POLICY BRIEF 2

Dedicated medico-legal units for better management of claims Policy paper for ASSA

August 2023

By Dr Jodi Wishnia, Dr Anke Nitzsche, Dr Mawadda Cassiem-Majal, Suhavna Khalawan and Adv Anele Ngidi

The authors all have experience in research or working within the medico-legal environment. JW, SK and Adv AN's work are affiliated with Percept, a transdisciplinary collective that aims to provide high quality research and analysis for some of the world's most pressing problems. Dr AN and Dr MCM work in the Western Cape's dedicated medico-legal unit.

Table of Contents

List of Figures

Terminology and Abbreviations

MML	Medical Malpractice Litigation
ADR	Alternative Dispute Resolution
DR	Dispute Resolution
NDoH	National Department of Health
PDoH	Provincial Department of Health

Foreword

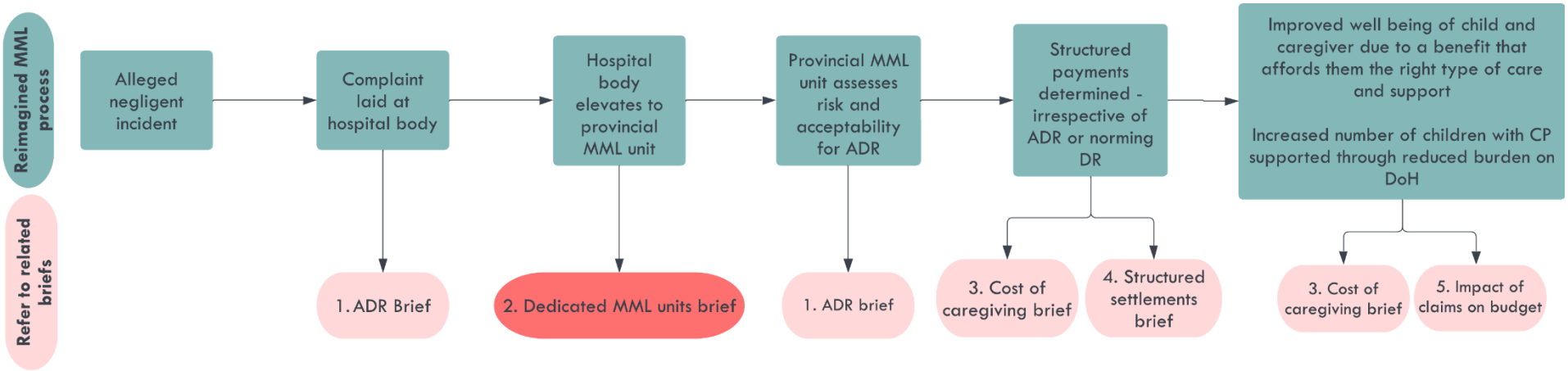
The Public Interest function was created by the Actuarial Society of South Africa (ASSA) to enable the organisation to pro-actively participate in public policy discussions. ASSA seeks to inform debate on matters of public interest in South Africa, especially when it is deemed that actuarial expertise 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. The figure below illustrates our reimagining of this space, based on the research and content of the policy briefs in this series.

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 second brief in the series and discusses the reimagining of dedicated medicolegal units to be set up in PDoHs to better support claims management. For contextual purposes, the Alternative Dispute Resolution teams mentioned in policy brief 1 will be separate teams located within each provincial dedicated medicolegal unit, responsible for alternative dispute resolution only.

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

Medico-legal claims against South Africa's public health sector are soaring. Minister of Health, Joe Phaahla, reported that in 2018/2019, the country paid out nearly R2 billion in claims, putting significant strain on an already stretched public health system. The crisis of medical negligence litigation signals a number of urgent imperatives. These include:

- the immediate need to improve the standard of care;
- the need to justly distinguish valid from invalid claims, and bolster mediation; and,
- the need to establish a system of compensation that balances the need for fair compensation with the broader goals of equitable resource allocation.

Ultimately, if we do not find evidence-based, people-centred, ways to manage medico-legal claims, we will enter a vicious cycle in which both public health budgets and quality of healthcare delivery are depleted. The SALRC published its report in November 2021, and one of its recommendations was for the public health sector to consider setting up ***dedicated medico-legal units to support better management of claims***.

