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MINI-DISSERTATION FOR MASTER'S IN MEDICAL LAW

Medical Malpractice Disputes in South Africa - the potential role of mediation as an alternate dispute resolution mechanism.

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Sincere gratitude to:

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To my wife, for taking this journey with my children and me for their understanding and support.

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"Ubuntu is recognized as being an important source of law within the context of strained or broken relationships amongst individuals or communities and as an aid for providing remedies, which contribute towards more mutually acceptable remedies for the parties in such cases. Ubuntu is a concept which, inter alia dictates a shift from (legal) confrontation to mediation and conciliation" --- Judge Colin Lamont.

DECLARATION OF ORIGINAL WORK

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LIST OF ABBREVIATIONS

ADR	Alternate Dispute Resolution
BATNA	Best alternative to a negotiated agreement
CCMA	Council for Conciliation, Mediation and Arbitration
DiSAC	Dispute Settlement Accreditation Council
HIV	Human Immunodeficiency Virus
IMSSA	Independent Mediation Services of South Africa
IMI	International Mediation Institute
MiM	Mediation in Motion
MPS	Medical Protection Society
NDoH	National Department of Health
NDP	National Development Plan
UK	United Kingdom
USA	United States of America
SAMLA	South African Medicolegal Association
SALRC	South African Law Reform Commission
SASOG	South African Society of Obstetricians and Gynaecologists
SASSA	South African Social Security Agency
UNDP	United Nations Development Programme
WHO	World Health Organisation
ZAR	South African Rands

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ABSTRACT

It is generally acknowledged that the progress of a nation is dependent on the health of its people. In South Africa, public health care services are compromised by the rapid escalation in medical malpractice cases and the high costs of settlements. The prevention of the impending collapse of public healthcare services has necessitated the exploration of alternate dispute resolution mechanisms for medical malpractice cases. Court-annexed mediation was inaugurated in certain Magistrates Courts, whilst more recently the State Liability Amendment Bill was introduced to structure the settlement of claims against the State.

Mediation is a 'neutral, non-coercive and non-adversarial' alternate dispute resolution mechanism that facilitates negotiations between disputants. It has been associated with high satisfaction rates, reduction in delays, and reduced costs in specific settings. Mediation is well established in labour disputes, family law, and community matters. However, its application to healthcare disputes remains novel and will require trained mediators. Moreover, issues relating to power imbalances, confidentiality, and privacy can complicate the process. In the background of these challenges, this dissertation explores the medical malpractice landscape in South Africa and the potential use of mediation as an alternative to litigation. The perception of mediation being more cost and time effective than litigation is not supported by evidence as studies show wide variation in these areas. A practice survey of medico-legal attorneys is also included in the dissertation, which highlights local experiences, current practice trends and costs, including the high cost of various experts, a significant cost driver in litigation cases. Similarly, the perceived benefit of decongesting the courts may not materialise, as most cases are settled before court dates that may have been set beforehand. Other potential benefits and challenges associated with mediation, including beneficial strategies for the successful implementation of mediation are discussed further in the study.

In summary, mediation has benefits such as open communication, personal interaction and transparency, provided that a neutral environment exists. Patient and provider satisfaction are also more likely given the privacy and confidentiality associated with mediation. Improved relations, which may become strained by the adversarial nature of litigation, are also more likely to be achieved with mediation. There will be reduced procedural and legal professional costs to an extent. However, the costs of experts and quantum payments will remain similar if they are determined by the same experts. The number of disputants who litigate after failed

mediation attempts may escalate costs further. It is proposed that the successful implementation of mediation is likely to be achieved with appropriate training of mediators and support staff, efficient administration, widespread access to mediation panels, and acceptance by the community as a suitable alternate to the courts.

CHAPTER ONE:
PERSPECTIVES ON MEDIATION IN DISPUTE RESOLUTION

1.1 INTRODUCTION

Throughout recorded history, disputes have been known to occur in most relationships, including family members, co-workers, superiors and subordinates, people and organisations, and even amongst nations.[1] In the field of healthcare**,** disputes often arise between patients and healthcare providers, dating back to ancient Greek times when harsh penalties such as the death sentence were imposed on practitioners whose patients demised as a result of unorthodox medical practices.[2] In Roman times, when a citizen suffered an injury due to medical malpractice, the *pater familias* could institute action against the medical practitioner for patrimonial loss, the inability to work and medical expenses incurred.[3]

In current times, an aggrieved patient or family member may institute a civil claim against a medical practitioner or health institution and file a criminal charge against the practitioner. They may also choose to lodge a formal complaint with a relevant regulatory body in their area in cases of alleged unprofessional conduct or medical negligence.

In South Africa, the number and value of medical malpractice claims have increased exponentially in the past decade,[4] and have impacted adversely on healthcare, especially in the public sector. A similar trend is also observed in developed countries such as the United States of America (USA), Canada, and the United Kingdom (UK) where malpractice claims and malpractice insurance costs have also increased.[5] Middle-income countries such as Kenya and

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[1] Christopher Moore *The Mediation Process: Practical Strategies for Resolving Conflict* 5 ed (2014) 3.

[2] Darrel Amundsen, 'The Liability of the Physician in Classical Greek Legal Theory and Practice' (1977) 32(2) *Journal of the History of Medicine and Allied Sciences* 172.

[3] Berkhouwer and Vorstman *Aansprakelijkheid van de Medicus* 16 as referred to in *Carstens (2004) Fundamina 7-8*, where it is explained that intentional malpractice was identified where for e.g. a medical practitioner poisoned a person, he would be guilty of manslaughter, negligent malpractice referred to cases where intention was absent, ignorant malpractice referred to cases where the medical practitioner was incompetent to perform the particular procedure.

[4] Michael Pepper and Melodie Slabbert, 'Is South Africa on the verge of a malpractice litigation storm?' (2011) 4(1) *SAJBL* 29. Also see Bateman 2011 *SAMJ* 101(4)216. See further Oosthuizen and Carstens 2015 *THRHR* 2015 (78) 269, where the trend in the rise in both the number and value of claims is confirmed.

[5] Patricia Danzon, 'The Crisis in Medical Malpractice: A comparison of trends in the United States, Canada, the United Kingdom and Australia' (1990) (18) 1 *Journal of Law, Medicine and Ethics* 48.

higher income countries like Taiwan have also recently documented increases in medical malpractice lawsuits , highlighting the rising trajectory of these claims globally.[6] Legislative reform measures and other initiatives taken to curb this trend in South Africa, are discussed later in the disserttion. The access to health is embodied in the Constitution of South Africa,[7] and the National Health Act[8], which provides the legislative framework for health care in South Africa. More specifically, Section 27 of the Constitution stipulates that the State must take reasonable measures within its available resources, to achieve the progressive realisation of these rights.[9] However, the current deluge of costly medico-legal claims poses a looming threat to the realisation of these rights, and those set out in the National Development Plan (NDP).[10]

Currently in South Africa, no legislation exists that explicitly addresses medico-legal claims, and medical malpractice claims are processed under common law.[11] Alternate global medical malpractice dispute resolution models have been reviewed by the World Health Organisation (WHO) and include inter alia : (1) specialised health courts to adjudicate claims, (2) medical review and screening panels to settle meritorious claims efficiently, (3) peer review of expert testimony to reduce bias, as well as (4) negotiation.[12]

[6] Tetsu Uejima, 'Medical missions and medical malpractice: the current state of medical malpractice overseas' (2011) 75 (2) *American Society of Anesthesiologists* 22.

[7] Constitution of the Republic of South Africa, 1996.

[8] National Health Act No. 61 of 2003.

[9] Constitution; s 27.

[10] National Development Plan 2030, South African Government available at *https://www.gov.za/*, accessed on 11 March 2019.

[11] South African Law Reform Commission (2017) Issue paper 33, Project 141.

[12] World Health Organization, 'Rapid Scoping Review of Medical Malpractice Policies in Obstetrics' (WHO 2015) available at *http:// www.whoreport malpracticemodels-12 Aug 2015*, accessed on 1 May 2016.

Mediation has a long and varied history in many cultures of the world, namely (i) the Panchayat in India,[13] (ii) mediation committees in China,[14] (iii) the Jirga in Afghanistan,[15] and (iv) community mediation in the Philippines [16] which are traditional forms of conflict resolution that are embedded in modern institutions. Several forms of mediation also exist in Africa, Asia, and in ancient Europe. In South Africa, the traditional Afrikaner community used the local dominee (Minister of the Dutch Reformed Church) to mediate over largely non-criminal disputes, while in African culture, mediation is embedded in the humanist value system known as *Ubuntu*.[17] Mediation has a focus on interests – the needs, desires, or concerns that underlie each party's specific position.

Mediation has been suggested as a potential option for medical malpractice dispute resolution in South Africa by professionals from the legal and medical fraternity.[18] Improved communication, lower costs, lower insurance premiums, improved patient care, and attention to emotional issues, have been suggested as potential benefits.[19] In parallel, legislation has been passed to ensure court-annexed mediation at the magisterial level with the hope of enabling the government to reduce litigation costs by diverting claims against the state to mediation.[20] Mediation is a flexible and confidential process in which a neutral person assists aggrieved parties in working towards a negotiated settlement of a dispute , however the parties remain in control of the process. The terms of resolution as well as decisions about settlement are determined by the parties. Further clarification of the purpose of mediation is provided in Rule

[13] Robert Hayden, 'A Note on Caste Panchayats and Government Courts in India' (1984) 22 *Journal of Legal Plurarlism* 43.

[14] Huang Yi, 'A Study of the People's Mediation System in China : Compared with the ADR System in Japan' (2015) 3(3) *Frontiers of Legal Research* 12.

[15] Ali Wardak, 'Building a post war justice system in Afghanistan' (2004) 41(4) *Crime, Law and Social Change* 319.

[16] Gill Tabucanon, ' Philippine Community Mediation, Katarungang, Pambarangay' (2008) 2 *Journal of Dispute Resolution* 501.

[17] Jacques Joubert, 'Embedding Mediation in South African Justice' *Mediate.com* (2012) available at *http:// www.mediate.com/articles/Joubertj1.cfm,* accessed on 23 September 2018.

[18] Marietjie Botes, 'A perfect solution to healthcare disputes' (2015) 551 *De Rebus* 28. Also see Claassen 2016 *SAJBL* 9(1)7; Dhai 2016 *SAJBL* 9(1)2. Further see Walters 2014 *SAMJ* 104(11)752 who share the view that mediation is a preferred alternative to litigation for medical disputes.

[19] Ibid.

[20] Nomfundo Manyathi-Jele, 'Court annexed mediation officially launched' (2015) 11(4) *De Rebus* 57.

71 of the Magistrates Courts Rules, which declares that the primary goal of mediation is to (i) ensure restorative justice, (ii) maintain relationships that may have become oppositional during litigation; (iii) promote efficiency and lower costs involved in resolving a dispute, and (iv) expose litigants to solutions that may exist out of the court environment.[21] Mediation is described as an 'alternate' mechanism as it is viewed as an alternative to the court process, which is more commonly used for the resolution of medical dispute cases in South Africa.[22] In mediation, parties participate of their own volition, and settlements are negotiated rather than imposed, which is in contrast to arbitration or judgements emanating from the courts.[23]

1.2 RATIONALE AND RESEARCH QUESTIONS

Public healthcare in South Africa is currently compromised by the increasing number of malpractice claims that have to be settled from limited provincial health budgets. A vicious cycle therefore develops, in which reduced hospital budgets contribute to a further decline in health care standards and subsequently, more litigation cases develop from poor infrastructure. Concerns within the healthcare fraternity are being raised about the sustainability of this trajectory and the ability of the State to finance healthcare in the medium to long term (See Figure 1). It is submitted that in the case of private practitioners, the rising cost of professional indemnity insurance has the potential to encourage practitioners to engage in a defensive style of medical practice, in order to avoid litigation. The investigation of alternate dispute resolution mechanisms is therefore necessary to ensure the sustainability of the public and to a smaller extent the private healthcare network in South Africa. Mediation has been considered to be 'efficient and cost-effective', whilst providing justice, meeting the expectations of parties and minimising humiliation and anger. This dissertation, therefore, endeavours to review the role of mediation in achieving these imperatives as an alternative to litigation, which is the current standard for the resolution of healthcare disputes.

[21] R.183 of GG 37448, 18 /3/2014; 4.

[22] Stella Vettori, 'Mandatory mediation: An obstacle to access to justice' (2015) 15 *African Human Rights Law Journal* 355.

[23] Ibid.

	Contingent liability (Rm)			Payments (Rm)		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
Eastern Cape	8,211	13,421	16,773	74.9	255.6	208.5
Free State	540	941	1,307	0.2	1.7	1.6
Gauteng	10,079	13,452	17,844	241.1	572.8	531.3
KwaZulu-Natal	6,725	9,957	10,292	103.5	90.4	251.3
Limpopo	1,197	1,607	2,116	35.6	9.6	74.8
Mpumalanga	1,459	2,366	5,243	7.6	15.2	34.3
Northern Cape	174	343	1,221	3.8	4.8	0.8
North West	34	856	1,285	13.2	6.4	29.5
Western Cape	193	182	32	19.3	28.1	38.4
Total	28,613	43,123	56,112	499.2	984.6	1,170.5

Figure 1: Contingent liability and claims settlements - all provinces: 2014-2017

The mediation process involves negotiation between the affected parties, which is co-ordinated with the assistance of a mediator who has to serve in an impartial capacity. Mediation has the potential to allow for enhanced communication, more privacy and confidentiality, a balance in the power relationship if it exists, and possibly a reduction in overall costs as well as compensation payments. The successful application of mediation in healthcare disputes internationally and other areas like income tax disputes are also discussed in the dissertation. Similarly, the challenges and limitations of mediation are elucidated, and an analysis of international models is described. The court-annexed mediation rules are highlighted, and recommendations with respect to the implementation of mediation are proposed. The dissertation attempts to expound the challenges and benefits of mediation for medical malpractice disputes, and clarify perceptions about cost and time benefits. It also attempts to highlight cost drivers in litigation cases, through the inclusion of a meta-analysis of relevant studies and a qualitative pilot practice survey respectively. A summary analysis of the findings is presented in the conclusion.

1.3 RESEARCH OUTLINE

The core of the dissertation is composed of five chapters, including an introductory and conclusory chapter**.** Chapter One commences with perspectives on mediation and includes a relevant background to these aspects**.** This is followed by the rationale behind the study and a literature review outlining the primary sources of literature that are relevant to the focus of the topic.

Chapter Two provides further insight into mediation with a brief review of cultural perspectives, the evolution through democracy and current mediation styles.

In Chapter Three, the court-annexed mediation rules in certain magistrates courts in South Africa, the attributes and challenges of mediation, and ethical considerations and concepts of justice are expounded on. The results of a small survey conducted amongst legal practitioners and a meta-analysis of relevant studies are presented here.

Chapter Four embraces perspectives on the implementation of mediation. This is followed by a discussion of 'mandatory mediation', followed by a dashboard of contributory causes of failure, and potential remedial strategies in mediation.

Chapter Five concludes the dissertation by providing a synthesis of the relevant aspects, and some of the limitations in the study. Criticisms of policy development and a summary analysis of contrasting expectations about mediation and litigation are presented.

1.4 LITERATURE REVIEW

In this section, an overview of medical malpractice litigation is presented with specific reference to increasing malpractice claims and its impact on the public health care system. This background substantiates the search for an alternative dispute resolution mechanism for malpractice claims predominantly within the public health care system in South Africa. Data on the legislative reform initiatives taken by the Department of Health are outlined thereafter. A situational analysis of the current medicolegal landscape in South Africa is discussed further, and data on potential strategies for a successful implementation is also presented.

1.4.1 The impact of medical malpractice litigation in South Africa

The Medical Protection Society (MPS), a leading global medical insurance company has confirmed an almost 550% increase in medical malpractice claims in South Africa compared with a decade ago and a 35% increase in the number of claims made against healthcare professionals between 2011 and 2016.[24] Similarly, public health departments like the Gauteng Department of Health has settled at least R1 billion in lawsuits since January 2015, while the Eastern Cape is facing payouts of R14 billion.[25] In KwaZulu-Natal medical negligence claims

[24] Pepper and Slabbert (note 4 above).

