POLICY BRIEF 1

Dedicated alternative dispute resolution units for better management of claims

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Table of Contents

List of figures

Foreword

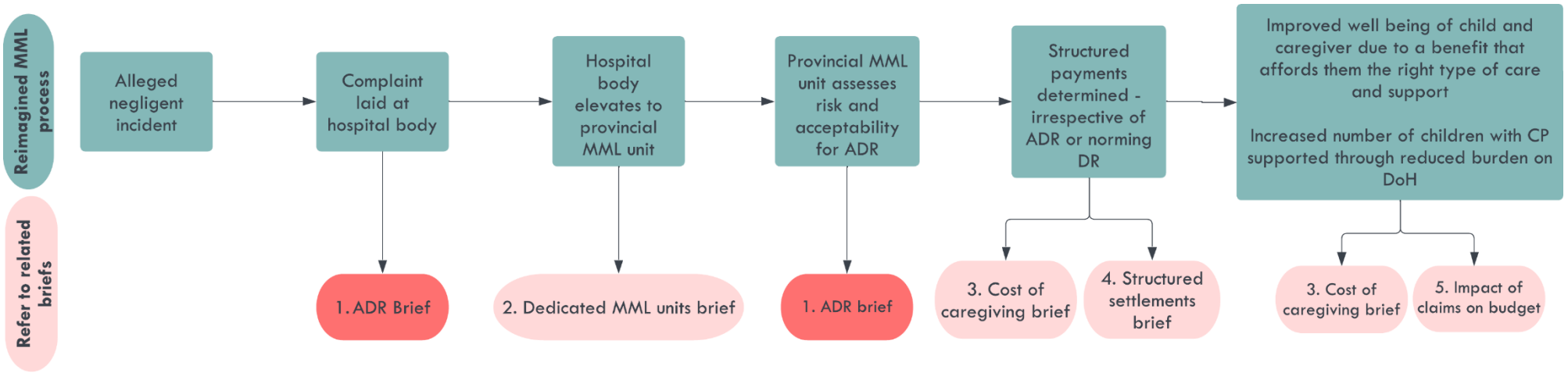
The Public Interest function was created by the Actuarial Society of South Africa (ASSA) to enable the organisation to pro-actively participate in public policy discussions. ASSA seeks to inform debate on matters of public interest in South Africa, especially when it is deemed that actuarial expertise can add value. ASSA can provide facts, figures, comments, and analyses of consequences on a wide range of topics where the actuarial skillset can provide unique insights.

There is no specialised legislation governing the medical malpractice (medico-legal) space in South Africa.[1,2] Claims are therefore dealt with by way of the common law.[1,2] This increases the risk of exploitation and abuse. The South African Law Reform Commission (SALRC) seeks to reform the law to address the risks inherent in using common law for medico-legal claims. In collaboration with other experts in this space, such as ASSA, the SALRC aims to draft legislation that will best serve the citizens of South Africa.

ASSA aims to provide feedback, research, and commentary throughout the process to help shape the SA medico-legal legislation space.[3] A series of work and policy briefs were commissioned to research the recommendations of the SALRC, of which this forms one of the briefs in the series. It is envisaged that the findings from this research would equip the SALRC with the evidence needed to tighten legislation and provide outcomes that are fair to all involved parties. It is our view that by linking these policy briefs together, one can understand the policy levers available to the SALRC to reimagine or shape the future of the medico-legal space.

Figure 1 shows the flow of the research briefs Percept was commissioned to write. The briefs follow the same order as a medico-legal claim and thereby paint a story of the necessary reform along the medico-legal journey. The brief herein is the first brief in the series and discusses the different mechanisms for dispute resolution.

Figure 1: Reimagining of the SA medico-legal space



Abbreviations

ADR - Alternative dispute resolution
DR - Dispute resolution
MML - Medical malpractice litigation
CP - Cerebral palsy
DoH - Department of Health

Background

As is public knowledge, and as summarised by many research papers, there are serious red flags around the quantum levels of medico-legal claims in South Africa.[1,2,4] The quantum of claims, the increase in relative claim sizes over the years, and the increase in case numbers is crippling the health sector, from a financial-, service delivery- and a future sustainability-perspective.[1,5] Other than the quantum of the individual claims, there are other issues around: how claims are paid; how claims are budgeted for; and, the opportunity costs that arise from the payment of large claims.

How claims are paid

Claims are paid under the common law rule of 'once-and-for-all'[2] and therefore paid out as a lumpsum. A proportion of this lumpsum is owed to the legal team defending the client, for their services. The remainder is often deposited by the plaintiff's attorney into a Trust, who administers the funds to the client (or appointed next of kin) over the course of their life. In the fourth brief of this series, entitled Structured Settlements[6], we go into more detail surrounding the current once-and-for-all, versus alternative options to consider for medico-legal payments in South Africa.