The research and policy brief contained herein follow this work and investigates the SALRC recommendation to establish dedicated medico-legal units. This policy brief provides a short summary on how medico-legal claims are treated globally and in South Africa, for context. It then goes on to describe a practical and implementable approach to setting up a dedicated medico-legal unit for South Africa's context.

This policy paper sets out a best practice way of establishing these units with the explicit aim of improving outcomes for patients and Provincial Departments of Health (PDoHs). Best practice has been considered by analysing the risks and inefficiencies from underperforming departments and taking key learnings from well-performing departments. The Western Cape's model is a key source of evidence from which to base this national policy recommendation as well as a review of the literature and the findings from the ASSA 2021 report mentioned above.[1,3] Unfortunately, efforts to engage with the KwaZulu-Natal medico-legal claim specialists were unsuccessful.

Management of medico-legal claims globally

Poor quality of medical care in a healthcare setting, for whatever reason including lack of resources, understaffing or inexperienced staff, can result in high levels of mortality (death) and morbidity (disability)[4] and can expose health authorities to the risk of litigation. There are two types of medical negligence: discrete negligence and systemic negligence. Discrete medical negligence is commonly understood as actions, or inactions, by a healthcare worker that resulted in a patient safety incident (PSI). Systemic negligence takes into account the systemic challenges in health systems (for example, staffing shortages and inadequate medical equipment) that can coalesce to result in a PSI.[5,6]

A certain level of discrete negligence is inevitable in a health system given the reliance on human resources, but this can be tempered by strong clinical governance systems that support clinicians and health staff in rendering their duties according to best practices.[7] However, where the clinical governance systems are suboptimal, the combination of

discrete and systemic negligence puts patients at risk of negative outcomes and can leave a health system vulnerable to an unmanageable level of medico-legal claims.

Most countries use one of two main systems for medical negligence claims, namely the no-fault system and the fault-based system. The no-fault system or strict liability is where an injured person is compensated without having to prove negligence through the court system. The quantum of payments in a no-fault system are regulated, making them more predictable, which allows the government to control the costs better.[8,9] Most importantly, it makes the process of claiming easier, with no associated legal fees.[10] The fault-based system is where patients need to prove negligence, which is done through the courts, with a heavy reliance on lawyers and subsequent legal fees for the claimants.

In many high-income countries (HICs), a more empowered patient population, who are aware of their rights to quality care, combined with weak regulation for managing malpractice claims, led to a substantially higher number, and quantum, of medical negligence claims (for example in Australia and the United Kingdom).[11,12] This led to a shift to a no-fault system for dealing with claims in some countries, or the establishment of payment 'ceilings' to control costs if the fault-based legal system remained.[10,13,14] The USA is one of the few HICs that has not shifted its medico-legal environment to a less costly approach and is still experiencing high medico-legal claims (in number and quantum of claim).

However, in most lower and middle-income countries (LMICs), negligence claims go through the fault-based legal system with no payment ceilings, and claims have continued to grow over the past decade (for example South Africa, Malaysia, India, Bangladesh and Nigeria).[2,14–16] If the litigation is directed at public health departments (rather than individuals), already constrained health budgets can come under pressure, and the resources available to make the required improvements in the quality of care are reduced. Countries with active legal industries (more common in middle-income countries than low-income countries) that have become aware of the vulnerability of health departments to litigation, are more likely to experience a growing number of claims.

As more and more countries commit to achieve universal health coverage (UHC), available public health funds need to be directed as far as possible to service delivery. Rising medico-legal claims compete with efforts to achieve this goal. Therefore, it is critical that countries still operating within a fault-based legal system urgently amend the legislation to protect healthcare funds for the public good.

Management of medico-legal claims in South Africa

South Africa, a middle-income country, is attempting to improve quality of care in the public health sector[17] despite a narrowing fiscal envelope.[18] Improvement of quality is the most important step to reducing claims, however, the governance of the claims process can also support PDoHs to better defend themselves; mediate and settle claims out of court; or decline to engage on claims outright due to insufficient evidence being brought forward by the claimant's legal representative. Therefore, the management of claims is a crucial

step in South Africa's plan to turn around its rising medico-legal claims and should happen in tandem with quality improvement efforts at the 'coalface' of service delivery.