[25] Gill Gifford, 'Medical malpractice litigation: Undermining South Africa's health system' (2017) available at *http://www.health24.com/*, accessed on 23 September 2018.

have increased from 50 in 2008 (more than R3 million in claims), to over 350 in 2015, with over R5 billion in pending claims.[26] Amongst the medical specialities, obstetricians and gynaecologists encounter the highest number of medical negligence claims brought against them for birth-related issues.[27]

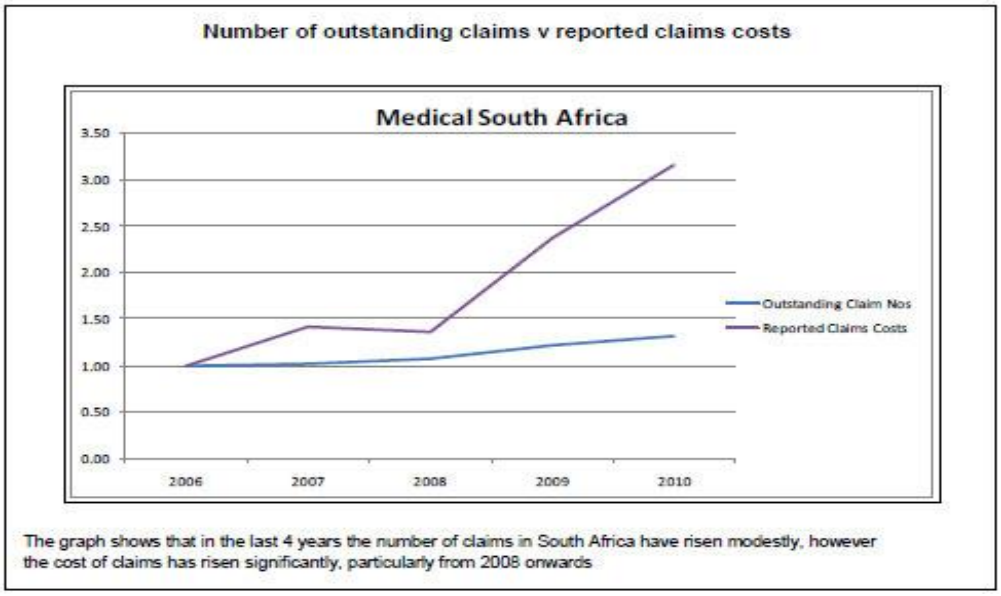

Figure 2: Medical Protection Society - reported medical claims[29]

The unintended negative consequences of rising litigation claims include (i) unaffordable professional indemnity insurance, (ii) high medical care costs in the private sector, (iii) the inability of the State to fund public healthcare , (iv) declining service standards , (v) defensive practices and over-servicing , and (vi) reluctance to practice in fields like obstetrics.[28] The causes for the increase in medical litigation claims payouts in South Africa are multifactorial, and include the lack of an efficient complaints system, causing aggrieved parties to choose litigation. Legal reform is necessary due to the inefficient and unpredictable legal processes for the handling of clinical negligence claims, which result in protracted legal processes and high costs in settling claims.[29]

[26] Chelsea Pieterse and Johnathan Erasmus, 'High cost of medical negligence' (2017) available at *http://www.news24.com/SouthAfrica/News/*, accessed on 24 September 2018.

[27] Letitia Pienaar, 'Investigating the reasons behind the increase in medical negligence claims' (2016) *PER 19*(1)1.

[28] Justin Malherbe 'Counting the cost: The consequences of increased medical malpractice litigation in South Africa' (2013) 103 (2) *SAMJ* 83.

[29] Graham Howarth, 'Challenging the cost of clinical negligence' (2016) 106 (2) *SAMJ* 141.

1.4.2 Legislative Reform - Policies, Frameworks and Models

i. New Developments: The State Liability Amendment Bill

The recently introduced State Liability Amendment Bill [30] provides for structured settlements for medical malpractice claims against the State. The purpose is to reduce the negative impact of large claims payments on the provincial health care budget. However, this is likely to increase the administrative workload for hospitals, and be inconsistent with inflation on the cost of goods or services resulting over time. Moreover, the above Bill stipulates that : 'a person may be ordered to receive ongoing treatment at a public health establishment, or when private care is required , the liability of the State will be limited to the cost incurred had treatment been given at a public health establishment'. It is also argued that it is unethical or inappropriate to force a patient to receive treatment in a hospital where he/she was exposed to medical negligence in the first place.

ii. Other local and international strategies

There is consensus in the medical community that the current medical malpractice system is both costly and inefficient.[31] To address these and related concerns, the Ministers of Health, Justice and Constitutional Development tasked the South African Law Reform Commission (SALRC) to investigate and generate proposals for reform. Subsequently, in Project 141, Issue Paper 33, the Commission requested public engagement and embarked on further activities.[32] Several models, policies and frameworks have been presented globally , which requires further review. A tabulation highlighting the characteristics and evaluative outcomes of WHO determined strategies is presented in Table 1.[33] It is evident from these findings that many of the strategies, including mediation, still need rigorous evaluation.

Locally, professionals from the legal, medical and administration arenas have proposed varying suggestions: Pepper and Slabbert propose better self-policing by the medical

[30] State Liability Amendment Bill (B16-2018), GG 41685 of 25 May 2018.

[31] National Conference of State Legislatures, 'Medical Malpractice Reform. Health Cost Containment and Inefficiencies' (2011) 16 NCSL, Briefs for State Legislators 71-74 available at *http://www.ncsl.org/documents/health/Introand BriefsCC-16.pdf* , accessed on 30 August 2018.

[32] South African Law Reform Commission (note 11 above).

[33] World Health Organisation (note 12 above; 24-31).

profession, special health courts, policing of expert opinions, alternative dispute resolution, a no-fault system and legislative reform.[34] Dhai proposes the establishment of a statutory body to consider and settle claims through mediation. [35] In places like Scandinavia and New Zealand, compensation approaches appear to work well when coupled with a no-fault system. [36] Howarth and Carstens propose the 'no-fault system' or the 'capping of non-economic damages', both of which require legal reform.[37] Evidentially, Guirguis-Blake analysed almost 45 000 cases in 10 states in the US and found that significant reductions in malpractice payments could be realised if total or noneconomic damage caps were operating nationally.[38] Roytowski reflects on legal reform initiatives in the USA that limit liability, and suggests that similar reforms could be implemented in South Africa.[39] Initiatives such as defensive medicine practice, damage caps, health tribunals, and practice guidelines are some of the reforms anticipated in the USA.[40]

In South Africa, a medico-legal summit and medical malpractice workshop were conducted in March 2017.[41] The recommendations emanating therefrom include proposals for various legislative amendments and short-term solutions, the enforcement of existing measures and the amendment of the State Liability Act 20 of 1957,[42] were approved by Cabinet in May 2018. In general, the proposals reinforce the consensus

[34] Pepper and Slabbert (note 4 above).

[35] Ames Dhai, 'Medico-legal litigation: Balancing the spiralling costs with fair compensation?' (2015) 8 (1) *SAJBL* 2.

[36] Siang Tan, 'Federal medical tort reform: Has its time come?' (2017) *Family Practice News* 1.

[37] Graham Howarth and Pieter Carstens 'Can private obstetric care be saved in South Africa?' (2014) 7 (2) *SAJBL* 69.

[38] Janelle Guirguis-Blake, 'The US Medical Liability System: Evidence for Legislative Reform' (2006) 4 *Ann Fam Med* 240.

[39] David Roytowski, 'Impressions of defensive medical practice and medical litigation amongst South African neurosurgeons' (2014) 104 (11) *SAMJ* 736.

[40] Michelle Mello, Allen Kachalia, and David Studdert, 'Medical Liability-Prospects for Federal Reform' (2017) 376 *N Engl J Med* 1806.

[41] Aaron Motsoeledi, Declaration Medicolegal Summit (10 March 2015) available at *http://www.health.gov.za/index.php/2014-03-17-09-09-38/notices?...medicodeclartion*, accessed on 30 September 2019.

[42] State Liability Act 20 of 1957.

that legislative reform is required urgently. However, reform measures to date remain developmental.

iii. WHO listed strategies and models

Table 1. Characteristics of WHO listed strategies, models and evaluative outcomes [43]

Programme/Policy/Model	Model/Strategy Description	Outcome Evaluation
Mediation	One of the most popular forms ADR proposed.	Evaluation pending
No-Fault Approach	An administrative system that processes claims and resolves disputes, without penalising physicians.	Administrative claims much lower
Safety Programs and Practice Guidelines	Evidence-based guidelines, educational modules and safety training programs for practitioners, error/incidence reporting system, unintended event disclosure policy, and training; outside expert review/audit and risk management models.	Reduction in mortality and claims in obstetrics and anaesthetics
Specialised Courts and Alternative Claim Resolution	Provide compensation outside the courtroom, with a judge (guided by a medical expert), specialised claims handlers or arbitrators with training in health court adjudication.	Evaluation pending
Communication and Resolution	Elements comprise expression of regret, factual explanation, consequences, and steps to manage the event and prevent its recurrence.	Evaluation pending
Caps on Compensation & Attorney Fees	Limits damages, such as pain and suffering, which may be adjusted annually for inflation.	Significantly reduced the frequency of both claims and lawsuits.
Alternative Payment System and Liabilities	Allows judges to order periodic and other payment plans for damages if the award exceeds a threshold.	Not reported

[43] World Health Organisation (note 12 above).

Programme/Policy/Model	Model/Strategy Description	Outcome Evaluation
Limitations on litigation	A fault-based filter to limit the number of claims entering the system.	Not reported
Multi-component Model	Different combination of strategies, e.g. capped damages, apology law, the statute of limitations, a limit on contingency fees, pre-trial screening etc. under a comprehensive model, Act, or Bill.	Not reported

iv. Malpractice Indemnity and the Consumer Protection Act

Exemption clauses have been instituted in the private health care sector to indemnify the institution or medical practitioner from potential liability that may arise from negligence. In *Osry v Hirsch, Loubser & Co Ltd* 1922 (CPD) 531 [44] and *Wells v South African Aluminite Co* 1927 (AD) 69,[45] South African Courts have upheld clauses in favour of contractual freedom. In *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA),[46] the exemption clause indemnified the hospital and employees from all liability for damage or loss, from direct or indirect injury to the patient by act or ommission.[47] In contrast, the Consumer Protection Act, effective from March 2011, states that 'unfair, unreasonable or unjust contract terms are prohibited and calls for a person, court, tribunal or commission to consider appropriate foreign and international law when interpreting or applying the Act'.[48] Similarly , in Section 2(1) of the English Unfair Contract Terms Act 1977 (c50),[49] it is stated that 'an individual cannot exclude or restrict their liability for death or personal injury resulting from negligence by referring to any contract term', in accordance with the Act.

[44] *Osry v Hirsch, Loubser & Co Ltd* 1922 (CPD) 531.

[45] Wells v South African Alumenite Co 1927 (AD) 69.

[46] *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA).

[47] Ibid.

[48] Consumer Protection Act No. 68 of 2008.

[49] English Unfair Contract Terms Act 1977 s 2(1).

Exclusionary clauses for medical negligence litigation in hospital contracts may lead the courts to draw on international law and instruments such as the Hippocratic Oath,[50] the Declaration of Geneva (1968),[51] the Declaration of Helsinki (as revised in 2000),[52] and the Universal Declaration of Human Rights (1948).[53] These instruments are central to the principles of medical ethics and do not necessary support exclusionary clauses in hospital contracts, both from an ethical and moral perspective.

In the context of mediation, exclusion clauses for medical negligence cases may hinder the prospect of settlement, as disputants may feel uncompensated. Although mediation may act as an intermediate step between disputes and litigation, exclusionary clauses can be challenged in a court, where the relevant parties may apply the Act, [54] leaving little role for mediation.

1.5 RESEARCH DESIGN AND METHODS

The study design is qualitative in nature and is based on desktop research involving primary and secondary data sources, including personal communication, seminars and press releases. The study includes a brief survey conducted amongst local legal practitioners with experience in medico-legal cases. The rationale for this survey was predominantly to identify the costs incurred in medical malpractice litigation. Further studies on cost and time savings have also been analysed and presented as a meta-analysis. Primary sources include, but are not limited to, (i) constitutional references locally and internationally, (ii) national legislature/policies/strategies, (iii) delict and case law references, (iv) statutory law references, (v) empirical research in journal articles, and (vi) patient databases. Secondary sources will include (i) scholarly articles from journals, (ii) published papers, (iii) qualitative and quantitative research papers, (iv) commentaries, and (v) original reports when available.

[50] Michael North, 'Greek Medicine - The Hippocratic Oath' available at *http://www.nlm.nih.gov/hmd/greek/greek_oath.html* , accessed on 10 March 2020.

[51] Declaration of Geneva. (World Medical Association, 1948).

[52] Declaration of Helsinki (World Medical Association, revised in 2000).

[53] Universal Declaration of Human Rights (1948) Article 5.2.

[54] Consumer Protection Act No. 68 of 2008.

CHAPTER TWO:

AN INSIGHT INTO MEDIATION AS A DISPUTE RESOLUTION TOOL IN SOUTH AFRICA

2.1 THE EVOLUTION OF MEDIATION IN SOUTH AFRICA

2.1.1 Mediation before democracy

The earliest dispute resolutions in South Africa were mediated by civic associations founded around 1901 in the Cape Town area.[55] Up to 1970, mediation did not seem to have formal recognition as a dispute resolution option in SA, until an increasing number of industry related disputes necessitated the need for other forms of dispute resolution. After democracy in 1994, many governmental and non-governmental institutions also sought to formalise community courts, formerly known as "*Makgotla*".[56] The Independent Mediation Services of South Africa (IMSSA), was created before 1994 , when forms of mediation and arbitration were utilised. This gave rise to the creation of the (1) Industrial Dispute Resolution Service, (2) the Community Conflict Resolution Service, and later (3) the Project Management Unit.[57] While mediation has become established in areas of labour, matrimonial, community and political disputes, its application to medical malpractice disputes remains limited.

2.1.2 Mediation after democracy

The South African Constitution, adopted in 1996, addresses dispute resolution through Section 34, which states *"anyone has the right to have any dispute resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent, impartial tribunal or forum".*[58] In keeping with Section 34, a pilot project on mediation was launched in 2014, and rules regulating the conduct of proceedings of magistrates courts were subsequently amended by The Rules Board for the Courts of law - introducing ADR

[55] Gardiol Van Niekerk 'Peoples courts and peoples justice in South Africa - new developments in community dispute resolution' (1994) 27(1) *De Jure* 19.

[56] Tim Murithi, 'Practical Peace-making Wisdom from Africa: Reflections on Ubuntu' (2006) 1(4) *JPAS* 27.

[57] Foraker Thompson, 'Traditional Conflict Resolution Methods Used in Black Townships in South Africa' (1992) 22 *International Journal of Group Tensions* 165.

[58] Constitution (note 7 above; s 34).

mechanisms by way of court-annexed mediation.[59] The High Court Rule 37(6) (d) stipulates that parties have to report to the court whether issues have been referred for mediation, arbitration, or decision by a third party.[60] This requirement, therefore, imposes a duty on the parties to take into consideration mediation and arbitration as a sentinel option for the settlement of their dispute. In support, a practice directive issued by the South Gauteng High Court , intended to reinforce Rule 37, stipulates that failure to comply with the rule will lead to the matters not being allocated for trial.[61]

2.2 MEDIATION STYLES AND ITS APPLICATION TO MEDICAL DISPUTES

The process of mediation has evolved into different styles which may be applied individually, partially or collectively to a dispute. A tabulation of these styles is presented in Table 2 below.

Table 2: Mediation styles that can apply to medical disputes

Type	Main focus	Role of the mediator
Facilitative	Assist the parties in reaching a mutually agreeable resolution.	Takes charge of the process, does not make recommendations, parties oversee the outcome, does not presuppose any knowledge of technical aspects, enhances the likelihood for the mediator to remain 'neutral'. [62]
Evaluative	Legal rights of parties and legal concepts of fairness more than the needs and interests of parties.	Assumes that participants want him/her to provide direction for settlement. - the mediator uses experience, training and objectivity.
Transformative	Empowerment of parties, and recognition by each of the other parties' points of view.	Meet with parties together, gives each other mutual recognition.[63]

[59] Ian McLaren 'Mediation of civil matters in the Magistrates and Regional Courts of South Africa' (2014) available *at http://www.mclarens.co.za/mediation-of-civil-matters/,* accessed on 14 August 2018.

[60] GN R315 of GG 19834, 12 /3/ 1999; 4.

[61] Alan Rycroft, 'Why Mediation is not Taking Root in South Africa' ACDS (2009) 2-3 available at *http:// www.usb.ac.za/disputesettlement/pdfs/,* accessed on 26 August 2018.

[62] Lieselotte Badenhorst, 'Facilitative mediation: Seeing more than the tip of the iceberg' (2014) 539 *De Rebus* 30.

[63] Zena Zumeta, 'Styles of Mediation: Facilitative, Evaluative, and Transformative Mediation' available at *http:// www. Mediate .com*, accessed on 26 September 2018.

The following relates to the application of the different styles to medical mediation: - (1) Evaluative mediation emphasises the legal rights of parties to a greater extent than their specific needs and interests, and disputes are therefore evaluated on the basis of fairness.[64] However, a specific focus on legal issues may have a disadvantage in that settlements may be limited to legal outcomes, without much attention to other attributes of mediation such as needs and interests, counselling and redress; - (2) Facilitative mediation does not dwell on the technical aspects of the dispute or provide direction in this regard. It is therefore suggested that a mediator employing this style should be from a nonspecific healthcare background for general medical disputes, but from a specialist background in more complicated cases to translate technical, medical and academic terminology in fields like neurology, orthopaedics and obstetrics. As the success of facilitative mediation is based on information and understanding, complex medical terms will need to be simplified to improve understanding; -(3) Transformative mediation embraces the concepts of empowerment and recognition as it seeks to accommodate each of the parties' needs, interests, values and points of view.[65] The advantage of this style of mediation is that it allows transparency, as the mediator meets with both parties jointly and offers recognition to both. This concept is likely to remove the 'underdog effect', where the usually lesser educated and poorly informed patient is given due recognition.[66] It is suggested that for a successful outcome in medical mediation cases, the mediator should draw from the relevant aspects of different styles as the case demands.

