, in that access to health care and the public good at large will be ensured. The counter-arguments to be addressed are concerns regarding the impact of litigation on the right to health care versus the rights of aggrieved patients to access the courts through litigation as provided for in section 34 of the Constitution of the Republic of South Africa. (Republic of South Africa, 1996) It will be argued that section 36 of the Constitution of the Republic of South Africa will allow for limitations to the rights. (Republic of South Africa, 1996) It will further be argued that the right to access the courts will need to be interpreted taking into consideration the constitutional rights of all people in society at large, especially the right to life and human dignity, which are entirely non-derogable as provided for in section 11 and 10 of the Constitution of the Republic of South Africa, respectively. (Republic of South Africa, 1996)

1.10 Ethics

Approval to conduct the study was obtained from the Graduate Studies Committee of Wits (Appendix A). As information in the public domain is utilised and there is no human subject involvement in this research, this study did not require Human Research Ethics Committee (HREC) review (Appendix B).

1.11 Research Outcomes

The outcome of this research will contribute to the development of guidelines and proposals for law reform in the context of mandatory mediation when medical negligence disputes arise. The research will be submitted for publication and will be presented at conferences.

1.12 Limitations

Literature with specific reference to mandatory mediation may be limited, however the limitation will be addressed by applying normative theories and the law to argue for the thesis statement.

1.13 Overview of chapters

Chapter 1: Introduction to the research.
In this chapter the background literature on medical litigation and the current crisis is analysed and critiqued, and the approach to research is outlined.

Chapter 2: Medicolegal context in SA, including liability claims, contract law and informed consent.
The current medicolegal climate in SA is discussed in this chapter. Contract law, law of delict, informed consent, medical negligence, medical litigation and compensation systems are briefly described and then used to discuss the medicolegal climate in SA.

Chapter 3: ADR processes and their usefulness in the healthcare context.

The basic principles and an overview of ADR mechanisms are explored. The three types of ADR mechanisms that are discussed are negotiation, mediation and arbitration. Argument is initiated for support for mediation as a form of dispute resolution mechanism prior to litigation in handling disputes in the SA health sector.

Chapter 4: Normative arguments for mandatory mediation.

Normative theories of deontology and consequentialism, as well as the constitutional rights narrative will be utilised to create an argumentative strategy in support of mandatory mediation. In addition, African indigenous values and Ubuntu have been drawn upon because these values have major bearing on mediation in the lived context.

Chapter 5: Conclusion and Recommendations.

This chapter ends the research report and concludes that there is a need for mandatory mediation in the South African medical litigation context. It offers recommendations as a way forward.

1.14 Timing

Activity	Apr 2019	May 2019	Jun 2019	July 2019	Aug 2019	Sep 2019	Oct 2019 - Oct 2020	Nov 2020 – Feb 2021	Mar 2021
Protocol Development									
Protocol Assessment & Amendments									
Ethics Application									
Writing up									
Examination Submission									

1.15 Funding

The research will be self-funded and the predicted expenses are outlined in the table below.

Item	**Costs**
Internet	R 600.00
Printing	R700.00
Binding	R500.00
Transport	R500.00
Total cost	R2300.00

1.16 Conclusion

The law of contract and delict when applied to a doctor-patient relationship, means that liability for medical negligence may be incurred should there be damages as a result of harm, negligence or breach of contract. (Coetzee and Carstens, 2011) In SA claims arising from medical negligence normally follow the legal process through litigation. (South African Law Reform Commission, 2017) Medical negligence claims in SA have been on the rise over recent years (Medical Brief, 2020) and have been described as having reached crisis levels. (Dhai, 2015) Alternative mechanisms other than litigation are available to resolve medical negligence disputes. (Amirthalingam, 2017). The following chapter outlines the medicolegal context in SA, including liability claims, contract law and informed consent.

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Chapter 2: Medicolegal context in SA, including liability claims, contract law and informed consent.

2.1 Introduction

This chapter aligns with the first objective of the study, that is to describe the current medicolegal climate in SA, as described in section 1.7 in chapter one. Prior to discussing the medicolegal climate, one needs to clarify a few terms that are relevant in this discussion. Contract law, law of delict, informed consent, medical negligence, medical litigation and compensation systems are briefly described and then used to discuss the medicolegal climate in SA.

2.2 Contract law

Contract law was briefly discussed in section 1.2 of chapter 1. Medical negligence claims in SA are handled in terms of the common law. The legal basis of dealing with most of the medical negligence disputes is often referred to as the law of obligations. (South African Law Reform Commission, 2017) The law of contract is considered as one of the law of obligations and in SA the doctor-patient relationship is governed by this law. (South African Law Reform Commission, 2017) Whenever a patient consults a doctor or hospital for medical treatment, there is a relationship that is formed between the two parties and such a relationship is contractual. Consensus allows for this contract to exist and legal formalities are not necessary to establish this contract. A doctor or hospital may be liable for damages should they breach this contract, on the basis of vicarious liability. (Coetzee and Carstens,

2011) Despite the relationship between a patient and a doctor or hospital being contractual, a majority of health care disputes are handled according to the law of delict, which will be described next. (South African Law Reform Commission, 2017)

2.3 Law of delict

The relationship between a patient and a doctor or hospital is also governed by the law of delict. Should a doctor or hospital fail to provide reasonable care to their patients, this law allows for such a liability to be incurred by a doctor or hospital in such circumstances if the patient suffered damages. (Coetzee and Carstens, 2011) In order to successfully lodge a claim in SA the five elements of delict need to be proven. These elements are: "conduct, wrongfulness, damage, causation and fault." (South African Law Reform Commission, 2017)

An act of omission or commission by a doctor or hospital is interpreted in terms of delictual liability as an element of conduct. Such a conduct may result in a medical negligence claim if it can be proven because it constitutes a legal duty or obligation in terms of the law of delict. (South African Law Reform Commission, 2017, Neethling and Potgieter, 2018)
Wrongfulness as an element of delict arises when a person's conduct infringes on one's rights as protected by the law or a legal duty that is owed is breached. (South African Law Reform Commission, 2017)

An element of damage is considered when one can prove that there were losses suffered as a result of a wrongful conduct and those damages can be settled in monetary terms. (South African Law Reform Commission, 2017) The element of causation provides that the harm

suffered by the plaintiff is related to the defendant's conduct. This is proven by the presence of two factors, namely, factual causation and legal causation. Factual causation determines whether the conduct is actually factually related to the harm suffered, once that factual link and legal causation is established, then the legal liability may ensue. (South African Law Reform Commission, 2017) The element of fault is determined by a conduct that is either intentional or negligent and claims arising from medical malpractice are mostly as a result of negligence. Such fault is established through measuring the defendant's conduct against that of a reasonable person. (South African Law Reform Commission, 2017)

The test for negligence and damages is further described in the case law of *Kruger v Coetzee 1966 (2) SA 428 (A)* (Supreme Court of Appeal, 1966) where judge Holmes JA said: "foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss". Furthermore, in a professional setup most cases of negligence will be supported by evidence provided by an expert in the field, to determine whether the conduct of the professional was in keeping with the relevant standard of care. (Simmons, 2018)

2.4 Informed consent

Informed consent in the context of the doctor-patient relationship, is governed by contract law. In healthcare it can be described in terms of hospitals or healthcare practitioners requiring patients to sign informed consent in order to stipulate in writing, the details of the contract between the two parties. (Coetzee and Carstens, 2011) The traditional way of considering health practitioners' obligations in terms of beneficence no longer applies in

modern society and a focus on patient autonomy is emphasised. The focus shifted towards providing adequate information to enhance the quality of the patient's understanding and therefore empowering their autonomy and self-determination. (Moore, 2013)

Informed consent is provided for in section 7 (1) of the NHA 61 of 2003, and consent needs to be obtained prior to the provision of a health service. (The Presidency: Republic of South Africa, 2004) The information that needs to be disclosed when obtaining informed consent is provided for in section 6 (1) of the NHA. Section 6 (1)(b) and (c) of the Act states that "every healthcare provider must inform a user of the range of diagnostic procedures and treatment options generally available to the user; the benefits, risks, costs and consequences associated with each option". (The Presidency: Republic of South Africa, 2004) The inclusion of informed consent in the NHA is a realisation of the right to bodily and psychological integrity, as provided for in the Constitution. (Republic of South Africa, 1996)

Allegations related to the lack of informed consent usually consist of complaints that the health care practitioner failed to fulfil the duty to supply sufficient information to the patient regarding the risks and available alternatives. The concept of patient-centred tests for disclosure arise in such cases. A doctor should disclose all information and risks, such that if a reasonable person was put in a similar position as the patient, and warned of such risks, she or he would be able to see the significance of such risks and make an informed decision. (Moore, 2013) Obtaining consent without disclosing material risks may result in medical negligence claims, as seen in the landmark case of *Castell v De Greef*. (South Africa. Supreme Court Cape Provincial Division, 1994) A doctor may incur liability for breach of

contract, and civil or criminal assault should they perform a procedure without the patient's informed consent. (Coetzee and Carstens, 2011)

2.5 Medical negligence

Medical malpractice and negligence are often used interchangeably. Medical malpractice is defined by McQuoid-Mason (McQuoid-Mason, 2011), as "negligent or intentional unlawful conduct on the part of healthcare practitioners that causes injury or damage to their patient or their patient's property." He further describes that "professional negligence occurs when health practitioners negligently fail to exercise the degree of skill and care of a reasonably skilled practitioner in their field of practice." (McQuoid-Mason, 2011) Malpractice encompasses acts that could be considered negligent as well as intentional ones. (McQuoid-Mason, 2011) For the purpose of this research, the term medical negligence will be used to describe either medical malpractice or professional negligence.

The test for negligence in general delictual claims uses the reasonable man test, where a reasonable man is placed in a similar position as the defendant and a test of how would such a person have handled a similar situation is applied. In the case of health care practitioners, the test will then be adapted to the test of a reasonable health care practitioner facing similar circumstances as the defendant. (South African Law Reform Commission, 2017)

2.6 Medical litigation

Litigation is the process of conducting or defending a lawsuit in court. (Emery et al., 2000) In terms of medical negligence, litigation refers to the patients making medical negligence claims or health care practitioners defending such claims. Any claim arising as a result of possible medical negligence is taken through the legal process. The claimant would seek legal representation, institute legal proceedings in the appropriate court to prove that harm ensued as a result of a breach of contract or delict. (South African Law Reform Commission, 2017) This process is described as medical litigation in this research. Section 34 of the Constitution of the Republic of South Africa provides for the right of claimants to access the court to resolve medical negligence disputes. (Republic of South Africa, 1996)

2.7 Compensation systems in SA

In SA there is no social insurance system for medical negligence claims. Claims against private practitioners and institutions are handled through proceedings in a court of law, either using contract law or the law of delict. Such claims will either be settled personally or by the indemnity insurance, for example MPS or commercial insurers, where health care practitioners have indemnity insurance. (Coetzee and Carstens, 2011) Those against the state are handled in terms of the State Liability Act, which provides for claims against the state, which arise out of lawfully entered contracts on behalf of the state. (South African Government, 1957)

2.8 Liability claims in South Africa

Claims made against the state based on medical negligence cite the Member of the Executive Council (MEC) for Health in the province concerned as the defendant for that particular claim. (South African Law Reform Commission, 2017) The implication of the MEC for Health is based on the principle of vicarious liability, where one person is liable for another's conduct even though they are not at fault. In the case of state liability claims, vicarious liability ensues because the health department and the employee at fault have an employer-employee relationship, and the employee would have been negligent while involved in the performance of their work. (McQuoid-Mason, 2011) The SA healthcare sector has seen a rise in medical negligence claims in recent times. This increase in claims encompass both the frequency and the amount that are awarded. (Oosthuizen and Carstens, 2015) This rise is mainly brought about by a variety of challenges in the healthcare sector, more especially the public sector. The challenges include factors such as lack of resources, shortage of skilled healthcare professionals and an increased disease burden, resulting in a society that's generally unhappy and subsequently more likely to sue. (South African Lancet National Commission, 2019)

It is very difficult to obtain empirical data regarding medical negligence claims in South Africa. (Coetzee and Carstens, 2011, Oosthuizen and Carstens, 2015) As a result of such difficulties, data from journals, website articles and media reports will be used to outline medical negligence claims in the SA healthcare sector. The medical negligence claims will be described in terms of the amount paid to settle claims or cost of litigation, as well as the contingent liabilities. Contingent liability is described by Christian et al (Christian and Ludenbach, 2013) as a term that encompasses different types of obligations. An example of

such obligations include one termed as: “a possible obligation” (Christian and Ludenbach, 2013), which arises “from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the entity.” In the context of medical negligence claims it includes the amounts that can possibly be incurred by an institution as a result of a pending lawsuit (Christian and Ludenbach, 2013). These claims will be discussed in relation to the private sector as well as the national and provincial health sectors.