Budgeting for claims

Recently, the notion that claim payments fall under 'fruitless and wasteful' expenditure in terms of the Public Finance Management Act, 1 of 1999 and by the Auditor-General has been upended. Departments of Health should now be aware that they are able to budget for claims, but many still do not. In the final brief of the series, entitled impact of claims, we discuss the options for budgeting for future claim pay-outs.

Opportunity costs of claims

There are also various opportunity costs that arise from paying out high costs from the already constrained health budget. These funds could be used for funding much needed human resources for health roles, particularly in the public sector which is understaffed and where additional human resources for health (HRH) will be required if the intention is to shift toward in-kind restitution rather than financial.[7] Employing more healthcare professionals would improve the quality of healthcare and likely reduce medico-legal claims in future. Claims also take away funding from other vital areas of the healthcare sector such as enabling a universal health coverage strategy and improving access to care, which are stated priorities for the country. In a related infographic, we show the opportunity costs for claim payments for provincial departments of health.

The focus of this brief

There are various recommendations made by the SALRC to resolve issues in the medico-legal context, but there is no silver bullet. Changing one or two things in isolation will not lead to the reform and impact needed. The sector needs wholescale reform that is: integrated; in the best interest of the patient; supports quality improvements; and ensures adequate financial resources for the public health sector.

One of SALRC's recommendations outlined in the discussion paper 141 was the need for **dedicated alternative dispute resolutions (ADR) teams in each province to support better management of claims.**[1] In relation to this recommendation, ASSA has commissioned this policy paper to understand how to bring these units to life.

Mediation is the most frequently used method of ADR in the South African context. While having the advantage of reducing legal cost and settlement values, it brings about other issues. Appendix 1 provides a summary of available ADR methods in South Africa, not just mediation. It locates these methods in terms of where they can be used, based on their current use locally and internationally. The pros and cons of each method are discussed after which a summary is provided on what methods can be used at different stages of the claims process and how with changes to some ADR processes, it can provide a dispute resolution that is fit for purpose.

The main section of this paper details an ADR mechanism specific for South Africa using a suggesting framework and the paper ends with recommendations and next steps that can be followed to implement ADR methods in South Africa.

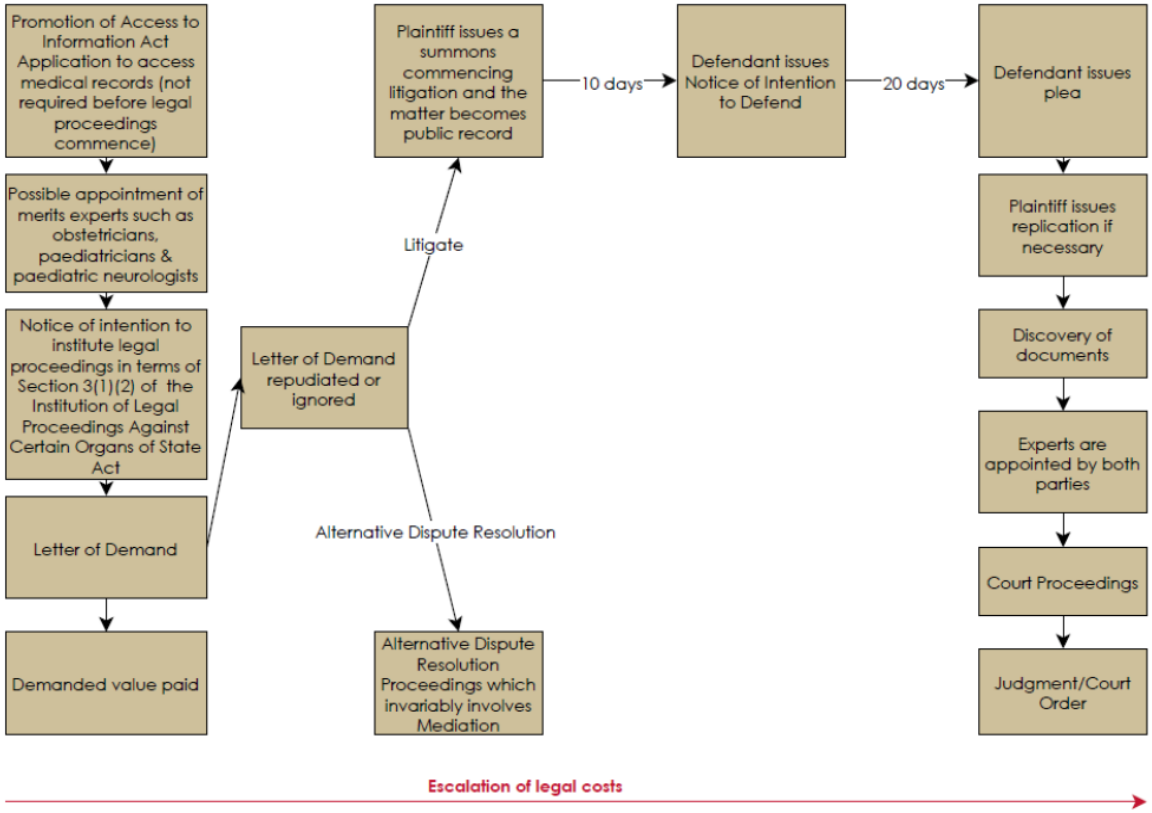
Overview of dispute resolution options for medico-legal claims in South Africa