2.3 THE RATIONALE FOR MEDIATION IN HEALTHCARE DISPUTES

The concept of holistic healing involves a triangulation of the biological, psychological and social aspects of an individual and aims to restore physical ability, mental stability and societal integration. In medical malpractice cases, the commission of a negligent medical or surgical practice may compromise an individual's physical function, but it also has psychological and social implications. An argument can therefore be made that the goals of medicine and that of medical litigation are diametrically opposed: - whereas the goal of medicine is to heal, the goal of the civil justice system is to adjudicate fault, determine and compensate for damages and set

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[64] Samuel Imperati, 'Mediator Practice Models: The intersection of Ethics and Stylistic Practices in Mediation' (1997) 33 (3) *Willamette Law Review* 706.

[65] Thompson (see note 57 above).

[66] Joseph Vandello and David Richards, 'The Appeal of the Underdog' (2008) 33 (12) *Personality and Social Psychology Bulletin* 1603.

legal precedents. According to Galton, litigation does not provide healing, closure, vindication, or cost-effective resolutions.[67] He also asserts that it does not provide the opportunity for future relationships or further communication. In contrast, the goals of mediation are more aligned with the goals of medicine, as it includes improved communication and understanding, the exchange of information, the opportunity to restore relationships, and may provide closure and healing. While it is noted that mediation is more patient orientated than litigation, it does not necessarily guarantee that a future relationship between the negligent doctor and his/her compromised patient may develop. Holistic healing may also not necessarily be achieved during mediation, as holistic healing is a complex and long-term phenomenon. The perceived benefits of cost-effectiveness are discussed later in the dissertation.

Localio et al [68] and Beckman et al [69] suggest that the reason patients resort to litigation is most likely related to miscommunication between themselves and health care professionals. They further assert that a perception of a lack of care by health professionals is the trigger for litigation, rather than professional negligence in the delivery of care.[70] In a survey of 226 patients, Tsimtsiou et al. demonstrated that an expectation of disclosure of a medical error exceeded the expectations for financial compensation, (82.2% vs 67.4%) in these cases.[71] Similarly, in a separate survey of 210 patients, Bismark et al. demonstrated that only 2.9% that were eligible for compensation had actually claimed.[72]

While patients and their relatives are legitimately entitled to expect truthful disclosure and honest apologies following adverse events, health care professionals are often not comfortable to communicate with them.[73] The litigation process does not compel the practitioner to disclose,

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[67] Eric Galton, 'Mediation of Medical Negligence claims' (1999) 28 *Cap.U.L.Rev*. 321.

[68] Russel Localio, Ann Lawthers, Troyen Brennan, et al, 'Relation between malpractice claims and adverse events due to negligence. Results of the Harvard medical practice study III'. (1991) 325 *N Engl J Med* 245.

[69] Howard Beckman, Katherine Markakis, Richard Frankel, et al, 'The doctor-patient relationship and malpractice. Lessons from plaintiff depositions' (1994) 154 *Arch Intern Med* 1365.

[70] Ibid.

[71] Zoi Tsimtsiou, 'What is the profile of patients thinking of litigation? Results from the hospitalized and outpatients' profile and expectations study' (2014) 18 (2) *Hippokratia*: 139.

[72] Marie Bismark, Troyen Brennan, Peter Davis, et al, 'Claiming behaviour in a no-fault system of medical injury: a descriptive analysis of claimants and non-claimants'. (2006) 185 (4) *Med J Aust*. 203.

[73] Thomas Gallagher, Amy Waterman, Jane Garbutt, et al, 'US and Canadian physicians' attitudes and experiences regarding disclosing errors to patients' (2006) 166 *Arch Intern Med* 1605.

communicate with or apologise to the aggrieved patient. In contrast, the nature of the mediation process can create an enabling environment for disclosure and apology. Compared with litigation, mediation can facilitate otherwise sensitive and difficult communication following an adverse medical event. Kraman et al[74] and Duclos et al [75] show that effective communication following adverse events can reduce the number of patients who initiate legal proceedings against their doctor and allow healing of a broken relationship at a much earlier phase. Unlike litigation, mediation also provides an environment for disputants to communicate directly without representatives or the fear of being prejudiced, as the mediator remains neutral.

South African law enables aggrieved patients to assert their legal rights in malpractice claims, and compensation may be sought for suffering resulting from the failure of a hospital or a doctor to provide reasonable care.[76] However, medical malpractice litigation can be complicated, lengthy and may be open to delaying tactics to increase both the financial and psychological burden on the opposing party.[77] Cases may drag on for years before they reach court and the trial stage. The case of *Mbhele vs MEC for Health,*[78] relating to medical negligence and stillbirth, lasted over a decade. Moreover, the notion that patients will be satisfied after litigation or that the court meets their expectations can be challenged further: - Beckman et al,[79] identified non -monetary reasons for legal action taken by patients against their doctor(s) such as : doctors' unavailability, discounting patient or family concerns, poor delivery of information, lack of understanding, and perceived lack of caring and/or collaboration in the delivery of health care. In a review by Young et al, most patients were found to initiate legal proceedings following an adverse medical event as they wanted an honest explanation, individual and organisational accountability and strategies to prevent recurrence

[74] Steve Kraman, Ginny Hamm,'Risk management: extreme honesty may be the best policy'. (1999) 131 *Ann Int Me*d 963.

[75] Christine Duclos, Mary Eichler, Leslie Taylor, et al, Patient perspectives of patient-provider communication after adverse events (2005) 17 *Int J Qual Health Care* 479.

[76] Coetzee L C and Pieter Carstens, 'Medical malpractice and compensation in South Africa' (2011) 6 (3) *University of Chicago Law Review* 1263.

[77] Danny Lee and Paul Lai, 'The practice of mediation to resolve clinical, bioethical, and medical malpractice disputes' (2015) 21 (6) *Hong Kong Med J* 560.

[78] *Mbhele v MEC for Health for the Gauteng Province* (2016) (355/2015).

[79] Beckman et al (note 69 above).

of mishaps. [80] Currently, the litigation system in South Africa does not focus on non-monetary remedies, however the scope for remedies such as apology and rehabilitative treatment exists.

On the other hand, the plight of the doctors involved in these cases is not well highlighted. Respondent doctors also suffer from different degrees of emotional disturbance -shame, fear, self-doubt, isolation, difficulty concentrating, etc -regardless of whether they believe an adverse medical event is due to their error.[81] Doctors also desire a quick resolution of potential claims, and assuming the respondent doctor is exonerated, the psychological stress associated with litigation may irreversibly damage the doctor's professional life.[82] Unfortunately, litigation does not provide doctors with a quick resolution or reassurance, and their indemnity assurers may go through prolonged negotiations in out of court settlements.

2.4 PERSPECTIVES ON OTHER OPTIONS

Mediation for medical malpractice disputes must also be considered against the other potential options for reform measures. Apart from statutory reforms to limit the access to courts, screening panels , as discussed earlier, can be used to assess the merits of court action and provide recommendations. However, such panels may require a multidisciplinary team of experts at a high cost. The establishment of a 'set of standards for expert witnesses' may also be considered, however, fixed remuneration for experts may not attract the highest qualified or most skilled experts in the field. Reform measures that directly address the size of the damages awarded, i.e. capping may be applied to the total amount of damages or could also include periodic payments so that future medical costs are paid as they arise instead of lump sum payments.[83] (see State Liability Amendment Bill) Although capping holds promise as an option, it is subject to legal challenges, and while beneficial to hospitals, it may result in inadequate compensation for serious cases such as cerebral palsy. Other fundamental reforms, such as enterprise liability, which involves shifting litigation from the practitioner to the specific health care organisation, has been suggested as an incentive to implement institutional, organisational changes for improved care.[84] This option may not apply to state hospitals where

[80] Magi Young, Charles Vincent, Angela Philips, 'Why do people sue doctors? A study of patients and relatives taking legal action' (1994) 343 *Lancet* 1609.

[81] Marc Newman, 'The emotional impact of mistakes on family physicians' (1996) 5 *Arch Fam Med* 71.

[82] Duclos et al (note 75 above).

[83] Patrick van den Heever, 'Medical malpractice: The other side' (2016) 568 *De Rebus* 49.

[84] Ibid.

practitioners already have indemnity, although vicarious liability may still apply in cases. No-fault schemes and other WHO listed structures, which do not penalise physicians, may result in practitioners not taking responsibility, may not improve on sub-standard care, and may result in a recurrence of errors if they are not brought to the attention of the doctor and accountability sought. Specialised courts such as the Competition Appeal Court, the Electoral Court, the Land Claims Court, the Labour and the Labour Appeal Court have already been established by Parliament to deal with specific areas of law. Noting the complexities that arise in medical malpractice cases, a sensible and pragmatic argument can be made to establish specialist courts to deal with medico-legal cases. However, for these courts to be timeous and cost-effective, and avoid similar backlogs as general courts, they should be established and accessible in different areas, which will be costly to maintain. The costs of separate administration of specialist courts (premises, court staff, and judges) are likely to be considerably high, if not more costly than the general courts already established. [85]

Arbitration is a more formal and binding form of ADR where an appointed arbitrator usually makes an award to the affected party. An arbitrator who is skilled and knowledgeable about the specific nature of the case should be chosen, in order to facilitate time and cost savings and circumvent litigation. As decisions are usually binding in arbitration, trial proceedings occur when one of the parties decides to appeal the decision. The success associated with arbitration is best quoted from the Council for Conciliation, Mediation and Arbitration (CCMA), which showed a success rate of 36% for its priority job-saving focus in its 2017/2018 Annual Report.[86] For the same period, a total of 148 403 conciliations were heard, and 18 942 arbitration awards were sent to parties, as explained in the report. However, criticism against arbitration is that it is rigid, adversarial, and only a step from an actual trial.[87] In comparison with mediation, the cost of arbitration is also higher.[88] It is also less likely to address non-monetary issues and other aspects of the mediation process, as the focus relates to an award.

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[85] Michael Moore, 'The role of specialist courts – an Australian perspective' (2001) *Fed J Schol* 11.

[86] Annual Report (2017/2018), Council for Conciliation, Mediation and Arbitration, available at *http:// www.ccma.org.za* , accessed on 16 January 2019.

[87] John Fraser, American Academy of Paediatrics technical report: alternative dispute resolution in medical malpractice (2001) 107 *Pediatrics* 602.

[88] Thomas Meltzoff, 'Alternative dispute resolution strategies in medical malpractice' (1992) 9 *Alaska Law Review* 429.

CHAPTER 3:

MEDIATION, LITIGATION AND HEALTHCARE DISPUTES - A CRITICAL APPRAISAL

3.1 INTRODUCTION

It is widely accepted that the wealth of a nation depends on the health of its people.[89] However, public healthcare in South Africa is threatened by escalating medical litigation claims, and hence, reform measures are urgently required. According to the Minister of Justice: 'the introduction of court-annexed mediation will enable the government to cut its huge litigation bill by diverting claims against the state to mediation'.[90] In concert, court-annexed mediation in certain Magistrates Courts in Gauteng and North West was inaugurated in 2014.[91] Mediation is practised globally, and in countries like Hong Kong, legal practitioners may be disbarred if they fail first to advise their clients on mediation before court litigation.[92] Similarly, in Britain, litigation attorneys are required to routinely consider whether their disputes are suitable for ADR, such as refereeing, mediation or arbitration.[93] As some professionals have proposed mediation as a potential alternative to medical litigation in South Africa, it is anticipated that South Africa may follow countries like the UK, USA, India, Mainland China and Hong Kong, where mediation is practised.[94] This chapter explores the attributes, challenges, ethical issues and justice associated with mediation, and includes a survey of cost drivers in litigation as well as a comparative evaluation of studies on cost and time savings associated with both modalities.

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[89] Forest Pinkerton, 'The wealth of the nation depends upon the health of its people, or the health of the people determines the wealth of the nation' (1957) 16 (5) *Hawaii Med J* 505.

[90] R.183 of GG 37448, 18 /3/2014; 4.

[91] GN 855 GG 38164/31- 10-2014.

[92] Neels Claassen, 'Mediation as an alternative solution to medical malpractice court claims' (2016) 9 (1) *SAJBL* 469.

[93] *Halsey v. Milton Keynes NHS Trust* [2004] EWCA Civ 576.

[94] Alan Nelson, 'Mediation best answer to solve conflict.' (2014) available at *https://www.iol.co.za* , accessed on 14 August 2018.

3.2 AN ANALYSIS OF COST DRIVERS IN MEDICAL LITIGATION - A BRIEF STUDY

Introduction: Litigation is currently a standard option for dispute resolution in medical malpractice cases. However, it is regarded as being costly due to expensive court processes and high professional legal fees. A brief survey amongst local medico-legal attorneys was conducted to observe their practice trends and determine the cost drivers in litigation. The attitudes and perceptions of these practitioners towards the use of mediation for medical disputes was also assessed.

Aim: The survey aimed to identify the high-cost drivers in medical litigation cases, and to compare and contrast these costs with mediation.

Hypothesis: Mediation is not significantly more cost-effective than litigation in medical malpractice cases.

Methodology: Ethical approval to source information from relevant individuals was obtained (Protocol reference No: HSS/1355/018M). Attorneys who are currently involved in medical malpractice, who were accessible and agreeable were included. Five legal firms from 2 major cities (Durban and Pietermaritzburg) were included as follows: Berkowitz, Cohen and Wartski Attorneys (Durban), Venesen Naidoo Attorneys (Pietermaritzburg), Judy Singh Attorneys (Pietermaritzburg), Tomlinson, Nguni, James Attorneys (Durban), Mohanlall Attorneys (Pietermaritzburg). Data were collated and analysed.

Results: A synopsis of the findings is presented in Table 3.

Discussion: Albeit a small analysis for the purposes of the dissertation, the information obtained provides a bird's eye view of the costs that are involved in litigation cases. Apart from mediators' fees, which may be significantly lower than that of advocates and attorneys, technical costs, out of pocket costs and most significantly, expert opinion costs may still prevail. Even in mediation, patient records, travel costs for parties and experts, and exhibits like scans and x rays may still be required to make a fair assessment. Specialist reports may still be required when negligence cases are complex and may even require a multidisciplinary team of experts. The oversight role of the mediator, even if he/she is a trained legal or medical professional, may require collaboration with other experts at a high cost. Reports from experts

are necessary to facilitate an informed discussion, as part of truth-telling and to promote fairness during an ethical mediation process. A tabulation of findings is presented in Table 3:

Table 3: Determinants of costs -a synopsis of findings

Item	Firm 1	Firm 2	Firm 3	Firm 4	Firm 5
μ Records and paperwork	R1000-R2000	R1000	R1000	R3000	R3000
§ Travel costs (clients, experts)	R2000 (local) more for afar	R30 000 (especially when experts need flights)	R20 000 (local and rural areas)	R50 000 (includes experts travel costs)	R100 000 (including flight costs for an expert)
α Exhibit costs (R 1000-R15000)	per investigation	per investigation	per investigation	per investigation	per investigation
Ω Total Legal Professional costs (variable and approximate)	R70000 per day	R 25 000 per day	R25000 per day	R35000 per day	R50000 per day
¥ Specialist reports (per report and variable	R20 -50 000	R 15-20000	R50000	R25000	R50000
β Expert consultations, examinations, liability assessments, quantum evaluation, actuarial assessments, etc	R 600000-R1m	R1m - R1.2m	R500000-R1m	R750-R800000	R500000-R1m
€ Cases declined (%)	80	20	no response	80	40
₸ Cases settled before court (%)	85	75	85	50	90

Key: Costs are quoted on average; μ- depends on availability, accessibility and types of records; §- depends on location, urban, rural, international; α- includes CT scans, X rays, MRI, etc.; Ω - includes junior and senior counsel (5-10 days per case) ;¥ - often more than 1 report; β- includes a broad spectrum of experts such as specialists, physiotherapists, occupational therapists, educational psychologists, behavioural experts, actuaries, alternate communication experts, life expectancy experts, architects, etc. ;€ -55% on average; ₸ - 77% on average.

Significant costs, apart from claims pay-outs, were related to the broad spectrum of experts employed, from all fields of expertise, including quantum and life expectancy experts. The argument, therefore, arises as to whether mediation can be considered fair, with ethical standards and justice in the absence of these costly experts. It is submitted that medical malpractice disputes may become complicated, and resolution through mediation may still require such experts to guide parties, as in the case of litigation.

Another area of concern relates to the high percentage of negligence cases (55%) that were declined by attorneys and the high percentage of cases that are settled out of court (77%). Firstly, if aggrieved patients are declined by legal practitioners, usually due to high initial investment costs and low chances of success, many may turn to mediation, creating a backlog of mediation cases, and defeating the purpose of timely resolution anticipated with mediation.