2.8.1 Amounts paid to settle medical negligence claims or the cost of litigation in the SA public health sector

In SA a budget for the provision of health care services is allocated to the national Department of Health, however the same budget is also used to pay out medical negligence claims. An increase in such claims results in the diversion of the money meant for the provision of health care services. (South African Law Reform Commission, 2017) In the public sector claims are directed towards the MEC of the province concerned through vicarious liability as explained in section 2.8 above. However, the money to pay the claims often runs into several million Rands, and it is in most instance sourced from the budget of the institution concerned. This diversion of funds meant for service delivery means that the hospital concerned will therefore have less money available to render quality service delivery, therefore increasing the probability of further negligence and more claims as a result. (South African Law Reform Commission, 2017)

Table 2.1 below illustrates the principal amounts incurred by the Department of Health towards medical negligence claims over four consecutive financial years between 2010/2011 and 2013/2014. These figures were presented at the March 2015 Medico-legal Summit and reported by the SALRC in 2017. The table indicates a significant rise in the total amount (all provinces combined) paid out over the years from just under R100 million in the 2010/2011 financial year to almost R500 million in the 2013/2014 financial year. The rise represents an increase of almost 500 percent in a period of four years. (South African Law Reform Commission, 2017) The payment for medical negligence claims continued rising over the years and according to the 2020 Budget Review by the National Treasury, payments for these claims reached R2 billion in the 2018/2019 financial year. (National Treasury, 2020)

The rise in the cost of settling medical negligence claims does not only reflect nationally but provincially as well. The Gauteng province saw a massive rise in principal amount pay out between the financial year ending 2010/2011 and 2013/2014. The amount paid out rose from just over R8 million in 2010/2011 financial year to above R153 million in 2013/2014, reflecting a rise of almost 20 times over the four financial years. (South African Law Reform Commission, 2017) In September 2019 a media report indicated that the Gauteng Department of Health already paid R237 million to settle medical negligence claims at various health institutions in the province, six months since the 2019 financial year began in April. This amount excluded the R29 billion in contingent liabilities the provincial department is facing this year. (Mokgobu, 2019) The figures reflected above indicate that there is a rise in the cost of settling medical negligence claims each year. The settlement of such amounts in this province would mean that the hospitals in Gauteng would have suffered massive budget diversions as the amount meant for service delivery provision would be used for medical negligence claims settlement instead.

Table 2.1: Principal amounts paid out for litigation on behalf of the Department of Health by the offices of the State Attorney during the years 2010/2011 to 2013/2014

(South African Law Reform Commission, 2017) Adapted with permission from SALRC. (See Appendix C)

Province	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Gauteng	R8 291 000.00	R30 930 758.24	R124 846 892.41	R153 612 355.49
Eastern Cape	R10 260 049.00	R25 336 038.36	R44 743 495.84	R49 513 108.93
Northern Cape	R6 810 428.00	R705 000.00	R-	R7 107 000.00
KwaZulu Natal	R22 695 078.06	R10 762 367.72	R14 767 477.56	R205 312 356.94
Western Cape	R9 210 000.00	R15 860 000.00	R11 710 000.00	R15 680 000.00
North West	R12 550 000.00	R753 602.57	R7 899 232.50	R698 940.17
Limpopo	R8 229 068.81	R3 457 954.27	R6 844 259.18	R21 959 395.55
Free State	R256 081.57	R988 604.43	R327 192.00	R673 373.00
Mpumalanga	R17 229 427.00	R13 252 319.44	R11 310 058.70	R44 408 386.64
Total	R95 531 132.44	R102 046 645.02	R222 448 608.19	R498 964 916.72

2.8.2 Contingent liabilities in the SA public health sector

In addition to the amount reported for the settlement of claims or the cost of litigation the SA public health sector also faces a burden of contingent liabilities. The contingent liabilities represent the cost of handling or settling medical negligence claims that are not yet concluded and those which the state may still be liable to settle at a later stage. Table 2.2 below represents the contingent liabilities for the financial year ending 2016 as reported at the Medical Malpractice Workshop in 2017. The amount as indicated in the table was reported to be at around R40 billion nationally for the 2016 financial year. (South African Law Reform Commission, 2017)

In 2017 the total amount of contingent liabilities for the South African National Department of Health rose to above R55 billion, which was a significant rise from the previous financial year. (Taylor et al., 2018) The amount of medical negligence claims keeps on rising each year and in the 2017/2018 financial year it was reported at R80.4 billion. (Kahn, 2019) In the 2018/2019 financial year, medical negligence claims against the nine provinces increased to R104.5 billion. (Medical Brief, 2020) The settlement of such large sums of money would mean that even more money is shifted away from the health budget meant for the provision of health care services.

A massive rise in contingent liabilities is also evident in the provincial departments as well. The Gauteng Health Department faced medical negligence claims totalling R573 million in 2009/2010 financial year as reported by Malherbe. (Malherbe, 2013) However this amount rose to around R13 billion in the 2015/2016 financial year end as indicated in Table 2.2

below. (South African Law Reform Commission, 2017) As stated above, the same provincial department is facing medical negligence claims totalling R29 billion in 2019. (Mabuza, 2019) This amount represents almost 60 percent of the total health budget allocated for the Gauteng Provincial Health Department.

The fact that the department is facing such a huge amount in contingent liabilities for medical negligence claims mean that with a budget of R50.8 billion, more than half of the allocated budget for health in the province will need to be diverted towards settling medical negligence claims. (Mokgobu, 2019) The alarming rate at which the costs associated with medical negligence claims continue to rise and this translates to a provincial health sector that is under continuous strain with regard to the budgetary diversions from service delivery towards the handling of these claims.

Table 2.2: Contingent liabilities for medical malpractice (South African Law Reform Commission, 2017) Adapted with permission from SALRC. (See Appendix C)

Department of Health	**Annual report for year ending**	**Contingent liability for year end**
Eastern Cape	31/03/2016	R13 421 136 000
Western Cape	31/03/2016	R182 025 000
KwaZulu Natal	31/03/2016	R9 957 126 000
Mpumalanga	31/03/2016	R1 459 497 000
North West	31/03/2016	R36 157 000
Limpopo	31/03/2016	R1 356 921 000
Northern Cape	31/03/2016	R118 064 000
Free State	31/03/2016	R940 545 000
Gauteng	31/03/2016	R13 452 064 000
Total		R40 923 535 000

2.8.3. Medical negligence claims in the South African Private Health sector

Even though the study will be focusing mainly on the SA public health sector, as the majority of the population relies on the public health sector (Coetzee and Carstens, 2011), it is prudent to mention that the private health is also affected by the rise in medical negligence claims. MPS which is the largest indemnity insurance for the private health care practitioners in SA, reported an increase in the average claim frequency of about 27 percent between the years 2009 and 2015. The amounts claimed also showed an increase of 14 percent per year in the same period. (South African Law Reform Commission, 2017)

MPS also reported a rise of 550% in medical negligence in medical negligence claims against their members in 2016 as compared to a decade ago. The quantum of claims exceeding R5 million rand also increased by 900%. (Claassen, 2016)

2.8.4 The consequence of rising medical negligence claims

The escalation in negligence claims has a direct impact on access to healthcare. The effect of the rise in negligence claims also affect the provision of quality health care in both the public as well as the private healthcare sector. (South African Lancet National Commission, 2019) The constant thought of facing a lawsuit amongst healthcare practitioners affects their clinical decision making and eventually results in frustrated practitioners as well as unhappy patients. (South African Lancet National Commission, 2019, Dhai, 2016) This ultimately becomes a vicious cycle that continues to fuel the rise in medical negligence claims.

The direct impact of the rising costs of handling medical negligence claims on access to health care needs to be urgently addressed and cannot be ignored. Society suffers the consequences because health care practitioners are forced to practice defensive medicine, shifting the focus from patient health and best interests towards avoiding possible medical negligence claims. An example of practising defensive medicine includes recommending a diagnostic test or medical treatment that is not necessarily the best option for the patient but mainly done to protect the physician against a potential medical negligence claim. This results in unnecessary clinical and diagnostic procedures, which could further burden the already strained health budget. (South African Lancet National Commission, 2019)

The fact that there is a lack of patient-centred complaint systems, (South African Lancet National Commission, 2019) results in litigation remaining the only available process of handling medical negligence disputes. The increasing burden of cases, lengthy delays, as well as lack of efficient and predictable legal processes all lead to rising costs of handling medical negligence claims. It is therefore important to note that the current medical negligence handling system in place lacks efficiency and fairness in the handling of such disputes. The process is adversarial, time-consuming and extremely costly. According to the SALRC, more than 75% of cases are reported to take more than five years to conclude and some have only been concluded after 15 – 16 years. (South African Lancet National Commission, 2019, South African Law Reform Commission, 2017)

2.9 Conclusion

Based on the above it is clear that the current medicolegal context in SA is cause for grave concern. The continuing rise in the cost of handling medical negligence disputes and the contingency liabilities inherent in the current system require being addressed urgently. The fact that the money to handle medical negligence is sourced from provincial and national health budgets, indicates that the impact these claims have on the provision of quality health care services is enormous. As a result, alternative methods of attending to the problem need to be explored.

The next chapter will consider alternative dispute resolution processes, namely negotiation, mediation and arbitration. The chapter will also look into comparative mediation implementation methods and the countries that have adopted mediation.

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Chapter 3: Alternative Dispute Resolution processes and their usefulness in the healthcare context.

3.1 Introduction

This chapter aligns with the second objective of the study, to describe the different forms of ADR mechanisms as described in section 1.7 in chapter one. The basic principles and an overview of ADR mechanisms are explored. The three types of ADR mechanisms that are discussed are negotiation, mediation and arbitration. Support for mediation as a form of dispute resolution mechanism prior to litigation in handling disputes in the SA health sector is also outlined.

3.2 ADR mechanisms

The design of a dispute resolution system involves first prioritising consensus-seeking processes like negotiation and mediation before resorting to rights-oriented processes like arbitration or litigation in the courts of law. (Brand et al., 2016b) Litigation as defined in the previous chapter, is the process of conducting or defending a lawsuit in court. (Emery et al., 2000) ADR has been described in the past as a collective term to describe the processes used to resolve disputes and conflicts without involving formal litigation processes. (South African Law Commission, 1997) However currently, some aspects of litigation, such as case management are included in these processes. ADR has developed as an adjunct to the legal systems in place, as opposed to being a process in complete contrast to litigation (Fiadjoe, 2004a)

ADR mechanisms are not static and continue to evolve as society gets to understand the nature of disputes better. The processes which attempts to firstly reconcile the interests of the aggrieved parties continues to be reorganised in order to resolve the disputes, before utilising the processes that involves right determination and power resolution. (Fiadjoe, 2004a) ADR includes processes that can be classified under three categories, as described by Fiadjoe (Fiadjoe, 2004a), namely, evaluative, mediative and adjudicative. All these processes are underpinned by the basic principles of negotiation. The evaluative process involves a non-binding evaluation of the case in order to determine the merits of the case and thereafter provide feedback to the parties. The mediative process involves the use of a neutral third party who facilitates the process for the parties to reach their own dispute settlement, without rendering a decision or an evaluation. In the adjudicative process, a neutral third party facilitates the process and then makes a decision for the parties. (Fiadjoe, 2004a)

The ADR umbrella has evolved to include a variety of processes, which includes "dispute prevention; negotiation; mediation; a mix of mediation/arbitration or arbitration/mediation; the institution of an ombudsman; private mini-trial; judicial mini-trial; pre-trial conference; early neutral evaluation; arbitration; administrative hearing; case management and renting a judge", as described by Fiadjoe. (Fiadjoe, 2004a) The goals of ADR are "to relieve court congestion, as well as prevent undue cost and delay, to enhance community involvement in the dispute resolution process, to facilitate access to justice; and to provide more effective dispute resolution" (South African Law Commission, 1997) as described in the South African Law Commission (SALC), Issue paper 8.