Litigation

Litigation is the primary and most widely used method for dealing with medico-legal claims in South Africa. Litigation is, however, a long, costly, disempowering and inefficient process and does not necessarily need to be used for all cases. Some cases can be settled using an alternative problem-solving process to provide a mutually agreeable dispute resolution for all parties involved.

Figure 2 outlines the legal process followed for medico-legal claims against the Department of Health.

Figure 2: Legal process for medico-legal claims[5]



The long timeline of the litigation process is apparent from Figure 2. For Cerebral Palsy (CP) medico-legal cases in South Africa, which have the highest quantums[3,5], the above claim process can take up to five years. During this time, medical practitioners that were involved in the patient care may be lost, and the quality of the evidence wanes. More importantly, children may grow without the proper care and financing needed and some injured children may even pass away during this time period.[5]

Alternative dispute resolution

Alternative dispute resolution refers to all forms of dispute resolution other than litigation or adjudication.[8] It seeks to resolve the issues related to litigation such as high legal costs, long time lines, and disempowerment of the parties involved in the dispute. The most frequently used methods of ADR in South Africa are negotiation, mediation, arbitration, the use of an ombudsman and administrative dispute resolution. **Even though the constituents of the approaches differ, the key common thread of their use is to enable parties to find mutually agreeable solutions outside of the court system.** [8] In practice, parties may combine the use of ADRs at various points of the process, to arrive at the best solution for all parties involved.[8]

Brownlee v Brownlee has set the precedent in South Africa for legal practitioners to have to consult their clients on ADR; failure or rejection of this prescription will lead to punitive cost orders brought against the legal practitioners.[9] In certain Magistrates' Courts across the country, the rules of court-annexed mediation were instated from December 2014.[10,11] However, court-annexed mediation has been put on hold as of March 2022[11]. But, the approval of the process illustrates that mediation is a

valuable dispute resolution method. It is also tagged on the Department of Justice's (DoJ) website as "quick and affordable".

Globally, ADR is gaining widespread acceptance, particularly over recent years.[9,10] In South Africa, the medico-legal space is fairly new in comparison to the rest of the world. This explains why there is not yet specialised legislation nor ADR-enabling structures. However, change is on the horizon.

There are many advantages of using ADR methods:

- It may potentially reduce the litigation burden on the state,
- It also allows more access to legal services, particularly given that the high cost of ligation means that access to courts isn't available to all.
- It may shorten the time frame between claim and payment and better suit the needs of all involved parties.
- The court process is limited to legal remedies and produces a win-lose resolution of the dispute, which can be a traumatic experience for both parties.
- The rules in ADR are more flexible than litigation. In court proceedings, parties are compelled to follow the Uniform Rules of Court, which are themselves rigid.