Secondly, the high percentage of out of court settlements (77%) found in the survey suggests that most of the cases are settled before going to court. This finding is consistent with data collated by Naidoo et al., who observed that approximately 70 % of medical negligence claims in South Africa are settled out of court.[95] In the USA, it is estimated that 95% of cases filed in some states settle before trial, while others are settled at the eve of the trial.[96] The implementation of mediation is therefore unlikely to achieve the aim of decongesting the courts, as the majority of cases are settled out of court. It may be justly argued, however, that legal professional fees and out of pocket expenses charged by attorneys are still significantly higher than mediator fees. However, there is no data for the overall cost of mediation in medical malpractice disputes, noting that the costs of experts outweigh legal professional fees, and appears to be the primary cost driver in litigation cases apart from claims pay-outs.

Nevertheless, a counter-narrative is that legal practitioners may view material settlements as a benchmark in litigation cases, whereas mediation addresses other non -payment benchmarks such as counselling and apology.

[95] Subashni Naidoo, 'Thousands of Doctors Negligent,' *Sunday Times*, June 6 2010 available at *http://www.timeslive.co.za/sundaytimes/article489475.ece/*, accessed on 20 January 2019.

[96] Adrienne L Krikorian, 'Litigate or Mediate? Mediation as an Alternative to Lawsuits' Mediate.com (2019) available at *http://www.mediate.com/articles/krikorian.cfm*, accessed on 8 January 2019. (See also Holman, note 214 below).

Interestingly, opinion was divided amongst the respondents as to whether mediation will reduce costs overall, as medical negligence cases are still guided heavily by expert opinion, which may be required even in mediation. The respondents suggest that mediation is likely to have better outcomes if the mediator is trained in the field, or has a medical and legal background. Facilitative mediation was the preferred type of mediation amongst all the respondents.

3.3 ATTRIBUTES AND CHALLENGES OF MEDIATION IN HEALTHCARE DISPUTES

3.3.1 Attributes of Mediation

In mediation, parties resolve issues according to their own needs, and both parties may be considered as winners compared with the 'winner-loser' scenario frequently associated with court outcomes.[97] In a comprehensive review of the literature, Kressel and Pruitt have suggested six categories to assess the outcomes of mediation, namely :-

i. user satisfaction;
ii. rates of compliance;
iii. rates of settlement;
iv. nature of agreements;
v. efficiency; and
vi. improvement in the post-dispute climate.[98]

While categorical data for the different benchmarks are sparse and variable, the authors indicate high user satisfaction rates for the mediation process, even when desired settlements are not necessarily achieved.[99] In the UK, the Centre for Effective Resolution (CEDR) quotes an aggregate settlement rate of 86% after mediation , whilst settlement rates in the USA, which are considered synonymous with mediation outcomes, are in the region of 60%.[100] This data however, was compiled from the survey responses of mediators themselves and remains

[97] Patrick van den Heever (note 83 above).

[98] Kenneth Kressel and Dean Pruitt, A *Research Perspective on the Mediation of Social Conflict, in Mediation Research: The Process and Effectiveness of Third-Party Interventions* San Francisco, Jossey-Bass Inc, (1989) 395,413.

[99] Ibid.

[100] The Eighth Mediation Audit: 'A survey of commercial mediator attitudes and experience in the United Kingdom' Centre for Effective Dispute Resolution (CEDR); 2018 available at *http://www.cedr.com*, accessed on 20 December 2018.

subjective, just as views from lawyers are likely to subjective on the disadvantages of mediation. Moreover, the data does not include actual time frames for post-mediation settlements. In Singapore, the Singapore International Mediation Centre, launched in 2014, has processed over 3,600 mediation cases since, with a settlement rate of about 70%.[101] A large proportion (80%) in this series, also report 'cost and time savings'. However, in this series, 40% of cases were related to construction disputes, and similar outcomes are not necessarily reproducible in medical disputes, negligence and personal injury claims, and other disputes.[102] Mediation has also been used in political disputes, often through community resolution bodies, for purposes of peace-making, and has the potential to be instrumental in preventing, managing and ending conflicts. Mediation in peace processes occurred in Sudan, Guinea, Somalia, Burundi, The Comores, Madagascar and the Central Africa Republic.[103] The literature demonstrates the widespread application of mediation for the resolution of a variety of disputes between multiple parties.

A further advantage of mediation is the ability to eradicate the concept of the 'zero sum game', described as a contest in which one person's loss is equal to another person's gain.[104] This phenomenon may be seen with litigation, where a case may be perceived as either 'won or lost', and where an aggrieved party benefits from financial compensation that is lost from the State. In this environment, medical litigation cases become challenging to resolve holistically because the nature and extent of the issues may not be fully established for fear of losing a case.[105] It must be appreciated that unlike simple disputes, medical litigation cases may be complicated by various clinical and ethical issues such as decisions for caesarean section, admission to intensive care units, and abandonment of resuscitation in limited resource hospitals. Such situations involve medical and technical details, which are amenable to discussion and explanation in mediation. In litigation, such detailed explanations and

[101] Ben Giaretta and Katherine McMenamin, 'Why mediate?' The Singapore Mediation Centre (2018) available at *http://simc.com.sg/mediate-2/,* accessed on 20 December 2018.

[102] Ibid.

[103] The African Centre for Constructive Resolution of Disputes (ACCORD), 'Towards enhancing the capacity of the AU in mediation*'* (2009) available at *https://www.africaportal.org/documents/5605/AU_Mediation.pdf,* accessed on 20 December 2018.

[104] James Marshall, 'Lawyers, Truth and the Zero-Sum Game' (1972) 47 (4) *Notre Dame L.Rev*. 919.

[105] Ibid.

disclosure may not be divulged entirely as it potentially weakens the chances of a successful defence. There is, however, no formal assurance that a doctor will divulge evidence that may be 'self-compromising or make self-compromising concessions' in any dispute resolution mechanism.

Mediation further provides a confidential setting where private sessions may be held with a mediator and information exchanged without fear or favour. Parties can further agree before the commencement of mediation proceedings, that confidential information should not be divulged in ensuing litigation if the mediation process fails.

It is further argued that mediation is better placed than litigation in the handling of moral and ethical issues about health care disputes. Limited resources and poor infrastructure and facilities that plague the public healthcare sector can lead to ethical dilemmas. Situations in public hospitals that can give rise to moral and ethical dilemmas include (i) competition for oncology treatments, (ii) admission to limited intensive care (ICU) beds, (iii) limitations in neonatal ICU units, (iv) prioritisation of access to theatres, and so forth. In *Soobramoney v Minister of Health, KwaZulu-Natal* 1997 (12) BCLR 1696 (CC), a case involving the cessation of renal dialysis in a state hospital after the depletion of private funds, the Constitutional Court held that: *'A court would be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it was to deal with such matters'.*[106] The ruling demonstrates the inability of the court to address the moral and ethical issues and makes a case for mediation, where the plaintiff (who demised from the illness) may have had the opportunity for better communication, empathy, understanding and acceptance, albeit no definitive treatment. Similar benefits of mediation in ethical and moral medical dilemmas have been demonstrated amongst 'pro-life and pro-choice' groups in Canada and the USA, proving successful in curbing violent actions between groups, while maintaining differences of opinion.[107]

Moreover, it is submitted that doctor -patient consultations are likely to occur in busy practices with limited consultation time and hastened communication, resulting in inadequate knowledge or understanding necessary for valid informed consent. This can lead to

[106] *Soobramoney v Minister of Health, KwaZulu-Natal* 1997 (12) BCLR 1696 (CC).

[107] Michelle Le Baron and Nike Carstaphen, 'Pro-life and Pro-Choice Advocates Seek to Bridge the Great Divide' (1998) available at *https://www.mediate.com/articles/prolifeC.cfm,* accessed on 24 January 2019.

misunderstanding and arguments amongst patients and may increase the risk of litigation. Whilst it is argued that a patient's attorney can facilitate communication and explanation in the pre-trial period, in the mediation process, a suitably trained mediator is well placed at a lower fee to bridge this gap, simplify complex terminology, empower parties with information, promote understanding and communication, and facilitate the effective resolution of cases.[108] Unlike in litigation, where both parties seek the opinion of many experts, some with vested interests, a mediator will be in a position to guide the parties to appoint a single or fewer independent experts judiciously. Many experts who may not be considered essential to a case, do not have to be engaged unnecessarily, thereby reducing the cost of these cases considerably. This will also reduce the frequency of written joint agreements between experts from opposing parties and reducing costs further.

Mediation also has the advantage of balancing inequalities and power. In Gladwell's book *Blink*, he asserts that in addition to monetary compensation, aggrieved patients may seek retaliation or exoneration of their moral position.[109] A mediator can identify power imbalances, and promote open discussion with the weaker party, in the absence of the implicated doctor or other members from the health institution. The 'weaker' party is therefore allowed to engage freely, without fear or apprehension, which may be difficult to achieve in a court environment, given the formal nature of it.

Mediation has also been shown to be less time consuming and less costly than arbitration or litigation, (if successful and not followed by ensuing litigation) as: - mediation is not subject to waiting times for trial dates, and according to the *Government Gazette*, mediation tariffs range between ZAR 4 500 and ZAR 6 000 as a maximum fee per day shared equally by both parties.[110] Concerning the reducing of delays in reaching agreements between parties, Szmania surveyed 13 ADR organisations in the US and found the average length of mediation was 1 to 3 days with cases closing between 85 and 165 days.[111] In contrast, according to Greer, litigation cases may take up to 5 years or more to resolve even in the USA.[112] Other benefits include

[108] Botes (note 18 above).

[109] Gladwell M, *Blink: The Power of thinking without thinking*. (2005) NY, US: Little, Brown and Co.

[110] GN 854 GG 38163/31-10-2014.

[111] Susan Szmania, 'Alternative dispute resolution in medical malpractice: a survey of emerging trends and practices' 2008 (26) *Conflict Resolution Quarterly* 71–96.

[112] Thomas E Greer, 'Alternative dispute resolution in medical liability cases' (2009) *AAOS* available at: *http://www.aaos.org/news/aaosnow/jul09/managing7.asp.*, accessed on 10 September 2018.

lower attorney's fees and a decreased preparation time for trials, i.e. 36 hours as compared with only 2.5 hours for mediation.[113]

Mediation is considered more informal , where 'formal laws of evidence and the rules of court' are not binding on the parties, who reserve their rights of withdrawal at any stage, in favour of litigation.[114] The focus in mediation is also client based and not rights-based, as is the case in litigation or arbitration, and settlememts are not limited to monetary compensation only. The 'bona fides' of both parties are accepted unconditionally, which can remove the anxiety that is often associated with court proceedings. Classen asserts further that mediation presents a safer place to protect one's dignity and reputation.[115]

In addition to advantages such as : increased privacy, greater flexibility, reduced costs, improved access and an emphasis on compromise, Seth suggests that mediation provides a forum for minority and disenfranchised groups to address their complaints. She asserts that the lower costs and relative informality associated with mediation may encourage minority groups to bring their grievances forward.[116] However, a counter-argument can be made for both the perceived accessibility and cost. Firstly, to be accessible to all communities and reduce the delays present in litigation, mediation panels would require widespread implementation which may be costly and challenging to monitor and evaluate. Secondly, litigation will not cost the party if it is agreed by their attorneys to work on a contingency basis.

3.3.2 Costs and time savings with mediation: a meta-analysis of studies

Studies that explore the perceived cost and time benefits of mediation compared with litigation generally include other alternative dispute resolution mechanisms collectively. A tabulation of comparative studies is presented in Table 4 below. It can be noted that cost savings vary between studies, the type of cases, and the type of intervention. A large multicentre study, conducted by the International Finance Corporation (IFC), evaluated more than '1000' cases that were resolved through mediation in Serbia, Bosnia and Herzegovina, and the former

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[113] David Sohn and Sonny Bal, 'Medical Malpractice reform: The Role of Alternative Dispute Resolution' (2012) 470 (5) *Clin Orthop Relat Res* 1370.

[114] Ibid.

[115] Claassen (note 92 above).

[116] Reva Seth, 'Mediation: The Great Equalizer? A Critical Theory Analysis' (2000) available at *https//: cfcj-fcjc.org*, accessed on 16 August 2018.

Yugoslav Republic of Macedonia, and compared the outcomes with those of similar court cases.[117] The study found that in Bosnia and Herzegovina, the direct costs of mediation averaged ± ZAR3150, about 50 per cent of the costs of litigation (about ± ZAR6580). [118] Jorquiera and Alvarez surveyed firms in nine Latin American countries on their use of ADR and found that they used ADR and the judicial system in 26 per cent and 17 per cent of cases in respectively (26% vs 17%).[119] These authors reported costs of approximately ZAR6034 for mediation and approximately ZAR200 130 for litigation.[120] In a Columbian study conducted in 2009, alternate dispute resolution mechanisms cost as much as half of the litigation cost. [121] Other studies of ADR analysed cost savings per party or case. Barkai and Kassebaum found savings of about approximately ZAR7 000 per party in the USA[122], while Hann and Baar found savings of approximately ZAR84 000 per case in Canada. [123] However, in this study, savings showed wide variation from about approximately ZAR28 000 to more than approximately ZAR280 000.[124] Stipanovich found similar cost savings in the USA in 2004. [125] Overall , from the analysis presented, it can be seen that a wide variance of between 3-50% exists when determining the reduction of costs when compared with the cost of litigation.

[117] International Finance Corporation, 'Evaluation of the PEP SE ADR Projects in Bosnia and Herzegovina, Serbia and Macedonia.' (2006) available at *http://www.worldbank.org/fpd/publicpolicyjournal*, accessed on 7 January 2019.

[118] Ibid.

[119] Carlos Jorquiera and Gabriel Alvarez, 'The Cost of Disputes in Companies and the Use of ADR Methods: Lessons from Nine Latin American Countries' (2005) MIF Study Washington DC: Multilateral Investment Fund.

[120] Ibid.

[121] Alvarez de la Campa. 'The Private Sector Approach to Commercial ADR: Commercial ADR Mechanisms in Colombia' (2009) World Bank, Washington DC available at *http:// www.fias.net/index.cfm*, accessed on 7 January 2019.

[122] John Barkai and Gene Kassebaum, 'Hawaii's Court-Annexed Arbitration Program: Final Evaluation Report' (1992) Program on Conflict Resolution, University of Hawaii.

[123] Robert Hann and Carl Baar, Evaluation of the Ontario Mandatory Mediation Program: Executive Summary and Recommendations (2001) available at *http://www.attorneygeneral.jus.gov.on.ca/*,accessed on 9 January 2019.

[124] Ibid.

[125] Thomas Stipanowich, 'ADR and the Vanishing Trial: The Growth and Impact of Alternative Dispute Resolution' 2004 1 (3) *Journal of Empirical Legal Studies* 843.

Table 4: A meta-analysis of studies on cost and time savings

Study / Authors	Country	ADR cost as % of litigation cost	Time savings (Months)
IFC (2006)	Bosnia and Herzegovina, YR Macedonia, Serbia	50	-
Jorquiera and Alvarez (2005)	9 Latin American countries	3–18	-
Alvarez de la Campa (2009)	Colombia	40–50	11
		Cost savings (actual)	
Barkai and Kassebaum (1992)	United States	Approximately ZAR 7 000 (per case)	4
Stipanowich (2004)	United States	Approximately ZAR 84 000 (per case)	1
Hann and Baar (2001)	Ottawa and Toronto	Approximately ZAR 84 000 (per case)	
Genn et al. (2007)	United Kingdom	-	None
Bingham et al. (2009)	United States	-	6

**ZAR 14= USD1*

It must be noted further , that the studies are limited by their heterogeneity, wide variations in cost savings estimates, the nature and type of cases, and general costs associated with the local judicial environment.

Despite the cost savings quoted (which are widely variable), it is suggested that in some cases which fail to be resolved through mediation, the total costs may be higher, if these cases invariably end up in court. Notably, in a study of involuntary mediation in London, Genn and

others (2007) found that only 14 % were mediated, as the rest returned to court.[126] The settlement rate in this study was 55 % and for cases that failed to settle on alternate dispute mechanisms, the total legal costs were approximately ZAR 28 000 to approximately ZAR 56 000 higher than they would have been had no attempt had been made to use ADR.[127] In 1994, Rosenberg and Folberg [128] reviewed neutral evaluation in California – a process in which an expert, usually an attorney, provides an evaluation of the dispute and offers an opinion on the likely outcome of a trial. They found that while about 40 % of parties believed that they had saved money, 38 % suggested that it added approximately ZAR 56 000 on average to the cost of litigation. Similarly, Wissler (2004), in a review of 27 studies of general civil mediation, also reported mixed results on cost savings.[129] Therefore, it is submitted that no definite conclusions can be drawn about significant cost savings with mediation in comparison to litigation, noting the variance and confounding variables among studies.

In the studies above, time was measured as the total time from filing a complaint to settling the case -also referred to as 'time to disposition'. Estimates of the differences in time between alternate resolution mechanisms and traditional litigation also showed variation among the studies. Time savings ranged from about a month to under a year and are shown in Table 4 above. Hann and Baar (2001) in Canada, found that at six months, 25 per cent of cases under mediation were disposed of , compared with only 15 per cent of control cases.[130] However, in this study, cases were under 'mandatory mediation', which may have different results from voluntary mediation, as discussed elsewhere in the dissertation. Barkai and Kassebaum (1992) found that traditional litigation took four months longer on average,[131] while Wissler (2004) in five studies of appellate cases, found the time to disposition was one to three months shorter

[126] Hazel Genn, Paul Fenn, Marc Mason, et al. *Twisting Arms: Court Referred and Court Linked Mediation under Judicial Pressure.* Ministry of Justice Research Series 1/07 (2007). Research Unit, Ministry of Justice, London. UK.