It is noteworthy that the issue of ADR has been a subject of debate in SA over a lengthy period of time. In 1997 the SALC reported in the same issue paper described in the previous paragraph, that many governmental and non-governmental institutions have been striving to provide dispute resolution procedures that are affordable and appropriate. The aim of exploring these ADR procedures, was to promote effective access to justice for all the people in SA. In 1996 the Minister of Justice requested the SALC to investigate all facets of ADR, in order to have a framework within which ADR could be formalised. The discussions surrounding ADR were deemed urgent by the Minister at the time, because the overburdened court system could be relieved by formalised ADR methods. The dispute resolution processes were categorised in the report as: those involving private decision-making by the parties themselves, for example, negotiation and mediation; and those involving private adjudication by third parties, for example arbitration. (South African Law Commission, 1997) This chapter will focus on negotiation, arbitration and mediation.

3.2.1 Negotiation

Negotiation is defined as "any form of communication between two or more people for the purpose of arriving at a mutually agreeable solution." (Fiadjoe, 2004a) The parties work towards a mutually agreeable outcome to resolve the dispute, in a manner that is fair to everyone involved. (Dhai, 2016) It is a primary form of dispute resolution that is simple and most effective. (Brand et al., 2016b) The parties may represent themselves or be represented by a negotiating agent. Those involved in the negotiation process, either the parties in dispute or their representative maintain control of the whole process. (Fiadjoe, 2004a)

The process involves back and forth communication between the aggrieved parties in order to reach an agreement. The aggrieved parties may share similar and opposing interests, which will be communicated until they have an agreement that is acceptable to both parties. (Fiadjoe, 2004c) It is the initial form of seeking consensus, and negotiation sometimes occurs naturally without the aggrieved parties being aware that the negotiation process is unfolding. (Brand et al., 2016b, Fiadjoe, 2004c) Negotiation is party directed and the whole process is close to the parties' circumstances and control, meaning that it can be driven and geared towards each party's own concerns. Unlike other dispute resolution mechanisms that are formal and occur in a formalised environment, negotiation is informal. Parties determine where the negotiation occurs and the timing, agenda and matters to be discussed. In addition, participants are chosen by the parties themselves. (Brand et al., 2016b) Negotiation is flexible and need not only focus on the initial dispute matter. It also allows the participants an opportunity to introduce other issues and use those as a compromise to settle the dispute at hand. (Brand et al., 2016b)

Varying terms are used to describe approaches to negotiation. Brand et al classifies negotiation into positional and interest-based negotiation. (Brand et al., 2016b) In positional negotiation each party takes a certain position and then focuses its negotiation in reference to that formally stated position. Each party will then attempt to justify its position. The process involves haggling between the parties, a compromise from the initial positions taken by the parties and ultimately a move towards a middle ground. Each party's ability to state its case, relative negotiation power and assertiveness strengthen the extent to which they can make a concession. (Brand et al., 2016b) The process may involve tactics such as "misrepresenting positions or interests; withholding material information; making threats or bluffing; staging a walk-out; the use of power; making concessions only in return for reciprocal concessions;

making small concessions slowly; haggling to a point of compromise." (Brand et al., 2016b) This type of negotiation is similar to the type of negotiation process described by Fiadjoe as competitive bargaining, where the main concern for negotiating parties is getting substantive results (Fiadjoe, 2004a).

In competitive bargaining parties may take extreme positions, falsify issues, mislead the other party and limit the information they provide, in order to gain advantage in the negotiation. (Fiadjoe, 2004a) Harpur uses the term distributive bargaining to describe positional negotiation where the focus of negotiation "is the positions each side adopts to obtain the greatest share of a fixed pie."(Harpur, 2004) The core characteristics and tactics involved in positional or competitive negotiation, can lead to the breakdown of trust and undermine relationships. (Brand et al., 2016b) This type of negotiation focuses exclusively on each party's position and does not take into account the mutual interests of each party. (Harpur, 2004) Hence, with regard to medical negligence claims, positional negotiation could lead to the breakdown of doctor-patient relationships.

Interest-based negotiation is a type of negotiation developed as an alternative to the traditional positional negotiation. (Brand et al., 2016b) This type of negotiation is also described as principled negotiation. (Fiadjoe, 2004a, Brand et al., 2016b) Principled negotiation requires that focus is put on the disputing parties' interests, in order to reach a satisfactory outcome for both parties. (Fiadjoe, 2004a) There are key elements that are used to guide the negotiation process in this type of negotiation. These elements includes "separating people from the problem; focusing on interests and not positions; generating a

variety of options to choose from, with the focus on creating value in the negotiation; insisting on using objective standards whenever possible." (Brand et al., 2016b)

Emotional factors on the part of aggrieved or injured patients have been shown to be the driving force for most medical negligence claims. (Bogdanoski, 2009) This is contrary to a general perception among society and medical practitioners that patients pursuing medical negligence claims do so purely for financial gain. Interest-based negotiation has been proven to provide the aggrieved patients and their families, an opportunity of addressing their emotional needs in addition to compensation. (Bogdanoski, 2009) Interest-based negotiation affords the patients and their families, as well as the medical practitioners an opportunity to experience the following possibilities: "an opportunity to explain or receive an explanation, an expression of regret, an apology, an expression of empathy, an expression of sympathy, the ability to gain closure, the conveyance of forgiveness and restorations of a valued relationship." (Bogdanoski, 2009) The ability of this type of negotiation to address patients' complex emotional needs in addition to compensation, makes it suitable to deal with medical negligence disputes holistically.

The challenge with interest-based negotiation is that the exchange of information between the parties may potentially slide into a positional agenda if one party adopts extreme offers and use negotiation tricks to force the other party closer to their position. This may occur as parties place their demands and ultimatums on the table, and argue each point. Consequently, such situations may centre the negotiations on tactics employed to gain maximum advantage over a fixed number of items. Medical negligence claims are often accompanied by strong emotions, which are often addressed by this type of negotiation. (Harpur, 2004)

However, if managed inappropriately it may lead to hostility and a positional type of bargaining. (Harpur, 2004) The diversion of an interest-based negotiation towards a positional type, will then compromise the ability of this type of negotiation to handle medical negligence disputes.

Negotiation can be argued to be a viable option to deal with medical negligence claims. However, one needs to take into consideration the challenges posed by the different negotiation approaches that may be undertaken. Such challenges include the breakdown of doctor-patient relationships in the case of positional negotiation as highlighted earlier. Interest-based negotiation seems to address the challenges posed by positional negotiation, however, there are concerns that need to be addressed when such a negotiation approach is used to deal with medical negligence disputes as highlighted above.

3.2.2 Arbitration

Arbitration involves the use of a neutral third-party to render a solution, through a binding process. (Cole and Blankley, 2005) It is a flexible process, that allows disputing parties to negotiate all aspects of the arbitration. The parties are allowed to choose the arbitrator who will hear the case, the location of the process, who is allowed to represent the parties, as well as the freedom to choose appropriate expert witnesses. (Cole and Blankley, 2005, Fiadjoe, 2004b) The process is consensual and depends on the agreement between the two parties in order to proceed. Arbitrators are expected to be independent and impartial. They are expected to act according to the applicable law. (Fiadjoe, 2004b)

In SA arbitration is governed by the Arbitration Act 42 of 1965 (South African Government, 1965), where an "arbitration agreement" is defined as "a written agreement providing for the reference to arbitration of any existing dispute or any future dispute relating to a matter specified in the agreement, whether an arbitrator is named or designated therein or not." In the case of medical negligence disputes the arbitration agreement would include the appointment of an arbitrator and the dispute requiring arbitration would be specified in the agreement.

The Arbitration Act 42 of 1965 (South African Government, 1965) allows for the appointment of an arbitrator to facilitate the arbitration process. An example of arbitration for a medical negligence dispute in the SA setting, is the arbitration between the families of the mental health care users affected by the Gauteng mental marathon projects as claimants and the national Minister of Health of SA, as well as the government, Member of Executive Council for Health and Premier of Gauteng province as respondents. The appointed arbitrator for this process was Justice Dikgang Moseneke. (Moseneke, 2018)

There are different forms of arbitration, namely: contractual and court-annexed. Contractual arbitration is a form of arbitration where parties have a contractual agreement to resolve their dispute through arbitration. This contractual agreement may be in place either before or after a dispute arises. (Cole and Blankley, 2005) The arbitration example made above is a form of a contractual arbitration, where upon the recommendation from the health ombudsman, the Minister of Health and the Premier of Gauteng were urged to enter into an ADR process with the individuals and families affected. The parties agreed to utilise arbitration before a single arbitrator. (Toxopeus, 2018) In court-annexed or court-ordered arbitration, parties are

compelled by the court to utilise arbitration to resolve their dispute before utilising other legal processes. (Cole and Blankley, 2005)

Arbitration is a consensual and voluntary process. The termination of an arbitration agreement may not occur without the consent of all parties, unless the agreement provides otherwise. (South African Government, 1965) The arbitrator has the legal authority to deliver a final and binding award, making the process more decisive in resolving the disputes. (Fiadjoe, 2004b) The ease of enforcement for arbitral awards is an advantage of arbitration. The arbitration process although guided by the applicable law, can take place informally outside the courts, as opposed to the formal litigation process. This allows the disputing parties to be free to adopt any forum or procedure that they would deem suitable in particular circumstances. (Fiadjoe, 2004b) Arbitration allows the parties to select a tribunal that fits the nature of their dispute by choosing an arbitrator whom is an expert in the field of the dispute. The process is held in private, making the process confidential. This can be advantageous when dealing with confidential patient issues that may be divulged during the dispute resolution process. (Fiadjoe, 2004b)

The disadvantage of arbitration is that the arbitrator makes a decision which is final and not subject to appeal. Such a decision can be disadvantageous if the judgement was erroneous. During arbitration the arbitrator makes a final binding decision that may not necessarily be the desired decision for the disputed patient. Another disadvantage of arbitration is that of the costs payable to hire a venue, arbitrator and administrative fees. (Nkabinde, 2018)

Advantages of arbitration as an ADR mechanism includes: the consensual nature of arbitration, the fact that arbitration agreements are enforced by the courts and subject to statutory regimes, and the delivery of a final and binding award. Arbitration also provides parties with privacy and may choose a tribunal that fits the nature of their disputes. (Fiadjoe, 2004b) When dealing with medical negligence disputes arbitration as opposed to litigation, is generally less time consuming and more cost-effective, yet still providing binding results. Arbitration also allows disputed patients and their families an opportunity to talk about their experiences, therefore, in the process debrief and find closure. (Toxopeus, 2018)

The concerns associated with this process will also need to be acknowledged. Arbitration proceedings may be costly, especially when the process takes place over a prolonged period. Parties may use the proceedings to gain a preview of the opponent's case and use that unfair advantage for litigation should the matter proceed to court. As the arbitration process and results are private, there is a possibility that they cannot be measured against objective standards of fairness. Arbitrations differ in terms of adjudication, some may follow the legality of matters, whereas, others may be based on basic fairness principles. This may result in awards that are different. (Fiadjoe, 2004a)

3.2.3 Mediation

Mediation, together with conciliation and consensus building falls under the mediative component of ADR mechanisms. It is the most popularly used process under this ADR group. (Fiadjoe, 2004a) Mediation is defined by Fiadjoe as; "a non-binding process in which an impartial third party, called the mediator, facilitates the negotiation process between the

disputants." (Fiadjoe, 2004a) The Rules Board for Courts of Law Act no 107 of 1965 (Department of Justice and Constitutional Development, 2014a) defines mediation as "the process by which a mediator assists the parties in actual or potential litigation to resolve the dispute between them by facilitating discussions between the parties, assisting them in identifying the issues, clarifying the priorities, exploring areas of compromise and generating options in an attempt to resolve the dispute." (Department of Justice and Constitutional Development, 2014a) This means that a mediator is appointed by the two parties to facilitate the process by allowing the parties to communicate issues and concerns relating to their dispute and therefore allowing the parties to agree on a settlement for their dispute.