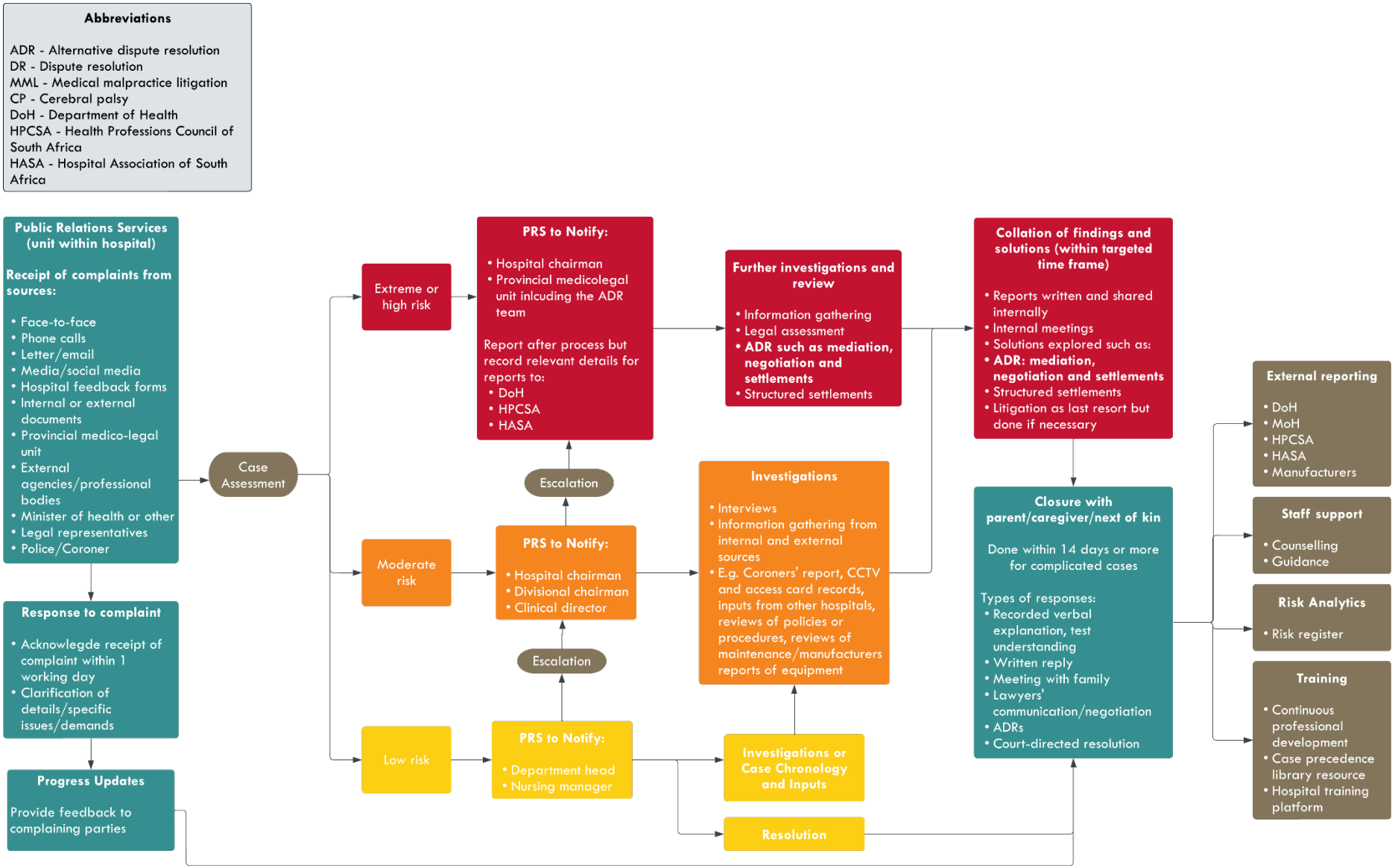
Despite the advantages outlined above, it is important to highlight that ADR is one of the alternatives available to claimants who seek dispute resolution and it should not be the only method available.[12] There is still space for litigation and the choice of dispute resolution should be chosen based on the details of the case. ADR seeks to fill the gap where, based on the facts of the case, litigation is inappropriate and does not meet the needs of the parties involved. It is hoped that more ADR methods can be enabled in the current medico-legal environment and used when necessary to provide parties with the best possible outcomes.

Lastly, ADR methods should be considered at the start of the claims process. If successfully used at the start, the time lapse between claims and payments will reduce dramatically. Vital care for the injured child and support for their families will also be delivered sooner and legal fees, for the provincial department of health (PDoH) and client, will be avoided. Both of these would help to reduce the costs associated with claim pay-outs.

Recommended ADR framework for managing medico-legal claims for South Africa's public health sector

Careful consideration has gone into a framework that can be used to enable early detection of complaints, unfair treatment, and general unhappiness of the users of the South African health system. The framework will strengthen the structures that are already in place within the healthcare sector. It will also support and enable the use of ADR in the sector. The framework was adopted from a study in Singapore[13] that has shown great promise and is easily adaptable for South Africa's local context. A few contextual changes were made for geographical and legislation differences. A diagram of the framework is shown in Figure 3, which can be used to understand the pathway of a medico-legal dispute if the framework is adopted. More details clarifying the operation of the framework are outlined in the section below.

Figure 3: Framework for managing dispute resolution within the South African health sector



Using the framework to guide resolution

Managing complaints

While the South African health system does have regulations on how the complaints process should be made visible for patients, often patients still feel unsure of what to do if they are dissatisfied with the service received.