[127] Ibid.

[128] Joshua Rosenberg and Jay Folberg, 'Alternative Dispute Resolution: An Empirical Analysis' (1994) 46 S*tanford Law Review* 1487.

[129] Roselle Wissler, 'The Effectiveness of Court Connected Dispute Resolution in Civil Cases' (2004) 22 *Conflict Resolution Quarterly* 55.

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[130] Hann and Baar (note 123 above).

[131] Barkai and Kassebaum (note 122 above).

for cases assigned to mediation than for other cases.[132] Bingham and others (2009), estimated that ADR overall saved about 88 hours of staff time and about six months of litigation time per case.[133]

In contrast, however, the RAND report (1996) in the USA concluded that there was no strong statistical evidence that the mediation programs significantly affected time to disposition, litigation costs or attorney view of fairness and satisfaction.[134] Similarly, Genn and others (2007) reported no significant impact of mediation on total case duration.[135] Wissler (2004), in a review of 27 studies of general civil mediation, reported mixed results in case duration.[136]

The researcher submits that no definite conclusions can be drawn about both times and cost savings compared with litigation. This is due to (i) the heterogeneity amongst studies, (ii) confounding variables, (iii) differences in substantive and procedural mechanisms, (iv) differences in types of cases and administrative efficiency, and (v) differences in population dynamics. In respect of medical mediation, heterogeneity amongst studies is likely to be increased by differences in the disease spectrum, clinical areas under dispute, differences of opinion amongst experts, and a large number of cases that are settled out of court. These and other confounding variables are likely to complicate the results of comparative studies of medical mediation and litigation.

3.3.3 Challenges of mediation

Mediation can be practised through different styles viz : transformative; evaluative; and facilitative, making it heterogenous. This has led to disagreement among researchers and practitioners in determining its effectiveness and the mechanisms available to evaluate it.[137] Mediation therefore has a broad scope by virtue of the different practice types , and lends itself to more evaluative or assessment mechanisms. Hernandez asserts that the diverging practices

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[132] Wissler (note 129 above).

[133] Lisa Bingham, Tina Blomgren, Jeffrey Nabatchi, et al, 'Dispute Resolution and the Vanishing Trial: Comparing Federal Government Litigation and ADR Outcomes' (2009) (24) 2 *Ohio State Journal of Dispute Resolution* 1.

[134] Alternative Dispute Resolution. Rand Institute for Civil Justice (2011) available at : *http:// https://www.rand.org/topics/alternative-dispute-resolution.html,* accessed on 19 July 2019.

[135] Genn et al. (note 126 above).

[136] Wissler (note 129 above).

[137] Jacob Bercovitch, 'Mediators and Mediation Strategies in International Relations' (1992) 8 (2) *Negotiation Journal* 99 available at *https://doi.org/10.1111/j.1571-9979.1992.tb00655.x*, accessed on 25 August 2018.

of professional mediators may impede the institutionalisation of standards, quality management, and control between professional groups.[138]

Other challenges associated with mediation include the issue of attaining justice and the perception that mediation may not provide persons the opportunity to achieve justice through the court system. However, even for those who may be considered as disempowered persons in medical negligence cases, it is suggested that justice is not necessarily the 'exclusive preserve of the courts' , as it can be achieved through other mechanisms.

Criticisms against mediation also include psychological aspects and the concept of prejudice. In a review of several social science studies, Delgardo et al , suggest that people who have prejudices are more likely to act on it in informal settings, thereby exposing the mediation process to such prejudice.[139] They intimate further that when the formalities of traditional adjudication are abandoned in favour of informal methods of dispute resolution such as mediation, minorities and disadvantaged people may be significantly disadvantaged. Arguably, the authors seem to suggest that when confronting opponents of higher status or power, disadvantaged or less powerful individuals should opt for formal litigation. It has also been suggested that the informal atmosphere of mediation further prejudices the disadvantaged group, as it enables the 'dominant or advantaged party' to exploit the balance of power and act in favour of their inherent prejudice. [140] Delgardo argues that when 'compared with the lack of formal rules that occurs in mediation, external and internal constraints inherent in the court proceedings are likely to prevent judges from demonstrating prejudice or bias', thus making the judicial system superior to the mediation process in reducing prejudice.[141] However, it is naïve to assume that formal litigation or judges are not without some form of prejudice, as Justice Dowsett aptly states : 'a legal system which relies upon professional judges accepts that every judge's background will be the product of a unique combination of circumstances – general education (formal and informal); theoretical and practical professional education and training; professional experience; and the whole range of life experiences (good, bad, common

[138] Ariel Hernandez, '*Mediation as Intervention of Choice – A Critical Analysis of Mediation in Identity Conflicts*' (2014) In: Nation-building and Identity Conflicts. Springer VS, Wiesbaden.

[139] Richard Delgado, 'Fairness and Formality: Minimizing the risk of prejudice in Alternate Dispute Resolution' (1985) 6 *Wisconsin Law Review* 1359.

[140] Ibid (1391).

[141] Ibid.

and uncommon)'.[142] Decisions by judges are also influenced by many different experiences, perceptions and biases inherent in a specific case.

Race and ethnicity may also influence the mediation process, as negotiations involving parties from different racial , ethnic and cultural backgrounds may differ compared with parties from similar backgrounds. Rubin and Brown suggest that people tend to negotiate more cooperatively with counterparts of the same race and culture than with persons of different races and cultures, as similarity tends to induce trust.[143] Moreover, racial and ethnic stereotyping that may occur during mediation may also occur in a courtroom.

The Bill of Rights in South Africa stems from historical prejudice and inequality, and the provision of these rights are fundamental to achieving social justice in the country.[144] Pro-rights critics posit that mediation is an effective way to control or undermine the human rights of historically disadvantaged groups by the imposition of values associated with society at large and those of the more politically and economically powerful .[145] Abel argues that the informal nature of mediation and its emphasis on compromise undermines the need to maintain the rights of the disadvantaged.[146] Additionally, pro-rights theorists suggest that mediation is ineffective in achieving a discussion of the principles, values and power imbalances that are inherent in conflict.[147] Pro-rights activists, therefore, punt the courtroom as providing a more 'enabling environment' for minority and other disenfranchised groups to address these types of power and socioeconomic imbalances. However, there is no robust data to support this view. The administrative capacity of the state, represented by the respective Departments of Health in medical litigation cases, may considered by pro-rights theorists as an extension of the influence of the state into higher society. In support, Seth argues that the application of informal

[142] Justice J.A. Dowsett, 'Prejudice – the judicial virus' (2009) available at *http:// www.fedcourt.gov.au* , accessed on 17 January 2019.

[143] Jeffrey Rubin and Bert Brown, '*The Social Psychology of Bargaining and Negotiation* 'Academic Press 2014.

[144] Constitution (note 7 above; Chapter 2).

[145] Anne Bottomley, 'What is happening to Family Law? A Feminist Critique of Conciliation' (1989) 8 *Can. J. Fam.L* 61.

[146] Richard Abel 'The Contradiction of Informal Justice' in *The Politics of Informal Justice* (1982) New York: NYU University Press,

[147] Ed Sparer, 'Fundamental Human Rights, Legal Entitlements and the Social Struggle: A Friendly Critique of the Critical Legal Studies Movement' (1984) 36 *Stan. L. Rev.* 509.

mechanisms such as mediation serves to expand the regulatory capacity of the State.[148] Pro-rights theorists argue further against mediation and claim that state-supported mediation prohibits the platform for social change that could result if members of minority groups addressed their collective needs through the litigation process.[149]

However, the notion of the court as an equalising or balancing forum for prejudice, particularly for the disadvantaged patient within the public health care sector, can be challenged. Given the high prevalence of prejudice in South Africa, particularly against race, gender, social class and ethnicity, it is suggested that a legal proceeding or court decision alone cannot suffice as an effective tool to eradicate any form of social prejudice. In medical malpractice matters, the court must rule based on expert opinion and tangible evidence, using the 'civil standard of a balance of probabilities', irrespective of social class or prejudice. It is suggested that some advantages the courts present include: (1) clear procedural and evidential rules, (2) formal processes of disclosure, (3) inspection, (4) evidence disclosure, and (5) court precedent, making the judicial decision more binding. Disclosure is however, also a part of the mediation process.

A further challenge with mediation concerns confidentiality and the protection of personal health-related information. Strategically, a disclosure such as HIV status or a statement made about a surgical procedure during the mediation process or even the provision of a document such as a cardiotocograph used in obstetric litigation could be damaging if used by the opposing party to testify in a later trial, or released into the public domain. Interestingly, 'mutual co-operation', which is necessary to achieve a satisfactory settlement in the mediation process may influence the outcome of a trial due to the revelation of sensitive information.

Mediation may also be open to both the acquisition and disclosure of confidential information. The private nature of proceedings in mediation may allow the sharing of sensitive information such as sexually transmitted diseases or HIV infection with an opposing party or mediator. The situation may arise when the opposing party or mediator him/herself may use information emanating from disclosure itself to influence the outcome of a court judgement. Public disclosure can compromise the confidentiality of patients as well as health professionals, by casting their professional status into doubt , more especially if the negligent practitioner is named in the public domain. Notwithstanding, the litigation process itself involves the

[148] Seth (note 116 above).

[149] Ibid.

provision of all relevant documents, including relevant personal health information, and the risk for dissemination of such information still exists.

Another challenge associated with mediation is the notion that it lacks finality. The settlement agreement reached during the mediation process may be disputed at a later stage by a party and be subjected to an ensuing lawsuit unless agreed differently by disputants. In this way, an additional problem may be created, where the resolution reached through the mediation process itself may be contested. Mediation is not binding; however, both parties can agree at the start of the process that the resolution agreement reached will be binding on all the parties involved.

3.4 MEDIATION AND THE CONCEPT OF JUSTICE

The concept of justice is underpinned by many theories ranging from traditional ideologies to modern day interpretations. Ancient Greek scholars referred to the word "*dikaiosune"*, indicating that 'there is justice within man and one which he operates in society.'[150] Cephalus suggests that justice involves 'truth-telling and the repayment of one's debts',while Polemarchus suggests that 'justice seems to consist in giving what is proper to him.'[151] Bhandari suggests that 'justice is doing good to friends and harm to enemies, also a traditional maxim of Greek morality.[152] Thrasymachus propounded a more radical theory of justice, defined as 'the interest of the stronger', while Socrates suggested that 'justice implies superior character and intelligence, which must also contribute to the self-fulfilment of the just man'.[153] Stawell presents a 'dual concept of justice -retribution and distribution', i.e. the justice of rewards and punishments for the individual, and the justice that distributes good things among many.[154] While differences of opinion exist across traditions, cultures and philosophical interpretations, some key elements such as truth-telling, retribution and distribution, among other concepts, can be embraced during the mediation processes in order to achieve justice.

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[150] Eric Havelock, *The Greek Concept of Justice: From its shadow in Homer to its substance in Plato* (1978) London: Harvard University Press.

[151] Nikolas Pappas, *Plato and the Republic*. (2003) New York: Routledge.

[152] Sujendra Bhandari, 'Plato's Concept of Justice: An Analysis' (1998) available at: *https://www.bu.edu/wcp/MainAnci.htm.,* accessed on 30 December 2018.

[153] Devin Stauffer, *Plato's Introduction to the question of Justice* (2001) New York: State University of New York Press.

[154] Melian Stawell, 'The Modern Conception of Justice' (1908) 19 (1) *International Journal of Ethics* 44.

In current practice, justice may be considered as 'the art of restoring and maintaining a balance between humans in their interactions and conflicts of interests, which requires protecting and embracing absolute values and standards'.[155] In law, justice is more accurately defined as a 'scheme or system of law in which every person receives his/ her/its' due from the system, including all rights, both natural and legal'.[156] The notion of access to justice is generally accepted as the ability of every person to invoke the available legal processes for redress irrespective of social or economic capacity and that every person should receive a just and fair treatment within the legal system.[157] However, this concept has evolved from that of access to legal services such as courts, tribunals and mediation panels to a broader one that includes social justice, economic justice and environmental justice.[158] According to the United Nations Development Programme (UNDP), access to justice is more than the ability to obtain legal representation and have access to Courts, but refers to the ability to seek and obtain a remedy to a grievance through an institution, be it formal or informal [159]. Kollapen also suggests that in the case of South Africa, justice is not the exclusive preserve of the courts and that the Constitution is designed to achieve justice in the broader sense. [160] He suggests further that various functionaries including government, independent insitutions, the private sector and civil society, take on an 'exclusive responsibility for the achievement of justice', making it more than merely access to courts. From the assertations above, it becomes apparent that the court is not the singular source for the attainment of justice. The question that remains is whether the perception of justice associated with meditation will be consistent with the perception justice that is traditionally associated with court decisions, which requires further research. It has been suggested that mediators do not have decision-making power , hence their neutral position will prevent them from imposing or applying their sense of justice to the outcomes.[161]

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[155] Sherif Elnegahy, 'Can mediation deliver justice?' (2017) 18 (3) *Cardozo J. of conflict resolution* 759.

[156] Justice – Legal Dictionary available at *https://dictionary.law.com/*, accessed on 26 September 2018.

[157] Muralidhar S, 'Legal aid practices: comparative perspectives' (2005) 26 (2) *Obiter* 261.

[158] United Nations Development Plan (UNDP): Access to Justice Practice Note 9/3/2004 available at *http:// www. undp.org.*, accessed on 26 September 2018.

[159] Ibid.

[160] *Open Society Foundation for South Africa, Access to Justice* -Round Table Discussion (Johannesburg; 2003).

[161] Kressel K and Pruitt D *A Research Perspective on Mediation of Social Conflict,in Mediation Research: The Process and Effectiveness of Third-Party Intervention* (1989) 395, 413

Wissler asserts that in delivering justice during the mediation process, three primary outcomes may be considered: (1) procedural justice, (2) distributive justice, and (3) restorative justice.[162]

Procedural justice refers to one's perception of the fairness of the rules or procedures that regulate a process or decision, however there are different opinions about procedural justice during the mediation process. MacCoun suggests the possibility of parties preferring to have a decision made by an independent party, which may be viewed as more acceptable than a situation where parties themselves control aspects of procedural fairness.[163] During mediation, an important issue concerns fairness during the procedure and in the outcome. It has been shown that a fair procedure can (1) increase the satisfaction of parties, (2) enhance their perception of overall fairness, and (3) their acceptance of the decision irrespective of the outcome.[164] Other components of procedural justice such as (1) respectful treatment; (2) even-handedness, and (3) trust and fairness can impact positively on the mediation process and result in improved satisfaction amongst disputants.[165] It is therefore important that procedural justice be practiced during mediation in healthcare disputes, irrespective of whether final decisions are made by patients, healthcare providers, or even an independent party.

In the context of resource allocation, especially in the public healthcare sector where resources are limited, distributive justice becomes relevant in its application to disease conditions that affect the majority. Evans suggests that achieving equity in health care can be considered as the 'absence of socially unjust or unfair health disparities'.[166] Rawls suggests that equity relates to social justice or fairness and is an ethical concept grounded in principles of distributive justice.[167] The *Soobramoney case,* where renal dialysis could not be continued due to limited resources and the obligation of the State to other aspects of healthcare, is a local case that

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[162] Wissler (note 129 above; 778).

[163] Robert MacCoun, 'Voice, Control, and Belonging: The Double-Edged Sword of Procedural Fairness' (2005) 178 *Ann.Rev.L.Soc.Sci.* 171.

[164] Jill Howieson, 'Procedural justice in mediation: an empirical study and a practical example' 2002 (5) *ADR Bulletin* 7.

[165] Kathy Douglas, 'Procedural Justice and Mediation' (2016) The Australian Dispute Resolution Research Network available at *https://adrresearch.net/2016/01/16/procedural-justice-and-mediation/*, accessed on 1 January 2019.

[166] Tim Evans, Margaret Whitehead, Fin Diderichsen, *et al,* eds *Challenging inequities in health: from ethics to action* (2001) New York: Oxford University Press.

[167] John Rawls, 'Justice as fairness' (1985) 14 *Philos Public Aff* 223.

highlights some of these issues.[168] The question therefore arises as to whether the case described above , or similar cases involving distributive justice can perhaps be better resolved through mediation. It is submitted that the mediation process is unlikely to achieve this for some of the following reasons:

i. mediation is designed to reach an agreement between parties, and not to identify systemic disparities ;
ii. health administrators and decision makers may not have an interest in mediation agreements unless it involves them directly ;
iii. outcomes from mediation are confidential unless otherwise agreed on;
iv. outcomes emanating from mediation are not organised in a systematic manner or presented in a coded form relevant to local and international epidemiological health forums ; and ,
v. mediation agreements may not be easily applied to influence constitutional or statutory judgements.