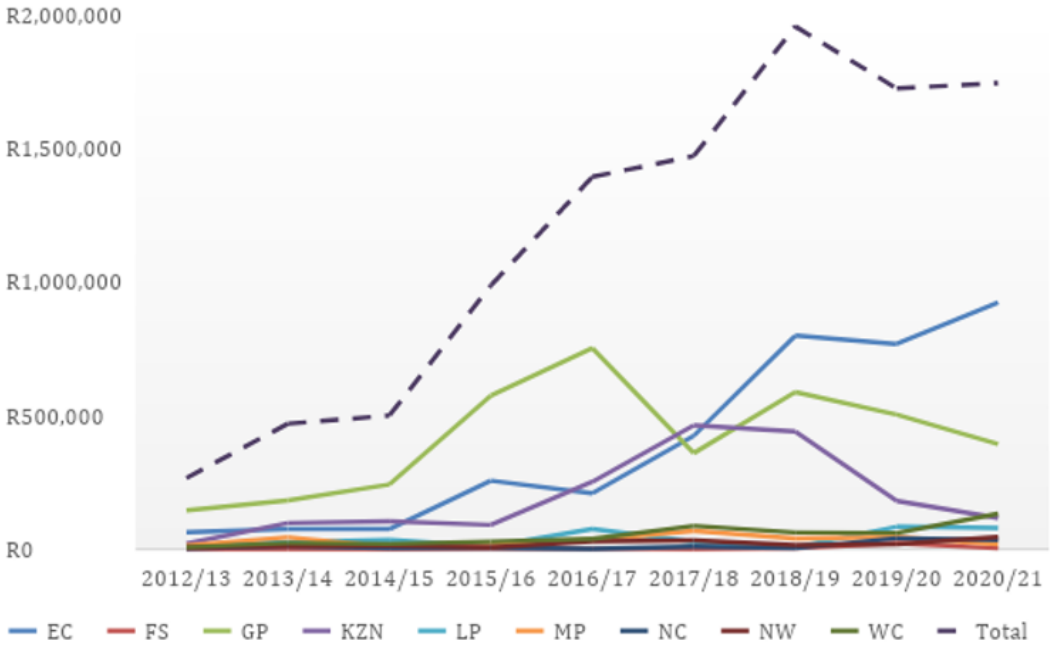
As previously mentioned, South Africa uses a fault-based system.[2] In the public health sector, claims are levelled at the Member of the Executive Council (MEC) of a PDoH and are paid from the PDoH's budget. As such, individual clinicians are not required to have personal medical malpractice insurance when working in the public sector. In the South African private sector, individual clinicians are litigated against and this has resulted in a large medical malpractice insurance industry with medical negligence insurance premiums growing so large that many of the targeted clinicians (for example obstetricians/gynaecologists and neurosurgeons) cite the premiums as the reason they no longer practice or practice 'defensive' medicine.[19,20] While both sectors need reform, this policy brief focuses on the public health medico-legal environment, wherein claims are paid from the available health budget and there is no available insurance mechanism to bear the brunt of these large pay outs.

Large variation between provinces over time, as well as between definitions used, do not hide the fact that the number and value of claims has increased exponentially throughout South Africa. Definitional differences arise from process-related differences between the provinces. For example, contingent liabilities can include summons-only cases, or notices as well. The SALRC 2021 report shows contingent liabilities for medico-legal claims to have reached R120 billion in 2020/2021, with an actual pay out of R1.7 billion (~1.5% of total contingent liabilities) in that same year, but the data on which this is based may differ between provinces.

Contingent liabilities are claims that have been made against the PDoH and therefore are potential liabilities, which have not yet been settled. The total contingent liability is always higher than the actual amount due after settlement. There are various reasons for this, such as, some of the claims may be without merit or the estimated cost is in accurate due to duplication in expert reports. This is partly driven by the 'no win, no fee' strategy introduced by the legal industry which both supports case-finding and removes financial barriers to litigation.[2] Once settled, these convert to liabilities in the public financial management environment. The detail of these liabilities is not published by the PDoHs and the amount paid each year is more often a function of the PDoH's available cashflow, rather than what is due. This makes it difficult to understand the true impact of claims on the health system for current and future years.