The purpose of setting up a standardised complaints procedure is to ensure that the patient understands that they are allowed to complain if they receive improper care and the same procedures will apply wherever they receive their healthcare services. It also provides guidance on how to complain, thereby empowering the patient in the process. Well-managed complaints processes can also have the knock-on effect of improving the quality of service delivery, because health professionals feel that they are (fairly) held to account.

A complaints process will assist with securing negotiations earlier on in the medico-legal process between all parties involved, as it provides the facility with an early warning system to intervene. Furthermore, the existence a team that handles complaints would assist with early disclosure, apology and pre-dispute mediation agreements (prelitigation resolution) which will hopefully reduce the escalation of claims to the litigation process. The set-up and monitoring of the complaints procedure can be done in collaboration with, and with support from, the Health Ombudsman.

The Public Relations Services (PRS) unit will receive complaints from multiple sources. The complaint process can be triggered by internal or external sources. For example, if a request for a patient file is made (requested by the patient in terms of Promotion of Access to Information Act (PAIA)[14]), this should be a clear flag that legal recourse is being investigated or contemplated. The team should then acknowledge receipt of the complaint within 1 business day or request for more information and ask any clarifying questions if the complaint is incomplete or unclear. The complaint must be formally lodged, well documented and given a claim number. The unit will need to provide regular feedback on unresolved claims both to their departmental principals and to the complainant. The team will also be responsible for categorising the incidences into three risk types, namely: low, moderate, or extreme. Categorisation will be based on standard guiding principles, possibly devised in collaboration with the Office of the Health Ombudsman (OHO), who already internally classifies complaints received into risk categories.[15]

No legal representation is foreseen to be needed for the resolution process if claims are categorised as low. All primary processes can be achieved, and negotiations may be reached if within standard parameters. Complaints of higher order risk profiles would need to be escalated to other areas for assistance in dispute resolution. One such example could be the provincial dedicated medico-legal units that we discuss in the second brief of the series, entitled dedicated medico-legal units.

Part of the responsibility of the PRS unit is to keep clear documentation of all disputes. Reports will need to be drawn up from these statistics and shared with the provincial medico-legal units, hospital managers and other stakeholders who would need to use such information. There should be a standard guideline of what to do if one

establishment is receiving more claims than average or than expected, to ensure areas requiring more intervention are prioritised to reduce the number of complaints.

Electing a mediation panel for alternative dispute resolution

In the proposed framework, it is suggested that a panel of mediators is made available that is contactable by the provincial medico-legal units (as discussed above). The administrative responsibilities of the set up and election of the mediation panel will lie with the ADR team within the provincial medico-legal units. The State must be willing to mandate its representatives to enter into settlements, which will be formalised by a binding contract at the end of the mediation process.[1]

The composition of the mediation panel is set out below:

- The panel should consist of mediators that are not in the employ of the South African government. Members should be from diverse backgrounds and belong to the following professions: medical doctor, legal professional, caregiver, nurse and actuary. Using medically trained legal practitioners would ensure that judgments are based on sound medical and scientific principles.[3]
- The members should further comprise different ethnicities, genders, and backgrounds and cannot be involved in any medico-legal litigation work during their tenure on the panel.
- There could be one panel per province or if legislation and logistics allow, there could be one panel for the country that would hear cases virtually. This could also assist with mediation standards being aligned across the country as well as a further layer of impartiality, and no prejudice, as the mediator may not have any ties to the community in which the claimant resides, which is more likely if the mediator hails from the same province as the claimant. Panel members should only be able to sit for a specified period of time to ensure.
- In each mediation session, it is suggested that at least three mediators are present from each of the five professional backgrounds highlighted above.
- These professionals should also further be governed by relevant ethical codes to ensure confidentiality and impartiality.
- The process should end with a formalised contract to make it binding and if the complainant accepts the outcome, that they cannot institute other proceedings or take the complaint to another forum.
- Mediators will be paid using a prescribed fee, either hourly or on a per case basis. Costs will be paid for by the State in the hope that the cost of an early mediation will save large litigation costs later in the claims process. [1]

It is vital that procedural fairness is maintained throughout the facilitation of mediation. The following points are to be considered for maintaining procedural fairness:

- **Resourcing the mediation panel**. The staffing of the panel can be done by use of the tender process, whereby a panel of mediators is appointed for a fixed period of time and rotated thereafter (not all at the same time to allow for continuity).
- **Without prejudice**. Mediators should clarify that the mediation process will take place on a without prejudice basis.
- **Legal representation**. Parties may appear with or without legal representation and neither party will be treated differently despite representation.