Mediation is however, well suited to the restorative element of justice in healthcare disputes. It is suggested that it provides a platform where (1) conflicts of interest, (2) grievances, (3) pain, and (4) negative psychological experiences can be addressed. A definition of restorative justice often used is an adaptation of Marshall's (1999) description which states that : 'Restorative justice is a process whereby parties with a stake in a specific offence come together to resolve collectively how to deal with the aftermath of the offence and its implications for the future'.[169] In the largest settlement (R25 million) to date in a paediatric case, the father of the child affected by an unsuccessful brain operation, is quoted as: I would give it all, and everything else I own, to have our lives back to the day before this doctor altered our lives forever.[170] This case demonstrates that the courts may not always administer restorative justice in medical negligence cases.

[168] *Soobramoney v Minister of Health* (note 106 above).

[169] Tony F Marshall, 'The Evolution of Restorative Justice in Britain' (1996) 4 *European* Journal *on Criminal Policy and Research* 21. (also see Hema Hargovan (2011) *Acta Criminologica: Southern African Journal of Criminology* 24(1) 67.)

[170] Sapa, 'R25m awarded in medical malpractice claim' (16 June 2013) available at *https://mg.co.za/article/2013-06-16-r25m-awarded-in-medical-malpractice-claim*, accessed on 02 January 2019.

In retribution, it is suggested that a patient may feel that the doctor or hospital responsible for the alleged negligence or mismanagement should suffer in a way that is 'commensurate' with the suffering of the victim. It is further suggested that achieving retribution in the mediation process will be challenging, as it may defeat the purpose of mediation and potentially lead to revenge. Much attention needs to be addressed to the psychological and emotional aspects of the patient in these types of cases. In retribution, the victim may benefit from material compensation for the loss of income, which can be agreed upon by both parties during the mediation process.

A fourth way to restore justice is through apology, for which mediation provides an ideal platform. It is suggested that after an adverse event, an apology can (1) reduce blame and remorse, (2) improve trust, (3) reduce discomfort and anger, (4) promote forgiveness of the 'negligent' doctor,and (5) build potential relationships. Chamsi-Pasha suggests that an appropriate apology may prevent the problem from escalating into a complaint and decrease the likelihood of a medical malpractice lawsuit.[171] Gara asserts that programs of disclosure and apology instituted in larger hospitals have resulted in significant reductions in legal expenses.[172]

3.5 ETHICAL ISSUES IN MEDICAL MEDIATION

Folberg and Taylor's often cited definition of facilitative mediation describes a process in which participants, assisted by a neutral person (mediator), isolate issues to develop options, consider alternatives, and reach a consensual settlement.[173] Barthel suggests that in addition to mediator neutrality,conflicts of interest, cultural norms, moral issues and individual circumstances are also important considerations for a mediator to ensure an ethical process.[174] Similarly, the disputants themselves have an ethical responsibility to be honset, show integrity

[171] Hassan Chamsi-Pasha, Hanoun Abdullah, Albar Mohammed Ali, 'Difficulties in apologising for a medical error' (2015) 351 *BMJ* h4997.

[172] Nicole Gara,'Apologizing for adverse outcomes' (2007) 20 (9) *JAAPA* 47-8.

[173] Jay Folberg and Alison Taylor, *Mediation: A Comprehensive Guide to Resolving Conflict Without Litigation* (1984) Jossey-Bass 7.

[174] Trip Barthel, 'Ethical Perspectives in Mediation' (2008) available at *https://www.mediate.com/articles/barthelT3.cfm* , accessed on 03 January 2018.

and obey the rules of the mediation process. Beauchamp and Childress [175] have identified bioethical guidelines that can be applied to medical mediation, namely:

i. autonomy – parties must be allowed to exercise their independence and freedom of choice to come to their own agreement/ settlement,
ii. nonmaleficence – parties should be discouraged from inflicting intentional harm to each other, either verbal, emotional, or even physical harm that may arise from arguments, anger and resentment,
iii. beneficence – parties should be encouraged to consider the welfare of each other. (it is suggested that this will be difficult to achieve as patients who have suffered serious bodily harm inflicted by a negligent doctor are unlikely to consider the welfare of the doctor after his/her acts of negligence), and
iv. justice – both parties should benefit from impartiality and fairness during the process.

However, given that mediation has a confidential nature and therefore a lower risk of accountability for potential dishonest practices , a mediator can engage in such practices. Similarly, intentional misrepresentation of facts may also be considered unethical and may be regarded as reason for a party to rescind a contract , claim restitution, and claim damages.[176]

Krivis argues that the professional rules of ethics require mediators to abide by the 'morality of the marketplace, as opposed to the rules of law'.[177] However, this view is not supported, and it is suggested that mediators be considered in the same light as attorneys and advocates. As asserted by Slabbert, to be regarded as 'fit and proper' there should be integrity, reliability and honesty in their undertakings.[178] Such attributes may influence the relationship that subsequently develops between a lawyer and a client. It is suggested that rules of conduct similar to those contained in Section 7(1) (d) of the Attorneys' Act [179] and Section 22(1) (d) of

[175] Beauchamp TL ,Childress J *Principles of Biomedical Ethics* 7 ed (2013) ch 4.

[176] Robin v Cupido, '*Misrepresentation by non-disclosure in South African Law'* Stellenbosch University available at *http://scholar.sun.ac.za*, accessed on 9 September 2018.

[177] Jeffrey Krivis, 'The Truth About Deception in Mediation' (2002) Mediate.com available at *https :// www.mediate.com/article/krivis11.cfm*. , accessed on 8 January 2019.

[178] Magda Slabbert, 'The requirement of being a "fit and proper" person for the legal profession' (2011) 14(4) *PER: Potchefstroomse Elektroniese Regsblad* 209.

[179] Attorneys Act 53 of 1979.

the Advocates' Act,[180] be developed for mediators, and unethical conduct amongst them should be dealth with in a similar manner as attorneys and advocates.

Furthermore, it is suggested that accredited medicolegal mediators be subjected to the Code of Ethics and Professional Responsibility for Family and Divorce Mediators, [181] which requires mediators to conduct the process impartially and ethically. The South African Dispute Settlement Accreditation Council (DiSAC) also contains a code for professional conduct for mediators and guides consultation in ethical dilemmas.[182] Health administrators, who may be drawn into medical disputes by virtue of their their role in hospital infrastructure matters , should likewise be honest, as trust between patient and health care institution makes for improved outcomes.[183] Similarly, medical practitioners are guided in their professional conduct by the respective regulatory councils and may face charges for unethical conduct. Other oaths and declarations, such as the Hippocratic Oath[184], and the Declaration of Geneva,[185] also call for commitment to ethical behaviour among health professionals. It is argued that these prescripts, which guide the ethical conduct of medical practitioners towards their patients, also be upheld during mediation, as it represents a continuation of the doctor-patient relationship. Similarly, as guided by the National Patients' Rights Charter, patients are also required to disclose all relevant material information to health care providers accurately.[186]

[180] Admissions of Advocates Act 74 of 1964.

[181] South African Association of Mediators, Code of Ethics and Professional Responsibility for Accredited Family and Divorce Mediators (2004) available at: *http://saam.co.za/documents/SAAM-Code-of-Ethics.pdf,* accessed on 5 January 2019.

[182] South African Dispute Resolution Council (DiSAC), Code of Professional Conduct for Mediators (2011) Version 1.

[183] Susan D Goold, 'Trust and the Ethics of Health Care Institutions' (2001) The *Hastings Center Report* 31(6) 26.

[184] Michael North (note 50 above).

[185] World Medical Association Declaration of Geneva. Switzerland, September 1948.

[186] South African National Patients' Rights Charter (1999) available at *http: //www.doh.gov.za/docs/legislation/patientsright/chartere.html.,*accessed on 6 January 2019.

CHAPTER 4:

PERSPECTIVES ON THE IMPLEMENTATION OF MEDIATION FOR HEALTHCARE DISPUTES

4.1 INTRODUCTION

Legislative reform measures for medical malpractice disputes should occur within a constitutional, statutory and ethical framework, whilst maintaining the right of all persons to access quality healthcare, irrespective of their health or financial status. Several preliminary proposals concerning legislative reform were made by SALRC after requests from the Ministers of Health and Justice and Constitutional Development to investigate the rise in medicolegal claims against the State.[187] In Section E of Issue paper 33, considerations for the implementation of mediation were suggested.[188] However, although mediation is practised in areas of labour disputes, family law and community matters in South Africa, its application in healthcare disputes, especially in the public health sector remains experimental. The purpose of this chapter is, therefore, to review some of the issues that are likely to influence the implementation of mediation for medico-legal disputes, particularly in the public health care system.

4.2 THE SOUTH AFRICAN LANDSCAPE

At the outset, it must be noted that the Minister of Health has endorsed medical negligence mediation to the extent that all such disputes involving state hospitals should be mediated.[189] The 'King III Report on Good Corporate Governance', as well as legislative reform since 1994, have created an enabling environment for mediation to be considered as an alternate dispute resolution mechanism for medical malpractice claims in South Africa.[190] The report endorses alternative dispute resolution as an essential component of good corporate governance

[187] South African Law Reform Commission (note 11 above).

[188] Ibid.

[189] Medical Negligence and Health Sector Mediation Training (2017), available at UCT Law at work, accessed on 27 September 2018.

[190] The Institute of Directors in Southern Africa, (2009) King III Code of Corporate Governance for South Africa *available at https://www.iodsa.co.za/page/kingIII*, accessed on 27 September 2018.

to manage and preserve stakeholder relationships.[191] However, it is suggested that this notion should be viewed with caution. The following reasons are cited:

i. the business and service environment in the corporate world, even in private hospitals, differs from the financial, administrative and service aspects in state hospitals;
ii. the character, content and settlement agreements in commercial disputes differ from medical malpractice disputes;
iii. human resources in the corporate world and private hospitals differ from that in state health institutions;
iv. healthcare establishments involve clinical governance rather than corporate governance.

Nevertheless, lessons can be learned from the United Kingdom, the United States and Canada, where mediation has been applied to medical disputes.[192]

However, it must be noted that such policies cannot simply be superimposed, as South Africa has different population dynamics, disease spectrum, and health care infrastructure compared to these countries. Medical mediation in South Africa is still developmental, and a blueprint for referral networks, professional forums and advisory and management services will need careful consideration before implementation. According to Simon-Meyer, an estimated total of 90 individuals, including medical negligence and personal injury lawyers, academics, healthcare practitioners and administrators, were accredited as medical negligence mediators in South Africa in 2017, however the uptake of their services remains low.[193] (see Table 5)

To facilitate the uptake of mediation for dispute resolution, mediators in South Africa have formed the Dispute Settlement Accreditation Council (DiSAC), to develop uniform accreditation standards for the profession.[194] Furthermore, as part of the Civil Justice Reform Project, approved by Cabinet in 2010, the Department of Justice has released a draft set of voluntary mediation rules aimed at unblocking congested courts and achieving speedy

[191] Jacques Joubert, 'Corporate Governance: Mediation primed to become key step in resolving disputes' (2010) available at *https://www.iol.co.za/...report/.../corporate-governance-mediation-*, accessed on 06 January 2019.

[192] Janine Simon- Meyer, 'Mediation could ease SA's medico-legal woes but it's no quick fix' (2017) available at *https://bhekisisa.org/*, accessed on 05 August 2018.

[193] Ibid.

[194] Dispute Settlement Accreditation Council (DiSAC) 'Mediation Accreditation Standards' (2011) available at *http://www. conflictdynamics.co.za*, accessed on 27 September 2018.

settlements.[195] However, it is suggested that decongestion of the courts may only be achieved if mediation panels are easily accessible, well-staffed, effectively administered and accepted by the community at large as a justifiable alternative to the courts, given the expectation of large compensation payouts associated with medicolegal claims.

Initiatives from professional bodies have also promoted the implementation of medical dispute mediation. The South African Society of Obstetricians and Gynaecologists (SASOG) has become the first professional body to institutionalise a pre-mediation process.[196] When a dispute arises, the organisation requests patients and doctors to agree to a free pre-mediation meeting to assist them in deciding whether to mediate or proceed with litigation. The discipline of obstetrics experiences very high litigation rates, particularly about poor neonatal outcomes, compelling the society to protect its members and the profession. Organisations such as Mediation in Motion (MiM) ® have developed mediation courses that have been customised for health professionals to train as mediators in anticipation of the implementation of court aligned mediation. The Centre for Mediation in Africa® also offers academic and practical courses in mediation by researching new and current best practices, to make mediation efforts throughout Africa more effective.[197] It is expected that medical malpractice insurers will also follow and offer alternative dispute resolution mechanisms as part of their contractual agreements.

4.3 TAX DISPUTES AND MEDIATION

On 1 April 2003, the Minister of Finance signed into law the Rules of the Tax Court as outlined in Section 107A of the Income Tax Act, providing new regulations under which tax disputes may be settled.[198] A lesson for medical mediation, is the stipulation of time frames, among other things: (1) 20 business days from the receipt of the notice of appeal for the Commissioner to decide the appropriateness for ADR and (2) 15 business days for the appointment of a

[195] GN 855 GG 38164/31- 10-2014.

[196] The South African Society of Obstetricians and Gynaecologists (2017) 'Pre-mediation meeting clause including standard procedure for dispute resolution' available at *http://www. sasog.co.za*, accessed on 25 August 2018.

[197] Centre for Mediation in Africa, University of Pretoria available at: http//: *www.centreformediation.org*, accessed on 10 January 2019.

[198] Income Tax Act 58 of 1962.

facilitator.[199] Data from SARS indicates that 79% of cases were resolved through a mediation process, and the remaining 21% were resolved in the tax court or tribunal. [200] In the UK, mediation has proved effective in resolving tax disputes in the small and medium-sized enterprises, with a 79 % success rate for resolving cases through 2016-17.[201] The tax mediation process in Quebec had a success rate of 75% and was associated with more significant benefits when the dispute was identified and submitted in the early stages.[202]

4.4 THE COURT-ANNEXED MEDIATION RULES

Section 34 of the Constitution of South Africa states: *'Everyone has the right to have any dispute that can be resolved by the law in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.'* [203] Aligned to this, the Rules of Voluntary Court-Annexed Mediation (Chapter 2 of the Magistrates' Courts Rules) were approved by the Minister of Justice and Constitutional Development, coming into operation on 1 December 2014.[204] Pilot project sites chosen were in Gauteng and the North-West Province. Case backlogs of over 1 900 cases have been noted in the recent past in some districts, and in Johannesburg, an average 60 000 cases are registered on the court rolls each year.[205] The objective of these rules, which is to be implemented in district and regional courts in South Africa, is to 'assist case flow management' by reducing a large number of disputes that appear before courts. The rules make provision for the referral of disputes for mediation at any stage during civil proceedings, provided that the presiding officer has not delivered judgment.[206] Within these rules, provision for mediation is made in 2 situations, namely: (1) before the commencement of litigation and, (2) at any stage during litigation before judgment,

[199] Customs and Excise Act 91 of 1964.

[200] Rycroft (note 61 above; 2).

[201] Kevin Elliott and Suzie Moore,' Use of mediation to help solve disputes' (2017) *Taxation*, available at *https://www.taxation.co.uk/article* , accessed on 7 February 2019.

[202] Tax Mediation Association,' Advantages and opportunities of tax mediation' (1981) available at *http://www.mediationenfiscalite.info*, accessed on 7 February 2019.

[203] Constitution (note 7 above; s 34).

[204] G 37448 RG 10151 GoN 183, 18-3-2014.

[205] Mnyathi-Jele (note 20 above; 1).

[206] Court Annexed Mediation Rules (see note 21 above).

and all disputes, including healthcare disputes, may be referred voluntarily and subsequently filed by both agreeable parties to refer the dispute for mediation.[207] A formal settlement agreement may or may not be made a formal court order, however, it remains effective and may be implemented should one party fail to adhere to the terms of the settlement agreement.[208]

4.5 MANDATORY MEDIATION FOR MEDICAL DISPUTES

Mandatory mediation, although not enforced in South Africa, is practised in countries like Canada, Australia and New Zealand.[209] The 'mandatory model' compels parties to mediate before a trial and contrasts to the 'voluntary model' that employs adverse cost orders at the end of the trial.[210] In the Canadian model, noncompliance with the requirements of mandatory mediation may result in (1) a cancellation of the session, (2) settlement of the mediator's fees and (3) may be subject to sanctions imposed by the Court.[211] Despite the strict compliance procedures associated with these rules, a review report demonstrates a significant reduction in time, costs and a high proportion (40%) of settlement.[212] No comparative data exists for South Africa, however, a higher percentage of 'out of court settlements' (70%) is noted in South Africa when compared to settlements achieved through mandatory mediation in the above model.[213] Similarly, in the USA, Holman indicates a 90% chance (2.3% vs 20%) of cases being settled without a lawsuit being filed.[214] Therefore, it is argued that if one uses settlement as a benchmark, a higher percentage of settlements will have to be demonstrated with mandatory mediation to consider it advantageous to litigation. Similarly, there is a paucity of robust data on other parameters such as legal fees and quantum assessment costs associated with mandatory mediation. The implementation of mandatory mediation in South Africa will be

[207] Ibid.

[208] Ibid.

[209] Joubert (note 17 above).

[210] Ibid.