The process is an extension of the negotiation process, where a mediator intervenes in a dispute to assist the disputing parties to communicate, utilise effective problem-solving and negotiation procedures to reach a mutually acceptable solution. (Moore, 2014) The mediator is a neutral person accepted by both parties and has no authority to make binding decisions for the disputants. (Moore, 2014) The decision to settle, as well as the terms of that particular resolution are in the control of the disputing parties and not the mediator. (Fiadjoe, 2004a, Brand et al., 2016b) The mediator controls the process with the help of the disputing parties. The process involves the setting and enforcement of ground rules by the mediator with the permission of the disputing parties. (Fiadjoe, 2004a) The ground rules assist the mediator to facilitate the process and may include rules such as common courtesy and one person speaking at a time. (Phillips, 2001)

Mediation involves key principles which need to be adhered to. These includes voluntariness (Brand et al., 2016a, Claassen, 2016), flexibility and informality (Brand et al., 2016a,

Fiadjoe, 2004a), confidentiality (Brand et al., 2016a, Fiadjoe, 2004a, Claassen, 2016), without prejudice, impartiality, neutrality and independence of the mediator (Brand et al., 2016a). The decision for any party to participate in mediation is ideally voluntary. Both the disputing parties agree to freely engage in the process of mediation. However, there are situations where mediation may not always be voluntary. There may be a clause stipulated in the contractual relationship between parties that compel them to use mediation as a first line of dispute resolution, before the use of other dispute resolution mechanisms, particularly litigation. (Brand et al., 2016a) The other instance where mediation may not necessarily be voluntary, is when the courts or a judge encourage parties to utilise mediation as a precursor to litigation. Mediation as the initial step to resolve disputes may be part of the required civil procedure, meaning that in order for parties to achieve justice, mediation has to be explored first. (Brand et al., 2016a) One should note that the parties would have to reach an agreement voluntarily and settlement is always completely voluntary. (Brand et al., 2016a) The voluntariness of the process would allow for mediation to be utilised as a form of resolving medical negligence disputes prior to litigation in the SA health sector. Either party may withdraw from the process at any time should they deem it necessary. They would still be able to utilise other dispute resolution mechanisms including litigation, should mediation fail to provide a settlement they agree with.

Despite mediation being structured, the process itself is flexible and informal. The decision about the context of the discussion, how the process is run and the location lies in the parties themselves. The flexibility allows for the process to be adapted or changed throughout the course of the mediation process. This affords the parties an advantage of full autonomy in their dispute resolution, as opposed to the formal court process employed during litigation. (Brand et al., 2016a, Fiadjoe, 2004a) The flexibility and informality of mediation provides for

mediation to take place as early as the dispute arises, without having to await formal proceedings as would be required for a litigation process. This flexibility would allow for the speedy resolution of disputes should the involved parties agree to mediate, and as a result utilising mediation as a form of dispute resolution in the SA health sector prior to litigation would prove highly favourable.

The process of mediation is confidential and conducted in a private space, meaning that whatever is discussed is only known by the parties and the mediator. (Brand et al., 2016a) During the process, parties can also communicate separately and confidentially with the mediator in private meetings. The mediator keeps the information from those private meetings confidential and only communicates the information to the other party if permission was given to do so. (Brand et al., 2016a) The private meetings in the mediation process are crucial in ensuring that parties are free to provide information necessary for the dispute resolution in a safe space. This is an important aspect of mediation that helps in driving the communication forward. (Brand et al., 2016a) The privacy and confidentiality provided by the mediation process allows for easy opt in by disputing parties, especially when dealing with medical negligence disputes, where sensitive medical information may emerge. Litigation may not necessarily always allow for privacy and confidentiality, as a result one would strongly support the use of mediation as a dispute resolution mechanism in medical negligence disputes, as opposed to litigation.

The other important characteristic of mediation, is the fact that mediation occurs on a without prejudice basis. This means that statements made in a genuine attempt to settle a dispute will be prevented from being put before the court as evidence of the admissions made by the

relevant party. (Brand et al., 2016a) The concept of without prejudice together with the confidentiality component of mediation also means that any concessions or offers made during the process, as well as the information discussed cannot be used as evidence in the subsequent litigation processes or other dispute resolution processes. (Brand et al., 2016a) This element of mediation provides a counter-argument against the claim that utilising mediation as a form of dispute resolution may jeopardise one's chances at litigation should mediation fail to provide a settlement agreeable to both parties. It can then be argued that the use of mediation as a form of resolving disputes in the SA health sector would not affect any subsequent litigation or any other dispute resolution process that may follow mediation.

The process of mediation makes use of a mediator that is impartial, neutral and independent to the parties. The mediator facilitates the process in a balanced manner, giving equal attention to the parties without judging. Regardless of a possibility of the mediator having experience in the particular area of dispute, he/she may not influence the outcome. The mediator would rather use the expertise to assist the parties to explore the issues further and enable the process to move towards a negotiated settlement. (Brand et al., 2016a) The use of mediation as a form of dispute resolution in medical negligence disputes is further supported by the fact that mediation allows parties to explore the issues related to their dispute and then decide on a settlement agreeable to both parties. This emphasises the autonomy mediation provides for the parties to actively resolve their own disputes as opposed to litigation where lawyers argue issues on the disputing parties' behalf and the judge provides a settlement for them.

Contrary to the general perception from the public and doctors, that disputed patients and their families are raising disputes purely for financial gain, studies have shown that patients pursue such claims purely due to emotional factors. (Bogdanoski, 2009) One does not dismiss the fact that financial compensation is not warranted in these cases, especially in light of the fact that the injured patient may not be able to work after the injury. Emotional factors important for the patient or the family to deal with the dispute may include: getting an explanation from the doctor regarding the complication/dispute, an apology, empathy, restoration of dignity and finding closure. (Bogdanoski, 2009) Mediation as opposed to litigation provides the aggrieved parties an opportunity to address their concerns through a mediator, thus providing an excellent platform to address the emotional factors outlined above. This further emphasises the fact that mediation not only assists with financial compensation, but also lead to a "therapeutic resolution" (Bogdanoski, 2009) to the dispute.

The emotional impact of medical negligence claims does not only affect the patient. The doctor concerned is also affected emotionally by the dispute. The opportunity provided by mediation to address such emotions with the patient, is very important. The platform will afford the doctor an opportunity to explain what actually transpired, show empathy and apologise as deemed necessary. This will offer the two parties an opportunity to restore their relationship and find closure to the issue. (Bogdanoski, 2009)

Allegations of medical negligence have the potential to damage reputations and future career prospects. In certain disputes doctors may feel that their professional integrity is being intentionally tarnished and would therefore strive to defend themselves at all cost. (Bogdanoski, 2009) The opportunity to engage with the aggrieved patient brought about by

mediation, has the potential to make both parties understand the rationale behind the dispute and therefore allow for co-operation towards settling the dispute. Mediation also provides an opportunity to address unreasonable disputes against doctors that would be addressed speedily without a tedious litigation process, with limited or no reputational damage and potentially restore the relationship between the two parties.

Medical negligence disputes addressed through litigation may take years before they are finalised, thus prolonging both the physical and emotional distress of the patient. (Nkabinde, 2018) Mediation on the other hand may provide settlement at an early stage, therefore saving the patient emotional distress associated with the prolonged litigation process. Early settlement of the dispute through mediation also has potential cost saving benefits. These costs can be equated to direct legal fees, cost of production lost by both parties while going through litigation, cost of losing or eroding longstanding doctor-patient relationships, as well as reputational costs from both a personal and professional point of view. (Brand et al., 2016a)

Another important advantage of mediation is the high settlement rate in places where it has been implemented effectively. Reports of settlement rates as high as 85% have been reported in the UK. In addition to the monetary settlement, mediation addresses other components of the dispute thus limiting the magnitude of the dispute and therefore functions as a more effective alternative to litigation. (Brand et al., 2016a) In commercial mediation the overall success rate has been reported to be as high as 89%, of which 74% constitute the proportion of cases achieving settlement on the day of mediation and 15% settling shortly after the mediation standing. (Penningtons Manches Cooper, 2019)

Implementation methods in Mediation

In SA, individuals were allowed to submit their intention to utilise mediation, as far back as 1991, as provided for by "Form 1 - Notice to submit Prospective Action to Mediation Proceedings in terms of Section 3(1) (a) (i) of the Courts for Short Process and Mediation in Certain Civil Cases Act 103 of 1991" (Department of Justice and Constitutional Development, 1991a) and "Form 2 - Notice to submit an Action already Instituted in the Court or Magistrate's Court in terms of Section 3(1) (a) (ii) of the Courts for Short Process and Mediation in Certain Civil Cases Act 103 of 1991" (Department of Justice and Constitutional Development, 1991b) In 2014 the Department of Justice and Constitutional Development allowed for mediation by the courts prior to litigation and after commencement of litigation through the forms described below: "Application for referral to mediation (Prior to litigation) , using FORM 1 (Rules 77(1) and (2))" (Department of Justice and Constitutional Development, 2014d) and "FORM 3 (Rules 78 (1)) Application for referral to mediation (After commencement of litigation)" (Department of Justice and Constitutional Development, 2014e).The department also has a settlement agreement form to allow the award of an agreed settlement which is administered through: "FORM 14 (Rule 82) Settle Agreement" (Department of Justice and Constitutional Development, 2014d)

In February 2020, an amendment to the Rules Boards for Courts of Law, which is the board that regulates the South African courts, allowed for the insertion of Rule 41A to the rule. (Department of Justice and Constitutional Development, 2020) The amendment guides the use of mediation as a dispute resolution mechanism. Rule 41A provides that for every new application for court proceedings, the plaintiff shall serve the respondent with a notice to

indicate whether they agree or oppose the referral of their dispute for resolution via mediation. Such a notice will be undertaken in accordance with Form 27 (Notice of Agreement or Opposition to Mediation Form), which is also provided for by the amendment. This amendment to the Rules Boards for Courts of Law came into effect on the 9th of March 2020. (Department of Justice and Constitutional Development, 2020)

The Department of Justice and Constitutional Development had avenues for individuals to opt in mediation as a dispute resolution mechanism. (Department of Justice and Constitutional Development, 2014c) The forms outlined above have over the years allowed for disputes to undergo mediation prior to litigation or after commencement of litigation, and in 2020 the amendment outlined above requires for parties to consider mediation prior to accessing the courts to resolve their disputes. (Department of Justice and Constitutional Development, 2020) The implementation of mandatory mediation in the South African healthcare sector may therefore utilise a similar provision outlined above, through the incorporation of an agreement to mediate section into the existing informed consent forms. Such an agreement would outline the agreement on the part of the patient that mediation would be utilised prior to exercising litigation in case a dispute arises. The mediation process can then utilise accredited mediators available on different platforms to facilitate the process.

In SA, organisations like Mediation in Motion (MiM) and Conflict Dynamics provide training for mediation. MiM serves as a not-for-profit organisation that connects accredited mediators with their clients. After completion of training, mediators' information is displayed on the MiM website for clients to easily connect with them. (Mediation in Motion, 2021) Conflict Dynamics also offers a mediation training course that aims to equip individuals to

mediate in most disputes including voluntary mediation, court-annexed or directed mediation. Qualified mediators are also displayed on their website, to ensure that clients seeking mediators can access their information. (Conflict Dymamics, 2021)

Prior to initiating the mediation process, the disputing parties jointly appoint a mediator and a pre-mediation agreement is signed by the disputing parties. The Department of Justice and Constitutional Development published a template of an agreement to mediate in the Government Gazette in 2014. (Department of Justice and Constitutional Development, 2014b) This agreement can be utilised by disputing parties who agree to mediate their dispute. Upon completion of mediation, the parties can then utilise the post-mediation agreement to record their settlement. An example of a post-mediation or settlement agreement used in SA can also be obtained from the Department of Justice and Constitutional Development website (Department of Justice and Constitutional Development, 2014f), attached in Appendix E.