- **Equal opportunity to be heard**. The mediators should ensure that the patients and plaintiffs are given an opportunity to fully state their position.
- **Documentation**. During this process, it should be ensured that both parties have access to the same documents and data for the purposes of the mediation.
- **Formulation**. It is the role of the mediators to help each party formulate their concerns and needs. Each party needs to devise the factors that are most important to them and which factors can be compromised on. From there, a list of alternative solutions can be drawn up and parties can then choose the option that arrives at the best outcome for all parties involved.
- **Voluntary.** Mediation will be a voluntary process but the option of mediation will be emphasised.
- **Confidentiality.** The mediation will be treated as confidential and this should be clarified by the mediators. No record of the mediation process will be kept, save for agreements reduced to writing. If there is no agreement, the parties may only record for the purposes of complying with Rule 41A that they met, and no agreement could be reached. No party will be allowed to call the mediator later to testify as their witness. The mediator cannot disclose the contents of any side discussions he may have with the other party.
- **Full and Final Settlement.** Any settlement reached during the mediation process will constitute full and final settlement of the dispute between the parties. Once a settlement has been reached, a formal, binding contract complying with the law of contracts will be signed by the parties.[1] The parties cannot get further relief in other forums. A settlement agreement would be sufficient for the purposes of enabling the State to make payment.
- **Avoidance of bad faith.** Guidelines will be provided to identify mediation in bad faith, and this practice will be prohibited. An example of mediation in bad faith would be a mediation merely to gather information on potential defences or to delay proceedings.[1]

There are various places within the claims process where clear guidelines are required, for example:

- To understand where a settlement can be established and if there is in fact liability (i.e., the elements of a delict have been met and the burden of proof met)
- When mediation is suitable
- The tariffs to be paid to mediators
- The responsible party to pay mediators.

These guidelines would need to be devised by the medico-legal units per province, based on historic pay-outs, research and in collaboration with other experts and provinces to ensure standardised quantums are arrived at.

Alternatives and other risk mitigation tools

The framework mentioned above appears fit for purpose and would not mean a complete overhaul of the current procedures and legislation that are in place. There are however, other alternatives that can be thought about in this space and are worth exploring as the complexity of the medico-legal environment increases, which include:

- **The use of insurance in this space, particularly in the public sector**. It could be in the form of insuring medical professionals at a hospital or provincial level in a group annually renewable type of insurance product or a reinsurance arrangement. The cost needs to be weighed up against the benefit of such a contract.
- **Designing the system such that it works similarly to other judicial systems** in South Africa or internationally, such as the small claims court[16] or the Road Accident Fund system. A No-fault system could be explored.
- **Investment into improving systems** especially in the public health sector. Electronic health records can support better quality care and secure patient information and data for decision-making and for accountability purposes.

Conclusion

The use of ADR methods in South Africa is still fairly low; litigation remains the most common choice for medical negligence cases. Litigation remains an important tool, especially for more complicated cases that can help to further shape the law. However, ADR methods should form part of the options provided to claimants. ADR can improve turnaround times and support quicker justice for patients, and a lesser financial burden for the State. Developing an enabling environment for the use of ADR methods is important but is not a silver bullet. ADRs also do not absolve health establishments or health professionals from rendering high quality, dignified care to all.

Appendix 1: Alternative dispute resolution methods

As previously mentioned, there is space for both ADR and litigation in South Africa's medico-legal environment. Complex cases, which cannot be optimally settled with an ADR method or that relate to complex questions of law, should be litigated. The medico-legal landscape in South Africa is still unshaped and under-developed and each case brings more experience and more guidance, contributing to a more just and sustainable medico-legal claims environment.

Notwithstanding the above, ADR is an important tool for cases that do not necessitate full litigation. The sections below discuss each of the most common ADR methods used in South Africa and the requisite advantages of each against each other, and litigation itself.

Negotiation

Negotiation is the most commonly used ADR method.[17] People use negotiation techniques daily to get what they want or to resolve a dispute, whether at home, in the workplace or in a business transaction.

The three most common negotiation techniques are set out below:

- **the positional negotiation** involves parties negotiating from their fixed positions or statements of what they want to get out of the situation[18], through a series of concessions attempting to reach an agreement
- **interest based negotiation** is based firstly on understanding the interests or needs of the parties involved and then negotiating to optimise the satisfaction of their respective interests or needs.[19]
- **principled negotiation** makes use of objective criteria to settle their differences, such as a fair, independent standard or certain negotiation principles. [17,18,20]

Negotiation can be used throughout the life cycle of a medico-legal dispute until resolution has been achieved. It can also be used in conjunction with other ADR methods and even within the litigation process but before judgment is given, if the dispute enters that stage. Negotiation can be used as soon as both parties understand the complete context of the issue and understand their needs to resolve a dispute. They can then negotiate with the other party to arrive at an amicable solution.