[211] Public Information Notice- Ontario Mandatory Mediation Program (1999) available at: *https://www.attorneygeneral.jus.gov.on.ca/english/courts/manmed*, accessed on 29 August 2018.

[212] Joubert (note 191 above).

[213] Naidoo (note 95 above).

[214] Mirya Holman, 'Most claims settle: Implications for ADR from a profile of medical malpractice claims in Florida' (2011) 74 *Law and Contemporary Problems* 103.

complex, as it is influenced by several factors including social, political, historic and socio-economic aspects. From a theoretical perspective, Nolan-Haley argues that mandatory mediation compromises the voluntary nature of the process and the nature of consent. [215] Anderson expresses similar sentiments about coercion both into and within the mediation process.[216] Other authors suggest that compelling parties to engage if they do not agree will result in a lack of positive attitudes to the process.[217] Similarly, the European Commission's Green Paper on Alternate Dispute Resolution suggests that there is no purpose in obliging persons to participate against their will.[218] However, conflicting views exist on the dynamics of mandatory mediation. Contrary views are suggested by Yee who asserts that mandating mediation can produce an efficient, cheaper, less emotionally-exhausting, and generally more satisfactory alternative to litigation, however supporting data is not available.[219]

It is therefore suggested that if mandatory mediation for healthcare disputes is considered for implementation in South Africa, it will need to be non -prescriptive, complemented by education and training of many mediators, legal practitioners and healthcare professionals to manage the ensuing influx of claims that are likely to arise.

Mandatory categorical mediation can be used to promote the use of mediation. In Italy, excessive delays in resolving litigation cases and concerns around access to justice, has prompted the introduction of mandatory categorical mediation in 1998.[220] Similarly, in England, quasi-compulsory schemes in the form of pre-action protocols were introduced following the Woolf Report, which was aimed at improving access to justice and reducing the

[215] Jacqueline Nolan -Haley, 'Consent in Mediation' (2008) 14 (2) *Dispute Resolution Magazine* 4-5.

[216] Dorcas Anderson, 'Mandatory Mediation: An oxymoron? Examining then feasibility of implementing a court-based mediation programme' (2010) 11 (479) *Cardozo Journal of Conflict Resolution* 485.

[217] Paul Venus, 'Court directed compulsory mediation- attendance or participation?' (2004) 15 *Australasian Dispute Resolution Journal* 29.

[218] European Commission, 'Green Paper on Alternative Dispute Resolution in Civil and Commercial Law' (Report, 19 April 2002) 37 available at *http:// publications.europa.eu*, accessed on 24 January 2019.

[219] Florence Yee, 'Mandatory Mediation: The extra dose needed to cure the medical malpractice crisis' (2007) 7 (393) *Cardozo J of Conflict Resolution* 444.

[220] Giuseppe De Palo and Penelope Harley, 'Mediation in Italy: Exploring the Contradictions' (2005) 21 *Negotiation Journal* 469- 470.

cost of litigation.[221] Anderson asserts that if mandatory mediation is implemented, it should not influence a parties' right to express their autonomy during the mediation process.[222] While mandatory mediation may be considered by some as an infringement on autonomy and voluntariness, it can possibly also increase awareness of mediation itself, as the process will be utilised more often. Interestingly, after Nigeria's government introduced provisions to support the arbitration process, a renewed interest in ADR is reported to have developed among Nigerians.[223] Although mediation in Nigeria does not enjoy the same statutory status as arbitration, it is becoming recognised as an appropriate mechanism to resolve minor disputes that would otherwise proceed to a civil court.[224] However, it is suggested that mandatory mediation will have a minimal role for medical disputes in South Africa, due to high out of court settlement rates, the absence of evidence of benefit over voluntary mediation, and issues relating to the restriction of autonomy and freedom of choice of disputants.

4.6 POTENTIAL CAUSES OF FAILURE AND REMEDIAL STRATEGIES

In South Africa, the application of mediation for healthcare disputes is novel and experiences are limited. There is, therefore, a paucity of robust data on the benefits and the causes for failure. Objective data may emanate after experiences with medical negligence mediation are gained and appropriate monitoring and evaluation programs are instituted. A collation of potential contributory causes for failure and remedial strategies is presented in Table 5:

[221] The Woolf Report., 1996 4 (3) *International Journal of Law and Information Technology* 268-281 available at *https://doi.org/10.1093/ijlit/4.3.268*,accessed on 29 August 2018.

[222] Anderson (note 216 above; 32).

[223] Emilia Oedema and Monalisa Odibo, 'How alternate dispute resolution mechanisms made a comeback in Nigeria's courts' (2017) Africa Research Institute available at *https://www.africaresearchinstitute.org*, accessed on 24 January 2019.

[224] Ibid.

Table 5: Dashboard of possible impediments to implementation and remedial strategies

Identification of the problem	Strategy
Currently, there is a lack of referral networks and professional forums that can provide patients with access to suitable mediators.	Mediators in South Africa have formed the Dispute Settlement Accreditation Council (DiSAC), to promote awareness and develop uniform accreditation standards for the profession.
The criteria for the suitability and competency of mediators is not established.	To develop a statutory framework for the accreditation of mediators in SA in conjunction with the SALRC and the Department of Justice and Constitutional Development.
Mediation may result in an inappropriate or prejudicial settlement when litigation could have achieved a better outcome or compensation.	Each party may engage legal representation and lawyers can support and advise their clients and assist in drawing up the final settlement agreement.
The contingency fees option may be an incentive for clients to opt for litigation as it does not cost them anything	Reformation of the Act to redefine contingency fees may be proposed.
A poor uptake of mediation due to a lack of knowledge about its existence, nature and role.	Increase awareness, empower people, roadshows, workshops and lawyers may advise clients.
A lack of respect for mediators who may not be competent in the medicolegal field.	The South African Medicolegal Association (SAMLA) has introduced training in medicolegal litigation and upskill mediators.
The Court-annexed Mediation Rules disallow attorneys from attending court-based mediation who are unable to protect the client's interests.	Attorneys could make relevant submissions for revision to the SALRC.
Concerns that inadequate capacity for the high volume of cases may compromise mediation.	Increasing the output of trained mediators, including from the legal and medical fields to improve capacity.
The nature of the Court-Annexed Mediation rules does not facilitate early negotiations.	The USA deposition process and the UK pretrial case management process present source references for relevant revisions

Identification of the problem	Strategy
A lack of knowledge of the ombud is and whether he/she has jurisdiction in an area	Increase awareness through Department of Health programmes and medical, social and legal media.
There is no allocated budget for the remuneration of mediators.	The department of health may allocate a separate budget for this purpose.
There is an absence of a panel of specialised medicolegal trained mediators available at short notice.	Once the training of mediators is increased, more panels can be set up in different jurisdictions/areas.

It is suggested that further challenges to the successful implementation of mediation include poverty; the geographic / remote location of adjudication institutions; physical inaccessibility; lack of knowledge of rights; procedural hurdles; and delays in the resolution of disputes. Studies indicate that the average South African household needs to save a week's income to afford a one-hour consultation with an average attorney.[225] It is suggested therefore , that state-funded legal assistance be enhanced and costs relating to the mediation process be kept minimal or subsidised to improve the uptake. The cost of the mediator fee imposed on both parties should be shared by the State when disputes involve public health institutions.

The public healthcare services in South Africa extends to rural areas where many of the primary care clinics and community health centres are located. These sites are frequently affected by shortages of supplies, staff and equipment, which contribute to poor outcomes and potential litigation. Access to mediation sites in outlying areas should, therefore, be improved by increasing the number of mediation sites to assist indigent patients who must travel long distances for multiple visits with a mediator. The establishment of these outlying mediation sites is echoed in a Department of Justice and Constitutional Development acknowledgement of the need to establish suitable courts in rural and township areas as far back as 1999.[226] These institutions should be physically accessible to patients with disabilities as well.

[225] AfriMAP & Open Society Foundation of South Africa, *South Africa: Justice sector and the rule of law* (2005) 29.

[226] Department of Justice and Constitutional Development '*Annual Report (2007/08)'* available at: *https://www.gov.za/sites/default/files/gcis_document/201409/complete0.pdf*, accessed on 24 January 2019.

To enhance the uptake of mediation for medical malpractice disputes, stakeholders must be aware of their rights. However, many South Africans have little knowledge of the law and human rights.[227] In this regard, the State is obliged to educate citizens about their rights of access to courts and social security.[228] A direct example to emulate is the Social Assistance Act.[229] It requires that the South African Social Security Agency (SASSA) distribute brochures in all official understandable languages to beneficiaries, informing them of their the rights, duties, obligations, procedures and mechanisms of the Act.[230]

As the introduction of medical negligence mediation becomes established, it is likely to remain ineffective if parties are faced with procedural hurdles when trying to access the process. This view is supported by Haywood and Hassim, who intimate that a 'substantive right on paper is of no benefit unless it allows a litigant to bring a case to court timeously and with reasonable cost'.[231] They also assert that procedural aspects influence access to legal remedies, efficiency, the way the law construes a dispute, and the possible outcomes.[232]

4.7 OTHER STRATEGIES TO ENHANCE MEDIATION IN HEALTHCARE DISPUTES

4.7.1 Enhancing through CARP - lessons from the USA

Several health care institutions in the USA have experimented with 'communication, apology and resolution programs' (CARP), to enhance the medical mediation process. CARP focuses on the communication of information and further support. In a nutshell, the hospital or healthcare worker : (1) meets with the patient and family member(s), (2) explains the adverse event and reasons, (3) offers an apology, and (4) engages on the prevention of recurrance. Where appropriate, fair financial compensation is offered without the filing of a lawsuit.[233]

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[227] Mathias Nyenti, 'Access to justice in the South African social security: Towards a conceptual approach' (2013) *De Jure* 44.

[228] Ibid.

[229] Social Assistance Act No 59 of 1992.

[230] *Esthé Muller v DoJCD and Department of Public Works* (Equality Court, Germiston Magistrates' Court 01/03).

[231] Mark Heywood & Adila Hassim, 'Remedying the maladies of 'lesser men or women: The personal, political and constitutional imperatives for improved access to justice' (2008) 263 *SAJHR* 278.

[232] Ibid.

[233] American Medical Association, 'Communication and resolution programs' (2018) available at *http:// www.ama-assn.org*, accessed on 19 January 2019.

Some of the objectives and potential benefits of introducing CARP, may include the following inter alia [234] :

- to improve communication and transparency about adverse outcomes;
- to support patients/families to achieve a fair, timely and healing resolution;
- to support clinicians in disclosing unexpected outcomes to patients;
- to improve patient safety by learning from errors and near misses and preventing future harm, and,
- to provide an alternative to lawsuits and their unnecessary costs by meeting the financial needs of injured patients/families quickly without resorting to litigation.

Utilising CARP, settlements of approximately ZAR212 500 were reported on average in some centres compared with others which were as high as ZAR1.3 M.[235] Additionally, the average duration of cases decreased from 2-4 years to 2-4 months.[236] Other research from the University of Michigan Health System (UMHS) showed : (i) a decrease in the rate of claims (7.03 to 4.52 per 100 000) per month ; (ii) a decrease in the number of lawsuits (2.13 to 0.75 per 100 000) every month ; (iii) a reduction in the median time (1.36 to 0.95 years) from reporting to resolution, and (iv) a 50 % decrease in the monthly costs for (a) total liability, (b) patient compensation, and (c) non-compensation-related legal cost.[237]

A variation of CARP is described as the 'limited-reimbursement model' and is used in Columbia.[238] In this model, disclosure is offered in addition to compensation for out-of-pocket expenses (up to ZAR 350,000) and lost time (up to ZAR 70,000). Both the disclosure of information and compensation occur independently of the actions of the doctor , however the option to pursue litigation remains. Kass and Rose found that physicians as well as patients were satisfied with the system, and as a result, only a small number of claims progressed to

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[234] Massachusetts Alliance for Communication and Resolution following Medical Injury –MACRMI (2012) available at *http://. www.macrmi.info/about-macrmi/,* accessed on 21 January 2019.

[235] Kraman and Hamm (note 74 above).

[236] Federal Interagency ADR Working Group, Report on the use and results of ADR in federal government, (2007) available at *http: //www.adr.gov/pdf/iadrsc_press_report_final.pdf.*, accessed on 4 February 2016.

[237] Ibid.

[238] Joseph Kass and Rachel Rose, 'Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs' (2016) 18 (3) *AMA J Ethics* 299.

litigation and compensation.[239] Similarly, Boothman et al. showed that early apology and disclosure programs could reduce litigation and claim settlement figures by 50% to 67%.[240] However, it must be noted that apology is not universally applied, as apology laws differ among states and remains conditional in certain states.[241]

While the above data appears encouraging; it is argued that the success rates associated with it cannot be extrapolated to the South African setting ,with the expectation of similar outcomes. The reasons are that the USA has well-established mediation models, different population dynamics and levels of education, a different disease spectrum, as well as healthcare infrastructure. As a way forward , it is submitted that the hospital or healthcare practitioner engage the patient/family member(s) and explain the adverse outcomes and related events. The practitioner should also offer an apology and discuss future preventative and rehabilitative measures when necessary. This should be included in hospital policy, and completed as soon as possible following an adverse event, even before possible mediation. It is submitted further that disclosure and compensation can occur without the determination of the physician's wrongful action. However, this should be left to the discretion of the patient, as they should retain the right to sue. Financial compensation may be offered to affected patients, and this should be determined by an internal panel of experts, with the provison for further negotiation by the patient and his/her legal representatives. It is submitted that this will be a significant cost saving measure in medical negligence claims, as high costs are associated with the remuneration of experts in these cases.

4.7.2 Choosing a suitable mediator

A mediator who has attained specific knowledge and competencies in the medical and health administration fields is more likely to oversee the success of healthcare disputes. This requires initial and on-going skills training and is further influenced by the personal attributes of a mediator such as impartiality and experience in the field. In accordance with mediation rules, a mediator may not be imposed upon the parties if they consider the individual as lacking

[239] Ibid.

[240] Richard Boothman, 'A better approach to medical malpractice claims? The University of Michigan experience' (2009) 2 *J Health Life Sci Law* 125.

[241] Sohn and Bal (note 113 above).

neutrality.[242] Shore suggests that to allow the parties to choose the mediator will 'promote cooperation, generate goodwill, and reduce delays and costs'.[243] He further suggests that there is minimal risk in accepting a mediator proposed by the other party, as the mediator is not a 'decision maker'.[244] It is suggested that for medical disputes, the aggrieved patient be allowed to suggest a mediator in this situation, and be accepted by the doctor, as this is likely to reduce concerns about transparency and power imbalances between establishments and patients. It is also proposed that a database of accredited mediators be established and listed on the department website to ensure access to suitable mediators. A suitable framework for this purpose is presented in the 'feedback digest model' as employed by the International Mediation Institute (IMI).[245] A feedback digest contains an independent summary of a mediator's profile and experience, according to specific guidelines. It allows parties an insight into the personality, competencies and characteristics of an individual mediator, and assists parties to choose an appropriate mediator according to the profile required.[246]

4.7.3 Achieving balance during mediation

Noting that patients who have suffered personal injury or incapacity may harbor potential anger and resentment, an adversarial environment can develop during the mediation process. Mnookin describes this approach as one where the negotiation process may be viewed as combative , in which the more aggressive negotiator wins, over the more conciliatory one.[247] He advises that adversarial and interest-based strategies should be balanced in mediation, or it will lead to competition between negotiators.[248] Buckley further reiterates the importance of achieving balance and suggests that failure to achieve this may increase the chances of an

[242] G 37448 RG 10151 GoN 183, 18-3-2014.

[243] Richard Shore,'Four Tricks That Makes Mediation Work' (2012) available at *http://www.forbes.com/sites/forbesleadershipforum*, accessed on 18 July 2018.

[244] Ibid.

[245] International Mediation Institute 'Choosing the Right Mediator' (2017) available at *https://www.imimediation.org* ,accessed on 10 September 2018.

[246] Ibid.

[247] Robert Mnookin, *Beyond Winning: Negotiating to Create Value in Deals and Disputes* (2000) Cambridge, Mass. The Belknap Press of Harvard University Press.

[248] Ibid.

impasse, and limit the options by parties.[249] In achieving balance, the health establishment should consider the sensitivities around loss, redress, continuity of care, compensation and the rights of patients, as outlined in the Patients' Rights Charter.[250] Similarly, the patient as an end user of the public hospital should consider the impact on financial and human resource constraints, the apologies tendered, and the acknowledgement of remorse made by the practitioner.

4.7.4 Ensuring effective communication

Apart from applying a strategy of good communication during mediation, healthcare disputes may require further discussions concerning complex medical treatments and surgical procedures. During the mediation process, these complex terms need to be communicated in a language that both parties understand. Misunderstanding resulting from language barriers should be prevented using an interpreter when necessary. The mediator must first ascertain the level of understanding of the aggrieved patient, ensure that terminology is understood and conduct the process in a simple, logical and sequential manner. It is submitted that paraphrased statements can be used by mediators to determine the level of understanding of the parties before proceeding with the process.[251] It is also submitted that an improved level of understanding may be achieved with the combined with the use of "open-ended questions" during the process.[252]

4.7.5 Achieving mutual co-operation

Fisher and Ury argue that for effective negotiation in mediation, parties need to consider ways that satisfy the interest of both disputants.[253] They further intimate that mediation can be made effective if parties cooperate by identifying their differences in interests, risks and beliefs,

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[249] Ross Buckley, 'Adversarial Bargaining: The Neglected Aspect of Negotiation' (2001) 75 *Australian Law Journal* 181-189.