In Singapore, the Mediation Act of 2017 was passed to promote, encourage and facilitate the resolution of disputes by mediation. (Republic of Singapore, 2017) The Act allows for the implementation of a mediation agreement in writing, either through a clause in a contract or through a separate agreement. The mediated settlement agreement can also be recorded as an order of the court, as provided for by the Mediation Act. Such an application can be made to the courts, regardless of whether the proceedings have commenced or not. The Act also allows the conversion of mediated settlement agreements to court orders, only if they are mediated through certified mediators or accredited service providers. (Goh and Gan, 2020, Republic of Singapore, 2017) The mediation process can be instituted by parties, either

through the direct appointment of a mediator or the use of a service provider like the SMC, for selecting a mediator. (Goh and Gan, 2020)

The European Parliament adopted a directive on mediation in 2008. (European Parliament, 2008) The purpose of this directive was to build trust in the mediation process within the European Union (EU). According to the directive, member states were to ensure implementation of the directive into national law by November 2010. EU member states such as France, Italy, Portugal, Greece, Austria and Estonia had implemented the directive by 2014. (Libralex, 2014) In the UK, mediation has been used for many years to resolve commercial disputes. The 'Woolf reforms', which aimed at simplifying and fast tracking civil litigation, encouraged most parties to consider ADR, particularly mediation to resolve disputes. (Penningtons Manches Cooper, 2019) The Civil Procedure Rules (CPR) are the primary source of domestic law in the UK and parties must refer to CPR pre-action protocols prior to commencing court proceedings. The CPR require that ADR, including mediation is utilised prior to parties seeking recourse through the courts and parties may be required to provide evidence that ADR had been considered. (Penningtons Manches Cooper, 2019) The UK implemented the EU directive (2008/52/EC) by incorporating it into English law, through the Civil Procedure Amendment Rules 2011, allowing facilitation and promoting settlement of cross-border disputes through mediation. (Libralex, 2014, Penningtons Manches Cooper, 2019) The amendment allowed for CPR to include provisions for making a mediation settlement enforceable. (Penningtons Manches Cooper, 2019)

Mandatory mediation

The settlement of disputes through the court system has been the traditional way of providing justice for litigants. The popularity of ADR mechanisms as an alternative to the court systems has been growing rapidly over the years. The adoption of mediation by courts to officially settle disputes has been reported as far back as 1976 in the United States. (Nolan-Haley, 1996) The addition of Rule 41A to the Rules Board for Courts of Law in SA, allows for the plaintiff to offer the defendant a notice to opt in or out of mediation when serving them with summons. The rule further requires that reasons for the refusal of mediation must be outlined, as provided for in Form 27. Section 3 (b) of the amendment also provides for the Judge or the court to direct the parties to consider referral for of their dispute for mediation at any time before judgement. (Department of Justice and Constitutional Development, 2020)

The amendment by the Rules Board for Courts of Law outlined in the previous paragraph strengthens the argument for mandatory mediation as a means to address the current medical litigation crisis in the South African healthcare sector. The option to consider mediation as a dispute resolution mechanism for arising medical negligence claims can be offered to patients raising disputes prior to utilising the courts, in accordance with the amendment. One can also argue that the amendment also allows for the healthcare practitioners and institutions to incorporate the mediation agreement in the informed consent forms and to encourage patients to consider mediation for arising medical negligence disputes.

The EU directive on mediation provides for parties to voluntarily consider mediation to resolve their disputes and provides that member states may elect for mediation to be compulsory before recourse to the courts. In order to encourage parties to utilise mediation prior to litigation, countries like England have chosen for mediation to be voluntary, however, in order to obtain legal aid, one would have to seek mediation first to resolve the dispute. Italy initially elected to make mediation mandatory for civil and commercial disputes before initiating court proceedings, however, the rule was later abolished in favour of voluntary mediation. (Libralex, 2014)

3.3 Conclusion

Litigation as form of resolving medical negligence disputes in the SA health sector is associated with a huge cost burden, as discussed in chapter 2. The SA health sector would benefit significantly if the money spent on the legal process was used for what it was actually allocated to, the provision of healthcare (Walters, 2014). In the health sector disputes arise mainly due to miscommunication, as a result mediation would be the most effective ADR mechanism, because it allows communication between the aggrieved parties. (Walters, 2014)

The fact that the two parties would be able to communicate their concerns to each other with the help of a mediator, clarifying miscommunications may resolve the issues without going through extensive proceedings as would be the case with litigation. This chapter highlighted the overwhelming advantages of mediation as a form of dispute resolution prior to embarking on litigation in the SA health sector. The next chapter will explore the normative arguments

in defence of the use of mandatory mediation as a form of dispute resolution prior to litigation in the SA health sector.

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Chapter 4: Normative arguments for mandatory mediation.

4.1 Introduction

This chapter aligns with the third objective of this study, to normatively articulate and defend factors justifying the use of mandatory mediation as a form of dispute resolution prior to litigation in the SA health sector. Normative theories of deontology and consequentialism, as well as the constitutional rights narrative will be utilised to create an argumentative strategy in support of mandatory mediation. The normative arguments will be used to answer the following normative questions raised in chapter 1, section 1.8 "Ought we address the constitutional concerns brought about by the current medical litigation crisis?" and "Ought mediation be a mandatory process when disputes with potential for medical litigation arise in the SA health sector?". Counter arguments will also be addressed. Deontology and consequentialism have been chosen for my arguments as these are the two major theories in medical ethics that are most applicable to my analysis. In addition, African indigenous values and Ubuntu have been drawn upon because these values have major bearing on mediation in the lived context.

4.2 Deontology

The moral theory of Deontology is used to argue that it is morally justified to use mandatory mediation as a means to address the medical litigation crisis the SA health sector. "Deontology is a rule-based theory" (Dhai et al., 2011), where a set of rules guide how people should live. The concept of duty was advanced by Immanuel Kant, who was the first philosopher to put this concept at the centre of ethics. (Dhai et al., 2011)

Kant considered human beings to be rational agents, with intrinsic worth, capable of making their own decisions and able to conduct themselves in a reasonable manner. According to Kant, moral goodness only exists when rational beings "act from a good will", with the understanding that their actions are in keeping with a moral obligation or duty. Kant believed that non-human animals possess limited rational capacities and therefore their actions are not guided by reason. He therefore, considered human beings to be the only reasonable creatures on earth. (Rachels and Rachels, 2019)

Kant's moral system stemmed from the thoughts outlined above and he believed that all of our moral duties can be derived from one principle which he termed the "Categorical Imperative". (Rachels and Rachels, 2019) Kant's categorical imperative is comprised of three components: firstly "it is a maxim-a general guiding principle", secondly "it is a universal law – a principle that applies always, under all circumstances, everywhere, and for everyone" and lastly "it requires the will to act accordingly – this is an appeal to a person's moral conscience". (Dhai et al., 2011) This imperative gives direction with regard to what needs to be done irrespective of one's desires or goals. The categorical imperative is the formula that allows for the acceptability of moral rules. (Beauchamp and Childress, 2013b) Beauchamp and Childress describe morality according to Kant's theory as grounded in reason and not determined by tradition, attitudes nor intuition. Kant termed the general rule of conduct a "maxim", and the moral worth of an individual's action depends exclusively on the acceptability of that "maxim'. (Beauchamp and Childress, 2013b)

In order to address the normative questions raised in the first paragraph of this chapter, as rational beings we ought to ensure that the actions undertaken to address the constitutional concerns brought about by the current medical litigation crisis, are in keeping with a moral

obligation. Furthermore, for one to consider the action of making mediation a mandatory process when dealing with medical negligence disputes with a potential for litigation as morally worthy, there needs to be reasonable grounds to argue that the "maxim" upon which such an action is taken is morally acceptable. (Beauchamp and Childress, 2013b)

4.2.1 Arguments for access to health care, life, dignity and children's rights to basic health care services

With the use of the theory of Deontology it is argued that there is a categorical imperative (Dhai et al., 2011) to ensure access to health care, life and dignity; and that the current medicolegal climate impedes this access. The Constitution of the Republic of South Africa "is the supreme law" of the country, any "law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled." (Republic of South Africa, 1996) The Constitution being the supreme law of the country, in my opinion, is to be considered a categorical imperative, a "maxim – a general action-guiding principle" and it is therefore everyone's duty to uphold it.

The Constitution being considered a categorical imperative is the formula that allows for the acceptability of moral rules in this context. (Beauchamp and Childress, 2013b). Access to health care services, is a constitutional right afforded to every person in SA, as provided for in section 27 (1) (a) of the Bill of Rights of the Constitution of the Republic of South Africa. (Republic of South Africa, 1996) Access to health care services is a moral rule contained in the Constitution and it is everyone's duty to ensure that it is upheld at all times. The categorical imperative tests the consistency of maxims and Kant believed a maxim must be capable of being conceived without contradiction. (Beauchamp and Childress, 2013b) Litigation as a form of settling medical negligence claims, together with the contingent

liabilities, takes up a significant portion of the health budget. The money used to pay these claims is sourced from the provincial health budgets. When drafting the budget the National Treasury, did not make provision for litigation costs, and therefore, the funds used to settle the claims diverts the funds that would have otherwise been budgeted for the provision of access to health care services. (Malherbe, 2013)

It was only recently that the National Treasury drafted plans to stabilise its medical negligence liabilities, as reported in the 2020 Budget Review. These plans include, the reprioritising of funding in the Department of Health's budget to pilot the National Quality Health Improvement Plan in 2020/21, as well as contracting law firms with medico-legal expertise to assist with claim management support and provision of legal services in some provinces. (National Treasury, 2020)

The provision of a separate budget for contracting law firms and addressing the medical negligence claims, still has an impact on health care, especially during the Covid-19 era, where there is significant need for extra funding, while the National Treasury is also under pressure to cut budgets due to the suffering economy. The diversion of such funds to settle medical negligence claims directly infringe the constitutional rights of the people to access health care services. For litigation to be considered a maxim and morally justifiable according to Kant, it should not bring about contradictions. The impact of litigation on the constitutional right to access health care, in my opinion contradicts litigation as a morally justifiable action to deal with medical negligence claims. The contradiction is brought by the fact that the Constitution must be upheld at all times, and such an infringement would render litigation an inconsistent maxim according to Kant, and as a result not morally acceptable.

The SA health care, more specifically the public sector is overburdened with problems such as limited resources, in the midst of a huge demand to service the majority of the population who rely on the public health institutions. This problem is now worsened by the increase in the quantity of medical negligence claims being paid. These rising litigation costs have a huge effect on the State's ability to fund health care. (Malherbe, 2013) The burden of finding additional funds to cover legal costs and settle medical negligence claims continues to further destabilise the public health system. (Malherbe, 2013)

The continued narrative of the medical litigation crisis and its impact on the health care system, bring forth further infringement on the constitutional rights of the people of SA. The Constitution of the Republic of South Africa, provides for the right to human dignity in section 10, the right to life in section 11 and section 27 provides for the right to have access to health care services including the right not to be refused emergency medical treatment. The Constitution further provides for the children's rights to basic health care services in section 28. (Republic of South Africa, 1996) The right to human dignity and life are entirely non-derogable, as outlined in the Bill of Rights, section 10 and 11, respectively. (Republic of South Africa, 1996) While section 27, with the exception of emergency services is subject to limitation of reasonable resources, this does not apply to section 28. (Republic of South Africa, 1996) Litigation adds to this limitation by further depleting the resources. In addition to the impact on access to health care services, the rights outlined above are also directly or indirectly impacted by the effects of medical litigation on the health care system. (Dhai et al., 2011) A further infringement of these sections of the Constitution would not be considered morally acceptable according to Kant. (Dhai et al., 2011)

The components of Kant's categorical imperative (Dhai et al., 2011), would place the Constitution as a general guiding principle, and as a universal law that applies at all times, unless when limited by section 36 of the Constitution. (Republic of South Africa, 1996) "Deontology falls within the domain of moral theories that guide and assess our choices of what we ought to do." (Alexander and Moore, 2016) Therefore, in order to answer the following normative question "Ought we address the constitutional concerns brought about by the current medical litigation crisis?", the theory of deontology would guide that "we ought to address the infringement of the constitutional rights outlined above". Failure to address the issue would mean that our moral conscience will be questioned, because we will be in contravention of all three components of Kant's categorical imperatives (Dhai et al., 2011). A conduct of ignoring the infringement of constitutional rights brought about by litigation will be inconsistent with the Constitution and therefore also in contravention of section 2 of the Constitution of the Republic of South Africa. (Republic of South Africa, 1996) Therefore, the theory of Deontology as outlined above will guide our moral answer to be "we ought to address the constitutional concerns about the current medical litigation crisis."