Mediation

In mediation proceedings, parties use a neutral independent third party, known as a mediator, to assist them in arriving at an amicable agreement.[21,22] The mediator facilitates discussions between the parties. (S)he helps them identify their issues, clarify their priorities, explore areas of compromises that they are willing to make and eventually generate options in an attempt to resolve the dispute.[22] Mediators do not have the power to impose a settlement in the procedure but are rather seen as a conversational partner in arriving at the solution. Mediation itself is non-binding unless, at the end of the procedure, parties reach a binding contractual agreement.[21] Mediation can either be voluntary or compulsory in terms of legislation for example in terms of the Labour Relations Act No. 66 of 1995, as amended.

There are many different types of mediation techniques, we list just three below:

- **Transformative mediation** where mediators focus on empowering disputants on solving disputes and to consider each other's needs and interests.[23]
- **Evaluative mediation** where instead of focusing on the parties interests, mediators also express their own opinions by making suggestions and recommendations[23]
- **Facilitative mediation**, in contrast to evaluative is the traditional type of mediation whereby the mediator reserves their own opinion and rather focuses on disputants reaching their own voluntary agreement. [23]

The advantages of mediation, in comparison to litigation, are as follows:

- **Confidentiality for all parties involved**. Privacy and confidentiality are two of the central concepts of mediation. Confidentiality exists on two levels. Firstly, mediation is conducted in private, and the contents are only publicised if the parties agree. Secondly, principles of privacy and confidentiality allow parties to communicate with the mediator, without any risk that the mediator may pass information from one party to the next without the consent of the party providing the information. This includes any agreement concluded after a successful mediation. Furthermore, all mediations are conducted on a strictly "without prejudice" basis and, consequently, information that was provided during the mediation proceedings may not be used against a party in subsequent court proceedings;
- **Cost saving** and reduced settlement values;
- **Time saving;**
- **Preservation of relationships**, which is particularly important in a patient-health professional relationship in case the patient needs to re-use the services of the healthcare practitioner or the health establishment in question;
- Creation of **creative solutions** that best suits the needs of both parties, such as agreeing to post mediation monitoring where the mediator ensures that the parties are abiding to the agreement once finalised e.g., payments are being made, the patient/plaintiff is being given access to the resources agreed to;
- **Informal and therefore flexible procedure.**

The disadvantages of mediation in general and in comparison to litigation are:

- Mediation cannot be made compulsory,
- Mediation is non-binding and not reported on,
- Mediation does not aid reform or development of the common law which is what is desperately required in this field of delict.

Mediation in terms of the Uniform Rules of Court

Uniform Rule of the court 41A was formulated by the Rules Board to address backlogs in the finalisation of court cases in the High Court because of congested court rolls. The Rule is intended to incorporate an effective, less adversarial resolution mechanism, that litigating parties must consider to resolve their disputes.

Sub rule (2)(a) compels a plaintiff to file a prescribed Rule41A Notice of agreeing or opposing mediation. And sub rule (2)(b) compels the defendant to file a prescribed Rule 41A Notice of agreeing or opposing mediation, *before* a plea or opposing papers are issued. The above notices according to sub rule (2)(c) must be substantially

in accordance with Form 27 of the First Schedule. According to sub rule (2)(d) the said notices will be without prejudice and not filed with the Registrar. In other words, they do not become part of the court file and are only produced when the issue of costs is determined once a ruling has been made. If one or both parties decide to oppose mediation, a clear and concise reason needs to be indicated in their sub rule (2) notices explaining why the case is not capable of being mediated.

Uniform Rule 41A does not regulate the mediation process, which is conducted outside the court system. The Rule requires parties to consider mediation and regulates the referral of the matter to mediation and the further conduct and course of the litigation if mediation is agreed to by the parties. Mediators as in terms of Uniform Rule 41A can be chosen by the parties from any source.

Mediation has been almost invariably used thus far within the medico-legal space, if ARD methods are suggested by legal counsel or sought after by claimants.