[250] Department of Justice, Patient Rights Charter available at *http://www.doh.gov.za/docs/legislation/patientsright/chartere.html*, accessed on 23 January 2019.

[251] Dennis Chamisa, *'The potential of alternative dispute resolution mechanisms in tackling the increase of lawsuits due to medical negligence in public hospitals'* (dissertation- University of Cape Town 2013).

[252] Ibid.

[253] Roger Fisher & William Ury, *Getting to Yes – Negotiating Agreement Without Giving'* (1981) Penguin Books, New York 5.

thereby facilitating an earlier settlement.[254] It is suggested that a flexible and open-minded approach that includes different points of view is beneficial to allow a resolution to develop.

4.7.6 Employing multiparty negotiation skills

The medical field that has the highest litigation rates, namely obstetrics, usually involves a multiparty team such as an obstetrician, midwife, paediatrician, paediatric neurologist, radiologist and even the hospital manager in specific cases, each of whom has a specific role in the mediation process. Such a multiparty engagement may complicate the mediation process due to a large number of different inputs. In this regard , Susskind and Mnookin identify issues such as : coalition formation, process-management issues and fluctuating alternatives, that can complicate multiparty engagement during mediation.[255] These authors suggest that the goal in multiparty involvement should be to 'maintain flexibility and build alliances' between the parties whilst maintaining relationships with different role-players. Good administration of the process , including financial and human resource management will help to ensure that the mediation process is run efficiently. The maintenance of proper records , and other resources should also be managed efficiently.

4.7.7 Support from the Courts

To promote the court-annexed mediation rules; courts can support the process by ordering a stay or suspension the of court proceedings brought in breach of a valid mediation agreement , which may subsequently encourage the use of mediation.[256] It is submitted that the escalation of the dispute to the court should be limited to a failure of the mediation process. Essentially, an attempt should be made to resolve a dispute through mediation before proceeding to litigation. The refusal or unwillingness to mediate can have adverse cost consequences even if the refusing party is successful.[257] The court may also consider the outcomes of pretrial screenings to gain insight into the strengths of the case, and determine the merits for a trial or referral for mediation. With the formalisation of court-based mediation within the civil justice

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[254] Ibid.

[255] ACCORD and African Union (2014) *The Mediation Process* available at *http://mediationsupportnetwork.net/*, accessed on 20 January 2019.

[256] Mowatt James, 'Some Thoughts on A Mediation Profession' (1993) 110 *South African Law Journal* 787.

[257] Gordon Exall, 'Mediate or else ? The cost consequences of refusing to mediate' (2013) 36 *Civil Procedure, Mediation & ADR* 1.

system, the courts will have a greater role to play in facilitating mediation. A refusal to mediate may have to be justified, and litigators may have to explain to their clients, the decision to decline mediation.[258]

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[258] Ibid.

CHAPTER 5:

CONCLUSION

The Roman scholar, Pliny the Elder, is quoted as saying: *'Semper aliquid novi Africam adferre,*' translated to mean: 'Africa always brings us something new.' [259] The implementation of mediation for medical negligence disputes in South Africa has principles that are embedded in the African humanist philosophy known as *Ubuntu*, which, among other things promotes mediation and conciliation.[260] The Minister of Justice is quoted as saying: 'we hope the pilot phase of mediation will culminate into a more rigid process whereby mediation could be compulsory and may extend to disputes that fall within the jurisdiction of the high courts'.[261] Mediation has a broad application, ranging not only from family, labour and tax disputes but to international conflicts where it has been successful at a political level.[262]

Mediation differs from litigation as it allows parties to resolve their issues through mutual co-operation. The process is private and confidential and may reduce trial costs if many of the peripheral issues can be resolved during the process.

Moreover, it does not prohibit access to 'trail' if unsuccessful, as the Magistrates' Courts Act 32 of 1944 permits parties to consent to a higher jurisdiction.[263] However, opponents of mediation may argue that privacy, confidentiality, and reducing trial costs are also a feature of pre-trial meetings for litigation cases and not an exclusive feature of mediation. In a systematic review of medical malpractice mediation and other alternative dispute resolution mechanisms in the USA, Sohn and Bal concluded that mediation in medical disputes was successful in

[259] 'Pliny the Elder' *The Concise Oxford Dictionary of Quotations*. (Ed) Elizabeth Knowles. Oxford University Press, 2003.

[260] Joubert (note 17 above).

[261] R.183 of GG 37448, 18 /3/2014; 4.

[262] William Zartman and Saadia Touval, 'International Mediation: Conflict Resolution and Power Politics' (1985) 41 (2) *Journal of Social Issues* 27.

[263] Magistrates' Courts Act 32 of 1944.

avoiding litigation in 75% to 90% of cases, saved costs of approximately ZAR700 000 per claim, and was associated with a 90% satisfaction rate among both plaintiffs and defendants.[264]

In a nationwide review on the aetiology of large malpractice claims, Makary et al., using the National Practitioner Data Bank in the USA concluded that large pay-outs (more than R14 million) were related to diagnostic errors, obstetrics and surgery.[265] Thirty-seven per cent of these claims involved physicians who were 'repeat offenders'. Makary, therefore suggests that the focus of quality improvement strategies and reform measures should be on clinical practice, patient safety, diagnostic tests and procedures, as these are more likely to provide real cost reductions.[266] This suggestion is supported , as fewer cases will present for mediation or litigation if adverse events are prevented with optimal patient management.

Krikorian showed that in some states in the USA, as many as 95% of cases are settled prior to a trial. [267] Similarly, in the USA, Holman found a 90% chance (2.3% vs 20%) of cases being settled without a lawsuit being filed.[268] Data from the practice survey presented in this study and other South African data shows that between 70-77% of litigation cases are settled out of court after an agreement between disputants and their legal teams.[269] It is therefore submitted that only some of the cost savings identified in the review by Sohn and Bal above may be reproducible in our environment. This notion is supported by the findings from the survey presented earlier, which revealed that significant cost drivers during litigation appear to be associated with expert opinion, which may still prevail in mediation cases when experts are engaged for clinical and quantum evaluations.

There seems to be no definite benefit of mandatory mediation over voluntary mediation. This is supported by an empirical analysis conducted by Peeples, who found lower success rates

[264] Sonn and Bahl (note 113 above).

[265] Martin Makary, Paul Bixenstine, Andrew Shore, et al, 'Catastrophic Medical Malpractice Payouts in the United States' (2014) 36 (4) *Journal for Healthcare Quality* 43.

[266] Ibid.

[267] Krikorian (note 96 above).

[268] Holman (note 214 above).

[269] Naidoo (note 95 above).

with court-ordered mediation.[270] Concerning the type of mediation style to be employed for medical dispute mediation, it is suggested that a combination of evaluative and facilitative mediation styles be adopted by mediators to facilitate the free expression of the concerns of patients and to gather necessary information timeously.

The use of mediation for healthcare and medical negligence disputes is also likely to present peculiar challenges. Unlike in family mediation, the relationship in medical mediation cases is likely to be short and does not facilitate long term relationships between parties. Other challenges to successful mediation are, among other things: complex medical terminology requiring trained mediators, multidisciplinary stakeholder involvement in patient management, power imbalances between the healthcare provider and the patient, and confidentiality and privacy issues that may involve the disclosure of sensitive health information such as HIV. Arguably, the most challenging situation relates to the face to face confrontation between doctor and patient, especially where negligence has resulted in severe or permanent physical incapacity. The absence of the doctor can be noted during the medical mediation process, possibly to avoid confrontation, or due to their reliance on medical insurance companies who have a paid responsibility to represent them.[271] In this case, the benefits of transparency and open communication will not be achieved, as the aggrieved patient is left to confront a representative rather than the doctor. A summary assessment of the expectations of mediation compared with litigation in medical malpractice disputes is presented in Table 6 below.

In analysing the policy development initiatives for mediation, it is concluded that an adequate involvement of institutional structures like government departments (Health, Justice), the media, the SALRC, professional bodies (SASOG), academics (health and legal) and broader society has occurred. In reviewing the methodological considerations, the following views are held :

i. a needs assessment was appropriately conducted - however, it was prompted by the budgetary constraints (the effect), rather than malpractice litigation itself (the cause) , and it excluded an assessment of the efficiency and efficacy of the legal system in dealing specifically with medicolegal litigation.

[270] Ralph Peeples, Catherine Harris, and Thomas Metzloff, 'Following the script: an empirical analysis of court-ordered mediation of medical malpractice cases' (2007) 1 *J Disp Resolution.* 101–118.

[271] Amirthalingam Kumaralingam, 'Medical dispute resolution, patient safety and the doctor-patient relationship' (2017) 58 (12) *Singapore Med J.* 681–684.

ii. a situational analysis was conducted -however, there is inadequate stratified data on medicolegal litigation cases (most data emanating from media reports and individual cases).

iii. a gap analysis on the resources, including fiscal, human resources, infrastructure, etc., needs to be evaluated further.

iv. comparative modelling in countries with similar resources needs further evaluation, as little or no comparative data exist.

It is submitted further that an initial step in ensuring the success of mediation is for all persons to be educated and have an understanding of the process. Parties should allow the process to develop and commit to it until an agreement is reached. As there is no single acid test to assess the 'pro-people' nature of an intervention, this should be evaluated by social auditing mechanisms. Furthermore, mediators should receive specific training or be trained professionals from either from a legal, medical or health administration background as they are required to analyse complex medicolegal issues.

In cases where mediation is unsuccessful, and an agreement cannot be reached, mediation may still have the benefit of narrowing down the issues for a future trial. It is submitted that mandatory mediation, despite being successful in certain countries, should not be adopted, as there is no proven benefit and it does not support the notions of ownership, willingness and cooperation. Preemptive mandatory mediation in the consent process may also be challenged in future court trials under the Consumer Protection Act.[272]

Table 6: Summary analysis of mediation vs litigation about the expectation

Expectations	**Mediation vs Litigation**
1-Patient Level: **(a) Monetary:** -Specific damages -General damages **(b) Non - Monetary:** -Acknowledgement -Explanation - Apology -Steps for prevention	Fiscal compensation using mediation will be similar to litigation – if financial compensation is established in the agreement, and suitable experts are consulted for fair settlement amounts. Mediation is likely to be better as it allows open communication, personal interaction and transparency in a mediator neutral environment.

[272] Consumer Protection Act 68 of 2008.

2-Medical /Legal Professional Level: -Cost-effective -Timeous -Higher settlement rates -Patient satisfaction -Provider satisfaction	It is unlikely for mediation to be more cost-effective than litigation in the long run, as most cases are settled out of court. There will be reduced procedural and legal professional costs to an extent. However, quantum payments will remain similar if determined by experts. It remains to be seen what proportion of disputants will settle or litigate after failed mediation as this may result in higher costs in the end. Patient and provider satisfaction are more likely in mediation due to the privacy and confidentiality associated with mediation.
3- Court Expectations (Court Mediation Rules): * - Promote access to justice - Promote restorative justice - Preserve relationships between complainants - Provide complainants with solutions to their disputes, beyond the scope and powers of a judicial officer - Speedy and cost-effective resolution of disputes	It is suggested that mediation also allows access to justice, and the Court Rules facilitate/ promote it. It is doubtful if restorative justice will be achieved in medical negligence cases as it is unlikely to be achieved completely even in litigation. Improved relations are more likely in mediation, which may become strained or destroyed by the "adversarial nature of litigation". It is suggested that mediation is potentially more effective for non-monetary issues. The potential for speedy and cost-effective dispute resolution through mediation will depend on the provision and administration of mediation clerks, panels and centres available. Compensation for specific and general damages for medical negligence cases is unlikely to be reduced in mediation.

* *Mediation clerks in selected magistrate's courts arrange a meeting between parties to determine submissions to the mediator. There are no court fees, mediators may charge according to a fixed tariff. Parties contribute equally to this fee, and the mediator will be chosen by the parties, with the help of a mediation clerk from a panel of accredited mediators appointed by the Minister of Justice and Correctional Services.*[273]

The limitations in the study relate to the paucity of prior research and reliable data on the topic as medical malpractice mediation is a new concept in South Africa, and data from international studies remain heterogeneous and inconsistent. The dissertation therefore adopts an exploratory rather than an explanatory design. However, it highlights the gaps in the literature and reflects on the need for future research. The use of reports in the study presents a further limitation as inherent bias cannot be verified easily without evidence. Nevertheless, the events quoted in the study are consistent with other source data and with current events regarding

[273] Department of Justice and Constitutional Development, 'Mediation Rules to ease the burden on country's Court Roll' (2015) *Justice Today* 2 (4) available at *www.justice.gov.za,* accessed on 21 January 2019.

medical litigation and alternate dispute resolution. Findings in this study were enhanced through cross-referencing from both medical and legal literature.

A further limitation in the study lies in the comparative appraisal of international legal prescripts, which differs in countries. The mediation rules in South Africa embed mediation in the civil justice process by providing that the filing of a notice of intention to defend, automatically activates mediation.[274] In Canada, however, court-based mediation is activated by request to mediate, filed by one of the parties, with legal consequences for a party who refuses to participate.[275] In the USA, the deposition process requires the parties to assess weaknesses before the matter goes to court,[276] and the UK has embraced a pre-trial active case management system. [277] Also, the case studies used do not demonstrate the outcomes of mediation *per se* and relevant data emanating from monitoring, evaluation and quality improvement programmes were not available for analysis.

Nevertheless, it is submitted that a few fundamental principles may be employed to achieve a successful mediation, namely:

i. the promotion of self-determination, willingness and voluntariness in the process;
ii. the enhancement of trust and promotion of credibility in the process; and
iii. flexibility and the willingness of parties to explore different solutions ranging from simple disclosure to apologies, chronic and rehabilitative medical care and financial compensation.[278]

It is encouraging to note that mediation service providers in South Africa have initiated steps towards formalising mediation, by forming the Dispute Settlement Accreditation Council (DiSAC), tasked with developing uniform accreditation standards for the profession.[279] Compared with commercial mediation in South Africa, for which training courses provide a

[274] R.183 of GG 37448, 18 /3/2014; 4.

[275] Joubert (note 17 above).

[276] Jay E Grenig, 'Taking and Using Depositions Before Action or Pending Appeal in Federal Court', (2004) 27 *Am. J. Trial Advoc*. 451.

[277] Kenneth Vorrasi, 'England's Reform to Alleviate the Problems of Civil Process: A Comparison of Judicial Case Management in England and the United States' (2004) 30 (2) *Journal of Legislation* Article 8.

[278] Cris Currie, 'Mediation and medical practice disputes' (1998) 15 *Conflict Resol Quarterly* 215.

[279] DiSAC (note 182 above).

foundation for interest-based mediation, they do not provide the competency required for medical malpractice disputes.[280] It is submitted that the Department of Health develops joint medicolegal education programmes and training courses with legal departments in tertiary institutions.

In the final analysis, it must be noted that no clear evidence exists to support mediation as the ideal cost saving device currently , or that the advantages will outweigh the disadvantages in our country. However, the success of mediation in the long term, especially for public healthcare disputes may be enhanced with the following elements:

- a stratified approach,
- extensive training and skills development of mediators and legal support staff,
- continuous monitoring and evaluation, and
- defined outcome measures.

The draft set of mediation rules released by the Department of Justice [281] presents an early step in this direction. Therefore, a positive and sustained input from all stakeholders is necessary to drive the process further.

Although mediation may not be the panacea for all medical malpractice cases , the dissertation concludes with the words of Judge Colin Lamont,[282] which highlights the inextricable link between mediation and *Ubuntu*, a philosophy that guides our daily lives and makes us South African:

> "*Ubuntu is recognized as being an important source of law within the context of strained or broken relationships amongst individuals or communities and as an aid for providing remedies, which contribute towards more mutually acceptable remedies for the parties in such cases. Ubuntu is a concept which, inter alia dictates a shift from (legal) confrontation to mediation and conciliation".*

[280] South African Association of Mediators, Accredited Training Institutes – Mediation South Africa (2017) available at *https://www.saam.org.za/training-and-events/accredited-training-institutes,* accessed on 19 January 2019.

[281] R.183 of GG 37448, 18 /3/2014; 4.

[282] *Afriforum v Malema* 2011 6 SA 240 (EqC).

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APPENDIX 1

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

2 October 2018

Dr Niren Ray Maharaj 973168544
School of Law
Howard Campus

Dear Dr Maharaj

Protocol Reference Number : HSS/1355/018M
Project title: Medical malpractice disputes in South Africa: a potential role for mediation as an alternate resolution mechanism

Approval Notification – No Risk / Exempt Application

In response to your application received on 2 August 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

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

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

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

Yours faithfully

.....

Professor Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committe

/pm

Cc Supervisor: Dr Donrich Thaldar
cc Academic Leader Research: Drv Shannon Bosch
cc School Administrators: Mr Pradeep Ramsewak

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