The argument above outlined the moral justification for the need to address the constitutional concerns about the current medical litigation crisis in SA, however one needs to outline how those concerns will be addressed. The previous chapter (section 3.2.3) outlined the overwhelming advantages of mediation, and in particular, the cost effectiveness of mediation. (Claassen, 2016) The arguments presented in the previous chapter, strongly argued for mediation as a feasible alternative to litigation in addressing the medical litigation crisis. The fact that mediation would address the constitutional imperative to access healthcare, would

therefore mean that implementation of mediation as a dispute resolution mechanism in the SA health care sector would be morally and constitutionally justified.

Despite the arguments brought forward in support of mediation as an alternative dispute resolution mechanism, one still need to answer the normative question raised in chapter 1, section 1.8 "Ought mediation be a mandatory process when disputes with potential for medical litigation arise in the SA health sector?" It was argued above that the normative theory of Deontology would guide that we ought to address the constitutional concerns brought about by litigation and that the implementation of mediation when disputes with potential for medical litigation arise in the SA health sector, would be morally justified. Furthermore, the impact of litigation on access to healthcare also infringes on human dignity and life, which are non-derogable as outlined above. Hence, addressing the infringement is ethically imperative. Therefore, the argument of implementing mandatory mediation would be morally justified.

The Rules Board for Courts of Law requires individuals to consider mediation prior to litigation, as provided for by the amendment to the rules in Section 41A. (Department of Justice and Constitutional Development, 2020) The amendment to the Rules Board for Courts of Law, would in my opinion be considered by Kant as a maxim. It will then be morally justified to follow amendments provided for by the Rules Board for Courts of Law, to require that individuals having any medical litigation disputes should first consider mandatory mediation prior to litigation as a solution to their dispute.

4.2.2 Counter arguments

The counter arguments to the normative argument addressed above need to be considered. Section 34 of the Constitution of the Republic of South Africa, states that: "Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum." (Republic of South Africa, 1996) This section could give rise to a counter argument that the aggrieved party has a right to a fair hearing before a court through litigation and this section is a categorical imperative that one needs to uphold. The response to the counter argument raised above is that the right to access the courts as provided by section 34 of the Constitution of the Republic of South Africa will still be realised through mediation. The section provides for "another independent and impartial tribunal or forum" where appropriate, and the section can be interpreted to allow mediation as such a forum. (Republic of South Africa, 1996) The reason for such an interpretation is that the characteristics of mediation includes impartiality and independence, voluntary and without prejudice, (Claassen, 2016, Kovach, 2005, Brand et al., 2016), and would therefore allow for the dispute to be resolved as provided for by section 34. Furthermore, the principle of justice will be ensured by the use of mandatory mediation as opposed to litigation, as the potential cost saving will ensure that there is fair allocation of the budget towards provision of health care and therefore distributive justice will prevail. (Dhai et al., 2011) Furthermore, utilising mediation does not mean one is giving up the right to go to court, because if mediation fails to resolve the dispute, resolution through the courts may still be accessed. The issue of compulsory mediation has also been previously argued that it merely delays party's access to the courts in a worst case scenario, however, it does not deny a party's right to a fair trial. (Libralex, 2014)

The principle of respect for autonomy may also be brought forward as a counter argument for mandatory mediation. Autonomy in simple terms denotes self-rule and when used in reference to an individual, it encompasses a person that rules self and is free from controlling influence by others. Beauchamp and Childress further describe autonomy with regard to three components, namely: intentionality, understanding and absence of controlling influences. (Beauchamp and Childress, 2013c) The principle of respect for autonomy is outlined in the International Bill of Rights, the Constitution of the Republic of South Africa and the Patient's Rights Charter. This principle aims to protect a person's liberty and agency, and there are to be no controlling influences to that liberty. (Engelbrecht, 2014) A counter argument related to mandatory mediation, could be that an individual's autonomy is infringed upon if one is not allowed to make their own choice and decision to pursue litigation to settle their disputes. The individual would not have been afforded an opportunity to exercise their own free will in making decisions. A further argument could be made that there was no absence of controlling influences in their decision making and therefore their autonomy was infringed in that their decision would not have been voluntary. The principle of autonomy goes hand in hand with informed consent, (Engelbrecht, 2014) meaning that, for autonomy to be exercised fully, the patient will need to understand the pros and cons of both litigation and mediation. Therefore, mandatory mediation can only be liberty limiting if there is full understanding of what it entails and the patient is forced to undergo mediation against his/her beliefs and better judgement.

The counter argument to the respect for autonomy raised above could be addressed in reference to a quote from Beauchamp and Childress: "respect for autonomy has only prima facie standing, and competing moral considerations sometimes override this principle." The statement highlights the fact that one's autonomous choice could be limited if it could

potentially harm others or endanger public health. In that situation others can justifiably restrict the exercise of such autonomy. (Beauchamp and Childress, 2013c) Autonomy, like most human rights enshrined in the Bill of Rights of the Constitution of the Republic of SA is subject to limitations, as provided for in section 36. (Republic of South Africa, 1996) In the case of mandatory mediation, a case can be made that, mandatory mediation is instituted to address a public health impact brought about by litigation. And that the constitutional limitation of autonomy in this context, is to protect the non-derogable rights of other citizens.

4.3 Consequentialism

With the use of the consequentialist set of theories (Dhai et al., 2011) it will be argued that there are overwhelming advantages of mediation as compared to litigation thereby bringing about greater good to society, in that access to health care and protection of the rights of the society at large will be ensured. Consequentialism defines morality according to an individual's conduct being guided in such a way that it brings about the best outcome, and what this theory considers right or wrong depends on the consequences of the actions, meaning "the end justifies the means". (Dhai et al., 2011) Morality according to consequentialism is dependent only on the consequences and not on the intrinsic nature of the act or anything happening prior to the act. (Sinnott-Armstrong, 2019) Consequentialism represents a set of theories that utilises a balance of good and bad consequences to determine if the actions are right or wrong. (Beauchamp and Childress, 2013b)

Mediation has been shown to be highly advantageous as compared to litigation: it is far less costly than litigation, less time consuming, voluntary, without prejudice, client based, private and confidential and addresses the emotional concerns. (Claassen, 2016) The fact that

mediation is less costly as compared to litigation means that the concerns with regard to litigation on the limitation of access to health care to the society at large is addressed. Accordingly, mediation potentially results in bringing about the greater good for society and therefore, the act of allowing mediation as a tool to address the medical litigation crisis will be morally justified, according to consequentialism.

4.3.1 The utilitarianism argument

Utilitarianism is a typical example of consequentialism "whose classic proponents were Jeremy Bentham (1789), John Stuart Mill (1861), and Henry Sidgwick (1907)" (Sinnott-Armstrong, 2019). This form of consequentialism is well-known and aims to achieve "the greatest happiness for the greatest number". (Dhai et al., 2011, Sinnott-Armstrong, 2019) The right or wrong of an action is determined by the consequences of people's actions. It requires that individuals should act in a way that results in the greatest possible balance of utility over bad outcomes. (Dhai et al., 2011) Classic utilitarianism is based on "hedonistic act consequentialism" (Sinnott-Armstrong, 2019). "Act consequentialism is the claim that an act is morally right if and only if that act maximizes the good, that is, if and only if the total amount of good for all minus the total amount of bad for all is greater than this net amount for any incompatible act available to the agent on that occasion." (Sinnott-Armstrong, 2019) Hedonism considers pleasure to be the only "intrinsic good" and pain as the only "intrinsic bad". (Sinnott-Armstrong, 2019)

The consequences associated with litigation as a tool to address medical negligence claims will be considered "intrinsic bad" (Sinnott-Armstrong, 2019) according to classic utilitarianism, as it results in the reduction of access to health care. The reduction in access to

health care for the majority of people, brought about by litigation will need to be addressed, for one to be morally right according to this theory. Leaving the medical litigation crisis to remains as it is currently will be morally incorrect according to utilitarianism, as it brings about more harm than good. The maximum balance of positive value over less value ought to always be produced. In the case where undesirable results are a consequence, the least possible disvalue ought to be produced. Achieving the greatest good for the greatest number is often described as a requirement for utilitarianism. (Beauchamp and Childress, 2013a)

Mediation will be considered morally justifiable, according to utilitarianism because it addresses the harm brought about by litigation. Furthermore, mediation brings about the greatest possible balance of utility by availing the funds for provision of health care, because of the cost effectiveness it is associated with. By reducing the effects of litigation on the provision of health care, mediation provides greater utility. Therefore, one would be acting morally by implementing mandatory mediation to address the current medical litigation crisis. The common good was referred by Aristotle as a good shared by the larger society where an individual belongs and that goods shared with others form part of a good life. Access to health care shared by all individuals in a society forms part of a good life and can therefore be interpreted as a common good. A single person's good life is interlinked with the common life individuals shared within a society, making the individual's good and the community's common good inseparable. The common good of the society is considered higher than that of individuals and should be prioritised. (Hollenbach, 2004)

Improving access to health care for the majority of people will be considered as "intrinsic good" according to classic utilitarianism. (Sinnott-Armstrong, 2019) and also achieving the greatest good for the greatest number. (Beauchamp and Childress, 2013b) Mediation has

been argued to have the advantages that will address the impact of litigation on access to health care, and will therefore be considered an act that brings about "intrinsic good" (Sinnott-Armstrong, 2019) Mediation can therefore be considered a common good because it addresses the impact of litigation on access to health care.

4.3.2 Counter arguments

The counter argument for consequentialism will be that it seems to overlook justice and rights. (Sinnott-Armstrong, 2019) The argument that could arise is that, the realisation of justice for the aggrieved patients seeking justice through litigation should be considered an "intrinsic good" in the same way as that of addressing the impact of litigation on access to health care is considered an "intrinsic good" (Sinnott-Armstrong, 2019). Actions that reflect fairness, what individuals deserve and are entitled to, have been used to describe what justice entails. Beauchamp and Childress interpret justice as treating people fairly, equitably and in an appropriate manner. They further attribute a "fair, equitable and appropriate distribution of benefits and burdens determined by norms" to the term distributive justice. (Beauchamp and Childress, 2013a) The formal interpretation of the principle of justice does not identify particular respects and criteria where individuals ought to be treated equally. However, it merely provides that individuals should be treated equally in whichever circumstances that are deemed relevant. This notion that equals ought to be treated equally raises concerns surrounding decisions about what should be considered equal and what components are relevant when considering equality. (Beauchamp and Childress, 2013a)

Utilitarian theories present the principles of distributive justice as among those that maximise utility. Therefore, any action performed as a rule of justice must be grounded in the principle

of utility, where the maximum balance of positive value over disvalue must be produced. (Beauchamp and Childress, 2013a) When using distributive justice as a counter argument when dealing with mediation and litigation, the maximum utility associated with mediation must be considered over the disvalue associated with litigation. The impact of litigation on access to health care can be considered a disvalue, whereas the overwhelming advantages of mediation and the potential to address concerns brought about by litigation can be considered an action of maximum utility. Therefore, mediation performed in the context of a rule of justice fulfils the requirement of an action grounded in the principle of utility.

4.4 African Indigenous Philosophy and Ubuntu

Ubuntu is a culture that originated in sub-Sahara Africa and it is a term that refers to "respectful treatment of all people as sharing, caring, and living in harmony with all creation." (Chuwa, 2014) Ubuntu forms part of the African indigenous philosophy. Ubuntu views an ideal and meaningful life, as the one where there is inner peace, which occurs as a result of the existence of harmonious relationships among individuals, society and their environment. According to Ubuntu individuals are dependent on one another and such relationships promote and sustain life. An individual cannot survive by themselves, separated from the society. Caring for others forms part of justice according to ubuntu. (Chuwa, 2014) Solidarity, sharing among the community and the good of the community are important aspects of ubuntu. According to some scholars, while ubuntu supports community solidarity, it also supports the human rights of individuals. (Engelbrecht, 2014, Cornell and Van Marle, 2005) Bennet et al (Bennet et al., 2018b), describes ubuntu as a behaviour that is virtuous, where human beings have a general ethical duty to care for one another and the community.