Research suggests that, in a healthcare environment, considering the complex yet delicate nature of healthcare disputes where professionals' reputations are at risk, as well as patients having the need to see the healthcare practitioner again for future healthcare episodes, mediation may provide a good alternative to litigation and lead to productive outcomes. [24]

Mpumalanga successfully reduced its medico-legal claims costs by approximately R270 million through the use of mediation by a specialised team based inside the PDoH.[3]

Arbitration

Arbitration is the most regulated form of ADR methods and involves the final determination of a dispute by an independent third party.[25] In comparison to the other types of ADR methods, arbitration is closer to court proceedings.[25] The involved parties lose control of the outcome of the dispute resolution process and the decision is final and cannot be relitigated.[25] The advantage of using arbitration however is that the dispute is resolved, and the determination is binding and enforceable. [11] The other advantages in comparison to litigation are aligned with other ADR methods, namely: it is quicker than litigation, cheaper, the process is private and the parties have more autonomy over the process in comparison to litigation (but less in comparison to other ADR methods).[26]

Differences between arbitration and mediation

The list below sets out the main differences between mediation and arbitration:

- **Process.** Mediation is based on a facilitated negotiation. Whereas, in arbitration proceedings the arbitrator hears the parties and gives their decision on the dispute in the same way that a judge would.
- **Formality.** The rules of mediation are far more informal and flexible than those of arbitration. In mediation, the parties have greater control over the rules and may for example agree that the mediator may talk separately to the parties. In arbitrations, the arbitration procedure and award is formal and governed by legislation, rules and case law. Arbitration is facilitated by an arbitration institution under its own rules.

- **Expert and panel composition** required to conduct ADR:
  - There are no legal restrictions on the number of mediators required. It is possible to have an odd or even number of mediators. There may only be an even number of arbitrators.
  - Arbitrators tend to be more expensive as they are generally retired judges or senior advocates or practising attorneys. They are usually appointed to deal with high value, complex commercial matters.
  - The Arbitration Foundation of South Africa has predetermined rules on how arbitrations are to be conducted depending on the type of matter.[27]

Arbitration could be used initially, or used as a second step after a mediation process has failed to result in a satisfactory resolution and negotiation or a more formal process is required by the parties involved.

Ombudsman

The referral of a dispute to an Ombudsman is another form of ADR. An ombudsman is an independent person who acts as a watchdog against the abuse of power and to which an unresolved dispute can be complained about. The office of an ombudsman can be established by legislation and is usually an industry-based organisation. Their role can be to determine dispute resolution or to merely facilitate the process of arriving at a resolution.

The South African Office of the Health Ombudsman (OHO) was established in 2016. The OHO is an independent body established in terms of the National Health Amendment Act of 2013. The main reason for its existence is to protect and promote the health and safety of users of health services in South Africa, of both the private and public sector. The OHO deals with complaints submitted if subpar services were received in the health sector and seeks to resolve these issues together with the parties involved.[15]

From the 2021/2022 annual report of the OHO, it is noticeable that complaints have been increasing since inception of the office. For the most recent period, 83% of disputes were resolved within the 25-day prescribed time. Most complaints (92.4%) for 2021/2022 were made via email which suggests that complaints are mainly coming in from the section of the population who are literate and who have access to technology. Nearly 99% of complaints received were classified as low risk and had the potential of being able to be resolved by the health establishments complained against. Call center complaints officers facilitated the resolution of complaints by contacting the health establishments in question and staging a mediation between the parties until a satisfactory resolution was achieved. The OHO has the capacity to take a more complex role within the dispute resolution sphere, but this is not yet being used by the public.[15]

Currently, the only standard with respect to complaints made at the health establishment is the number of days it should be resolved within. There are no standards in terms of how complaints should be resolved, or by whom. Once such a process is in place within all health establishments, the ombudsman could play a secondary role, where complaints are escalated to the Ombudsman if no resolution is found within the complaints procedure of the health establishment. The

ombudsman could do audits or request periodic reports to ensure that the standard is adhered to, currently performance on complaints procedures for the public sector are self-reported on in annual performance plans of departments of health.

International models of ADR

Medical malpractice lawsuits are on the rise globally.[9,10] Some countries however have more developed legislation within the medico-legal space. The World Health Organization (WHO) did a rapid review of various medical malpractice dispute resolution models in various countries such as USA, UK, Canada, Japan and Denmark. The authors then chose the models, which in their opinion, provided the best results for medico-legal cases, such as decreased litigation costs and reduced settlement amounts. The models selected were:

- the no-fault approach;
- safety program and practice guidelines (using best practices to reduce and mitigate unsafe acts within the healthcare system);
- specialised health courts as an alternative to judicial courts for alternative medico-legal claim resolution;
- communication and resolution between patient and medical practitioner outside the court room;
- caps on compensation and attorney fees (limitations to punitive damages),
- alternative payment system and liabilities;
- limitations on litigation (reduction on the amount and type of claims that enter the system); and,
- multi-component models (a combination of the above models).[28]

We deal with the concepts of 'no fault', claim caps, alternative payment models in the following briefs associated with this ASSA work on medico-legal claims in South Africa.

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