The concept of ubuntu is further signified by the realisation that an individual's humanity is affirmed by viewing others as equally human and the willingness to share the world with them. Ubuntu therefore, brings about the concept of interconnectedness in a community. (Bennet et al., 2018b) The concept of interconnectedness and interrelatedness is further emphasised by Mbiti (Mbiti, 1969), through the understanding that among African communities, one is considered a person provided he/she belongs to a community, a family and a clan. In addition to that, the interconnectedness stretches to the living dead (ancestors), plants and animals. (Kahaka, 2019, Mbiti, 1969) Mbiti used the term "kinship" (Mbiti, 1969), which he describes as "one of the strong forces in traditional African life." He describes this kinship as a drive for social relationships between people in a community, that determines the behaviour among individuals. (Mbiti, 1969) Due to the overwhelming advantages associated with mediation, the individual's choice to utilise mediation as a means to address medical negligence disputes could be a behaviour in keeping with the kinship described by Mbiti. Mediation addresses the disputed parties' concerns and as a result it is likely maintain a healthy relationship between parties and their communities. Therefore, it can be argued that mediation will be in keeping with the maintenance of the personhood, as described by Mbiti.

The application of ubuntu in the SA legal system occurred in previous cases through different roles such as, mediating conflicting laws, promoting national unity and reconciliation, ensuring equality and setting new norms of conduct. (Bennet et al., 2018a) The role of ubuntu in mediating conflicting laws, can determine which of the conflicting rights should be applied in particular situations. (Bennet et al., 2018a) With regard to medical negligence disputes, the culture of ubuntu would encourage access to health care for the entire society and addressing issues that have an impact to that access would be a priority in a society that adheres to ubuntu principles. This is supported by the notion of community solidarity explained earlier.

Therefore, when there are conflicting dispute resolution mechanisms, such as mediation and litigation, a dispute resolution mechanism that would address medical negligence disputes without negatively impacting on the society at large would be considered acceptable according to ubuntu.

Ubuntu culture promote unity and reconciliation. (Bennet et al., 2018a) Therefore, the advantages of mediation such as allowing the disputed parties to discuss their concerns and feelings about a dispute, would mean that medical negligence disputes are addressed while maintaining relationships, as opposed to litigation and would therefore maintain a society that is living in harmony. Ubuntu ensures that equality, which is a constitutional right for every citizen, is upheld. (Bennet et al., 2018a) Therefore, when addressing medical negligence disputes and their impact on access to health care, equality need to be taken into account. A dispute resolution mechanism that is available for all people and does not impact on the rights of others would be considered equitable. Mediation as a dispute resolution mechanism that would be available to all, especially if it is a mandatory first step to address medical litigation disputes, would be the most equitable, as it has overwhelming advantages as compared to litigation.

When new norms of conduct or acceptable behaviour need to be set, the concept of ubuntu can be applied to set such standards of acceptable behaviour, especially if that new norm is not a commonly utilised method. (Bennet et al., 2018a) Litigation was described as the common form of resolving medical negligence claims, as described in chapter 1 and 2. This means that most patients would choose this method should they encounter such a dispute. The impact of litigation has also been described in chapter 2. In addition, the advantages of mediation were described in chapter 3. When considering whether mandatory mediation can

be set as a means to address the current litigation crisis, ubuntu would guide whether such a new norm would be acceptable.

4.4.1 Counter arguments to ubuntu

Ubuntu has encountered many objections when applied to SA law. Some of those objections include, that it is too general and vague to be used in legal arguments, it serves only specific group interests and that it cannot contribute to the solution of contemporary problems. (Bennet et al., 2018b) The arguments described in section 4.4 above shows that ubuntu can be applied to address specific situations such as the medical negligence issues at hand, and therefore, cannot be deemed general and vague. Ubuntu in this case was used to support the solidarity of the majority of society affected by the impact of medical negligence claims on access to health care, and can therefore, not be viewed to be specific to only a specific population. The arguments above were also in favour of ubuntu bringing solutions to contemporary problems such as a threat to constitutional rights.

4.5 Conclusion

This chapter considered arguments and counter arguments in support of mandatory mediation as a means to address the current medical litigation crisis in the SA health sector, based on the normative theories of deontology, and consequentialism and African indigenous values in particular Ubuntu. The arguments highlighted that mandatory mediation will be morally justified according to these theories and values. The next chapter will outline the conclusion and recommendations of the study.

4.5 References

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Chapter 5: Conclusion and recommendations

As with any contractual relationship, doctor-patient relationships may result in damages that may require assumption of liability on the part of the negligent doctor. Litigation as the most commonly utilised method of resolving medical negligence claims has been shown to be associated with escalating costs which have an impact on the health care system. The cost associated with litigation has been described to have reached crisis levels. Alternatives to litigation when addressing medical negligence disputes were outlined. The advantages of mediation as a means to address the litigation crisis were explored and normative arguments in support of the institution of mandatory mediation were presented. This study aimed to normatively assess whether mediation ought to be a mandatory process when disputes with potential for medical litigation arise in the SA health sector. This chapter concludes the research report and offers recommendations as a way forward.

The medicolegal climate in SA was outlined in chapter 2 in order to highlight the extent of the crisis brought about by litigation. The contingent liabilities associated with litigation in the SA public health sector has seen an exponential rise over the years. The national contingent liabilities were reported to be around R100 billion in 2018/2019 financial year, which is more than double the amount reported at the end of 2016. The amount of money paid by the National Treasury to settle medical negligence claims or the cost of litigation rose 20-fold from 2010/2011 to 2018/2019 financial years. Over these years the money used to settle these claims were not budgeted for by the National Treasury and were sourced from provincial health budgets. These costs associated with litigation are of concern, as they have a huge impact on the provision of health care services and represent a crisis in the health care

sector. The current medicolegal context in SA as portrayed in chapter 2 is cause for grave concern. The continuing rise in the cost of managing medical negligence disputes and the associated contingency liabilities need urgent attention. The conclusion made from the outline of the medicolegal climate re-emphasised the fact that, in addition to addressing the cause of these medical negligence disputes, alternative resolution mechanisms need to be explored.

When a situation reaches crisis levels, the feasibility of other alternatives need to be explored. ADR mechanisms such as negotiation, arbitration and mediation can be utilised as alternatives to litigation when dealing with these disputes were outlined in chapter 3. The overwhelming advantages of mediation as a means to address medical negligence disputes were highlighted. This means that disputed parties can enter into a mediation agreement voluntarily, through a process that is flexible and informal. The proceedings of mediation are confidential, impartial and neutral, while the parties are assured that whatever is discussed in mediation cannot be used against them in court as the process is without prejudice. The independence of the mediator and the fact that parties agree to their own settlement also serves as a huge advantage of mediation. The potential cost-effectiveness of mediation as compared to litigation also adds to the advantages of mediation as an effective dispute resolution mechanism. The reported high settlement rates of disputes handled through mediation and the fact that a higher percentage of those reported settlements are done on the day of mediation, further add to the advantages of mediation. Various countries in the EU, such as the UK, France and Italy, as well as others such as Singapore, have successfully implemented mediation. This provides a point of reference for countries like SA when implementing mediation.

In order to support the argument that it would be morally justified to implement mandatory mediation as a means to address the current medical litigation crisis, normative theories such as deontology and consequentialism, as well as African indigenous values such as ubuntu were utilised in chapter 4. The theory of deontology was used to argue that there is a categorical imperative to ensure access to health care, life and dignity; and that the current medicolegal climate impedes this access. The theory argues that constitutional concerns brought about by litigation need to be addressed, as it infringes on access to health care, as well as non derogable rights such as human dignity and life. The arguments and counterarguments offered with regard to the theory of deontology support the conclusion that the implementation of mediation as an alternative, when dealing with disputes with a potential for medical litigation that arise in the SA health sector, would be morally justified. The implementation of mandatory mediation would also be morally justified as it was argued that it would not impact on the person's right to access the courts, but merely delay such access, while still utilising mediation.

The consequentialism set of theories were used to argue that mandatory mediation would be morally justified. The overwhelming advantages of mediation as compared to litigation, means that mediation brings about the greater good for society and therefore, according to consequentialism, utilising mediation as a tool to address the medical litigation crisis will be morally justified. When one considers the advantages of mediation and the potential of mediation to address the current medical litigation crisis, mediation brings about the greatest possible balance of utility. Mediation is also considered a common good because it addresses the impact of litigation on access to health care. Therefore, the conclusion drawn from the consequentialist set of theories, was that it would be morally justifiable to implement mandatory mediation to address the current medical litigation crisis in the SA health sector.

As the culture of ubuntu would encourage access to health care for the entire society and addressing issues that have an impact to that access would be a priority in a society that adheres to ubuntu principles. Mediation with its overwhelming advantages would be an ethically acceptable dispute resolution mechanism according to ubuntu. Ubuntu supports the rights of individuals and their community. It was argued that the implementation of mandatory mediation would not infringe on the rights of individuals and the community. It can be therefore be inferred that mandatory mediation as means to address the current litigation crisis would be morally justified. Personhood was described to be related to the interconnectedness of the individual to others and their community. Mediation was described to maintain relationships between the disputed parties, therefore maintaining the interconnectedness as required by ubuntu. It can then be concluded that mandatory mediation would be ethically justifiable according to African indigenous ethics.

Overall, the normative arguments presented in chapter 4 are in support of mediation as tool to address the current medical litigation crisis and therefore, this study recommends the adoption of mediation as a first line to address medical litigation disputes. The normative arguments also showed that the implementation of mandatory mediation would be considered morally acceptable and as a result, the study also recommends the implementation of mandatory mediation as a first tool to address the arising medical negligence disputes.

The Rules Board for Courts of Law as described in chapter 4, requires individuals to consider mediation prior to litigation, as provided for by the amendment to the rules in Section 41A. Therefore, in keeping with the amendment this study recommends that individuals having any medical litigation disputes should first consider mandatory mediation prior to litigation

as a solution to their dispute. In Singapore the implementation of mediation was achieved through the Mediation Act of 2017, which guides parties on the utilisation of mediation. Parties may choose their own mediators or utilise organisations like SMC to choose mediators. The Act further provides for parties to have an agreement to mediate through the insertion of mediation clauses to contracts or separate mediation agreements. In SA, the amendment of the Rules Boards for Courts of Law in section 41A guides the implementation of mediation in a similar manner. A database with accredited SA mediators can be implemented, where parties can select a mediator of their choice. Mediation organisations operating in SA, such as MiM or Conflict Dynamics can also be used to source accredited mediators for parties. In the UK, the implementation of mediation was added to the CPR. In SA, the amendment to section 41A also allows for implementation of mediation.

The question that arises pursuant to the above recommendations is, how can mandatory mediation be implemented in a society where litigation is common? Informed consent as discussed in chapter 2 allows for the disclosure of information regarding various aspects of health care provided to the patient. Therefore, this study recommends that the information about mediation and the agreement to utilise mediation in case of arising disputes must be incorporated into the informed consent form prior to accessing health care, in a similar manner as obtaining consent for medical treatment. The recommendation is that a clause for the agreement to mediate be added to the consent for medical treatment as shown in Appendix F (South African Medical Association, 2012).

References

South African Medical Association. 2012. Guidelines: informed consent [Online]. Available: https://www.samedical.org/images/attachments/guideline-on-informed-consent-jul012.pdf [Accessed 12/03/2021].

Appendix A: Approval of Title

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

06 January 2021
Person No: 700588
PAG

Dr HJ Moutlana
Po Box 496
Midstream Estate
1692
South Africa

Dear Dr Hlamatsi Moutlana

Master of Science in Medicine: Approval of Title

We have pleasure in advising that your proposal entitled *Mandatory mediation as a means to address the medical litigation crisis in the South African Health sector* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Appendix B: Ethics waiver form

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

University of the Witwatersrand Student Ethics Declaration Form

(To be completed during the protocol assessor meeting)

Background

All Research conducted by a University of the Witwatersrand student, with human subjects or animals, requires approval by the Wits Human Research Ethics Committee or Animal Research Ethics Committee, respectively.

If research has been undertaken without the necessary ethics approvals, this is considered an ethics violation. This will be reported to the relevant structures, the data will have to be discarded, and in the case of students, they cannot use the data towards their degree.

To prevent any ethics violations, the ethics requirements for the proposed project will be discussed with you at the protocol assessment.

Declaration

Based on the current protocol assessment (and any proposed changes suggested by the assessor committee), we, the undersigned, understand that the proposed research requires:

1. Human Research Ethics clearance certificate (Waiver)	~~Yes~~	No
a. Covered under existing supervisor ethics	Yes	No
b. Requires a new HREC application	Yes	No
2. Animal Research Ethics clearance certificate	Yes	~~No~~
3. No Human or Animal Ethics Clearance	Yes	~~No~~
4. Unclear, will seek appropriate guidance from the HREC/AREC committees (whichever relevant)	~~Yes~~	No

Signatures

Supervisor/s: _____ Student: _____

Hlamalsi Moutlana.

Date: 9/10/2019

11 March 2019/MP

Appendix C: South African Law Reform Permission to use tables published in the SALR Issue paper 33, Project 141 (Medicolegal Claims)

Permission to use tables published in the SALR Issue paper 33, Project 141 (Medicolegal Claims)

Van Zyl Ronel <RoVanZyl@justice.gov.za> 19 November 2019 at 11:31
To: Jacob Moutlana <drhlamatsi@gmail.com>

Dear Dr Moutlana

You are most welcome to use any information in published South African Law Reform Commission (SALRC) research papers, such as Issue Paper 33 on Project 141: Medico-legal Claims, as long as the relevant SALRC research paper as the source of your information is appropriately cited and referenced. The SALRC retains copyright in its published documents, but encourages members of the public to engage with and use the research work that the SALRC produces.

The information that you refer to is obviously now dated. I am working on the next document (a discussion paper) to be published in 2020 as part of the Project 141: Medico-legal Claims investigation, but since it is still a work in progress I am unfortunately unable to provide you with information that will appear in the discussion paper at this stage. As you would have noticed from the sources cited in Issue Paper 33, the SALRC did not generate the information in the tables you refer to, but obtained it from other sources. It is fairly difficult to get hold of these types of statistics in the first place, as the national and provincial Departments of Health are not generally willing to share information to anyone outside those departments. If I do find similar information in the public domain as part of my research for the discussion paper on Project 141, I will let you know.

Best of luck with your dissertation.

Regards

Ronel van Zyl

South African Law Reform Commission

Tel: 012 622 6337

Web: http://salawreform.justice.gov.za

http://www.justice.gov.za/salrc

[Quoted text hidden]

Appendix D: Pre-mediation Agreement

FORM MED-6

(Rules 77(4) & 78(3))

COURT: FILE NO:

AGREEMENT TO MEDIATE
(Prior to and after litigation)

PARTIES:

AA Claimant

And

BB Respondent

(To be completed by mediation clerk)

We, the undersigned, (hereinafter referred to as "the Parties") agree to mediate the dispute between us, as set out in the Application for Referral to Mediation, on the terms and conditions in this agreement.

1. PARTICULARS OF CLAIMANT:
   - Surname/Name _____
   - First Names _____
   - Residential address _____
   - Business Address _____
   - Postal Address _____
   - Telephone _____
   - Cellular no _____
   - Fax no _____
   - Email _____

2. PARTICULARS OF RESPONDENT:

Surname/Name _____
First Names _____
Residential address _____
Business Address _____
Postal Address _____
Telephone _____
Cellular no _____
Fax no _____
Email _____

3. MEDIATOR

The Parties hereby agree to appoint the under mentioned mediator:

Surname _____
First Names _____
Address _____
Telephone _____
Cellular no _____
Fax no _____
Email _____

4. MEDIATOR'S FEES

4.1 The Parties and the mediator agree that the fees to the mediator will be paid in accordance with the tariff determined by the Minister.

4.2 A deposit of R_____ toward the mediator's fees and expenses, as determined by the mediation clerk, will be paid to the clerk of the court prior to the commencement of mediation. Any unearned amount in fees, paid as deposit, will be refunded to the Parties.

4.3 The Parties shall be jointly and severally liable for the mediator's fees and expenses.

4.4 Should payment not be timely made, the mediator may, at his/her sole discretion, stop all work on behalf of the Parties and withdraw from the mediation.

4.5 The Parties understand that they shall be responsible for two hours of the mediator's time at the above stated rate for any appointment which they do not attend and do not provide at least 24 hours advance notice of the cancellation.

5. DATE, TIME AND VENUE

5.1 The first mediation session will be held on / / at am/pm.

5.2 The mediation venue will be_____
but may be changed by agreement between the Parties and the mediator.

6. DURATION OF MEDIATION

The Parties agree that the anticipated duration of the mediation is _____hours/days.

7. MEDIATION PROCESS

7.1 The Parties understand that mediation is a process in which a mediator facilitates communication between the Parties and, without deciding the issues or imposing a solution on the Parties, enables them to understand the issues and reach a mutually agreeable resolution of their dispute.

7.2 The Parties understand that it is for the parties, with the mediator's concurrence, to determine the scope of the mediation and this will be accomplished early in the mediation process.

8. NATURE OF MEDIATION

8.1 The Parties understand that mediation is an agreement-reaching process in which the mediator assists parties to reach agreement in a collaborative, consensual and informed manner.

8.2 It is understood that the mediator has no power to decide disputed issues for the Parties.

8.3 The Parties understand that mediation is not a substitute for independent legal advice.

8.4 The Parties understand that the mediator's objective is to facilitate the Parties themselves reaching their most constructive and fairest agreement. The Parties also understand that the mediator has an obligation to work on behalf of each party equally and that the mediator cannot render individual legal advice to any party and will not render therapy within the mediation.

8.5 The Parties state their good faith intention to complete their mediation by an agreement. It is, however, understood that any party may withdraw from or suspend the mediation at any time, for any reason.

8.6 The Parties also understand that the mediator may suspend or terminate the mediation if she/he feels that the mediation will lead to an unjust or unreasonable result, if the mediator feels that an impasse has been reached, or if the mediator determines that s/he can no longer effectively perform his/her facilitative role.

9. MEDIATOR IMPARTIALITY

9.1 The Parties understand that the mediator must remain impartial throughout and after the mediation process. The mediator shall therefore not champion the interests of any party over another in the mediation or in any court or other proceeding.

9.2 The mediator will provide copies of correspondence, draft agreements, and written documentation to the Parties' legal representatives at a party's request.

9.3 The mediator may communicate separately with an individual mediating party, in which case such discussions shall be confidential between the mediator and the individual mediating party unless they agree otherwise.

10. MEDIATOR'S INDEMNITY

The Parties agree that the mediator shall not be liable for any act or omission directly or indirectly connected to the mediation.

11. FULL DISCLOSURE

Each of the Parties agrees to fully and honestly disclose all relevant information and documents, as requested by the mediator, and all information requested by

any other party to the mediation, if the mediator determines that the disclosure is relevant to the mediation discussions.

12. CONFIDENTIALITY

12.1 It is understood between the Parties and the mediator that the mediation will be strictly confidential and without prejudice.

12.2 Mediation discussions, written and oral communications, any draft resolutions, and any unsigned mediated agreements shall not be admissible in any court proceeding, unless such information is discoverable in terms of the normal rules of court. Only a mediated agreement, signed by the Parties may be so admissible.

12.3 The Parties further agree to not call the mediator to testify concerning the mediation or to provide any materials from the mediation in any court proceeding between the Parties.

12.3 The Parties understand the mediator has an ethical responsibility to break confidentiality if he/she suspects another person may be in danger of harm.

13. LITIGATION

The Parties agree to refrain from pre-emptive maneuvers and adversarial legal proceedings (except in the case of an emergency necessitating such action), while actively engaged in the mediation process.

14. PRESCRIPTION

The Parties are aware that the process of mediation shall not suspend, stay or interrupt prescription of any of the parties' claim and the onus rests on each party to take steps to interrupt such prescription for the duration of the mediation.

15. SETTLEMENT AGREEMENT

Should the Parties settle the dispute between them, the Parties agree to reduce the terms of the settlement to writing, with the assistance of the mediator.

16. BREACH OF AGREEMENT

Any party breaching this agreement shall be liable for and shall indemnify the non-breaching parties and the mediator for any loss, including all costs, expenses, liability and fees, including attorneys' fees, which may be incurred as a result of such breach.

17. NON-VARIATION AND WAIVER

The Parties agree that any amendment or variation or waiver of any term of this agreement must be in writing and signed by the parties, including the mediator.

SIGNED AT_____ ON_____

WITNESSES:

1. _____

2. _____

_____
CLAIMANT
PERSONAL CAPACITY/
DULY AUTHORISED
(Attach copy of authority/ resolution)

WITNESSES:

1. _____

2. _____

_____
RESPONDENT
PERSONAL CAPACITY/
DULY AUTHORISED
(Attach copy of authority/ resolution)

Appendix E: Post-mediation agreement

J 628

REPUBLIC OF SOUTH AFRICA

FORM 14
(Rule 82)

SETTLEMENT AGREEMENT

COURT: …….. FILE NO: ……..

PARTIES:

…….. Claimant

And

…….. Respondent

Whereas the parties referred their dispute to mediation;

And whereas the parties have settled the dispute between them with the assistance of the mediator;

And whereas the parties hereby record the terms and conditions of the settlement;

Now therefore it is agreed as follows:

1. TERMS OF SETTLEMENT

……
……
……
……
……
……
……
……

2. AUTHORITY TO ENTER INTO SETTLEMENT

Each person signing this agreement in a representative capacity warrants that he or she has full authority to bind his or her principal to this agreement.

3. CONSENT TO JUDGMENT

The Claimant/Respondent agrees that in the event of failure to comply with any term of this agreement, the Claimant/Respondent shall be entitled to lodge with the clerk/registrar of the court the written Consent to Judgment signed by the Claimant/Respondent and obtain judgment in accordance with the provisions of section 58 of the Magistrates' Courts Act 32/1944.

4. NON PAYMENT

Should any amount payable in terms of this agreement not be paid on the due date the full amount outstanding shall immediately become due, owing and payable.

5. CONFIDENTIALITY

5.1 It is understood between the parties and the mediator that the mediation will be strictly confidential and without prejudice.

5.2 Mediation discussions, written and oral communications, any draft resolutions, and any unsigned mediated agreements shall not be admissible in any court proceeding, unless such information is discoverable in terms of the normal rules of court. Only a mediated agreement, signed by the parties may be so admissible.

5.3 The parties further agree to not call the mediator to testify concerning the mediation or to provide any materials from the mediation in any court proceeding between the parties.

5.4 The parties understand the mediator has an ethical responsibility to break confidentiality if s/he suspects another person may be in danger of harm.

6. ORDER OF COURT

The parties agree that this settlement agreement is/is not forthwith to be made an order of court.

7. BREACH

In the event that this agreement has not been made an order of court and any party breaching the agreement, the aggrieved party will be entitled to make application to court to make this agreement an order of court and to enforce the terms of hereof.

8. NON-VARIATION AND WAIVER

The parties agree that any amendment, waiver or variation of any term of this agreement must be in writing and signed by all parties.

SIGNED AT ……..… ON …….

WITNESSES:

1. ……..

2. ……..

_____
CLAIMANT
PERSONAL CAPACITY/
DULY AUTHORISED
(Attach copy of authority/resolution)

WITNESSES:

1. ……..

2. ……..

_____
RESPONDENT
PERSONAL CAPACITY/
DULY AUTHORISED
(Attach copy of authority/resolution)

Appendix F: Consent for medical treatment with the agreement to mediation clause

I,……..(full name), have been informed by Dr……..about the nature, alternative treatments, benefits, risks and implications involved in undertaking this treatment (specify)……

All the relevant information regarding the aforementioned treatment was explained to me and I have understood. I was given an opportunity to ask questions and to consider whether I want to proceed with the treatment. I therefore voluntarily agree to the treatment. I understand that I am free to withdraw my consent to undergo this treatment at any stage.

In the event that a dispute of any nature (e.g., medical negligence) arise out of or in connection with the treatment I am undertaking, I agree to utilise mediation as a first line to resolve the dispute.

Signed:

……..	……	……
Patient (Full name)	Signature	Date
……...	……	……
Doctor (Full name)	Signature	Date
…….	……..	……..
Witness 1 (Full name)	Signature	Date
……	……..	……
Witness 2 (Full name)	Signature	Date

Appendix G: Plagiarism Report

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