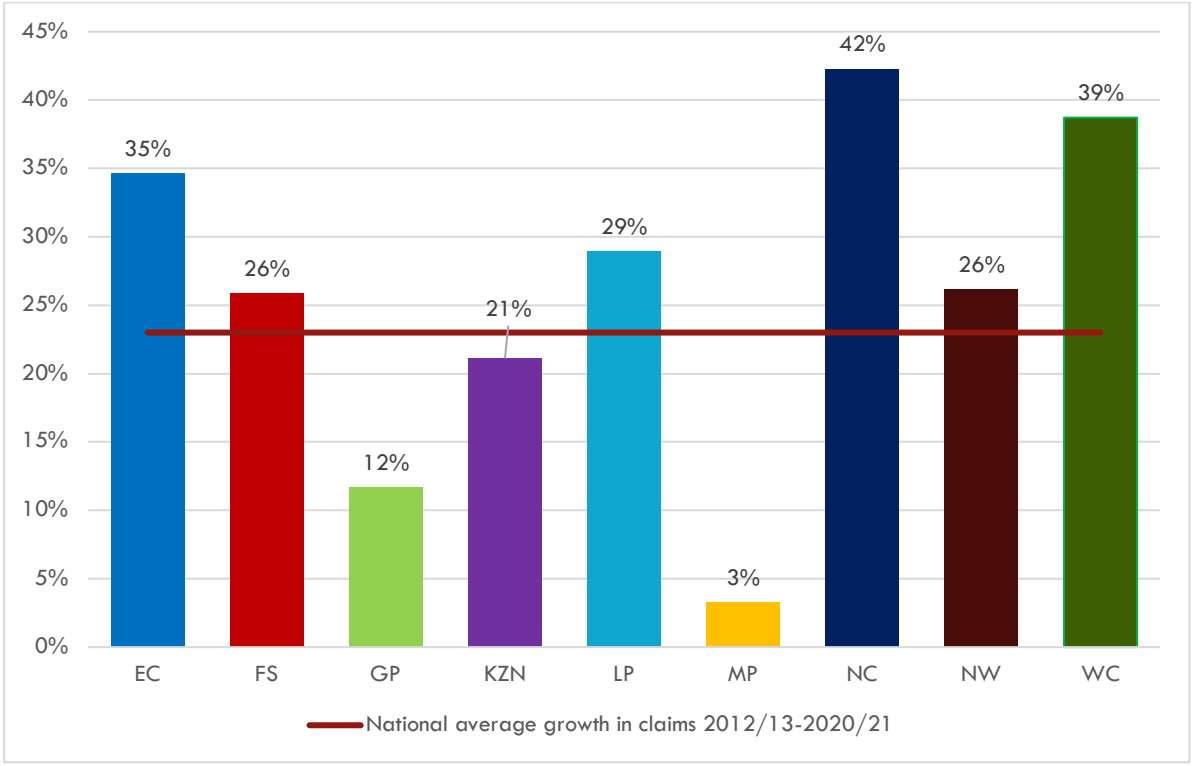
Figure 2 shows the nine-year actual claim pay outs, by province, for the period 2012/2013-2020/2021, while Figure 3 shows the annualised growth rate over the same period.[1,21] All provinces except Gauteng (GP), KwaZulu-Natal (KZN) and Mpumalanga (MP) breach the national average claims growth rate of 23%, but this should be interpreted with caution given the definitional discrepancies described above.

Figure 2: Nine-year claims payment history (R'000), by province [1]



Data source: South African Law Reform Commission (2021)

Figure 3: Annualised percentage growth in the number of claims litigated in the period 2012/2013-2020/2021



Data source: South African Law Reform Commission (2021) and Whittaker, G. (2021)*

* The growth rates were recalculated by Percept as the cited rates in the SALRC 2021 report were incorrectly calculated.

It is important to also understand the number of claims being paid each year to evaluate the financial impact per claim, on a provincial basis (increased growth could be due to an increase in number of claims or in quantum of claim amount). The latest comprehensive data showing average claim size, by province, is available for the financial year 2018/2019. The Eastern Cape (EC) shows the highest average claim size by far at R9.1 million and MP and Free State (FS) the lowest at R1.4 million respectively.[21] This reflects the lack of standardisation and/or payment ceilings in claim pay outs, which creates a vulnerability particularly for provinces with weaker governance systems. It could also be a reflection of more severe cases in some provinces, but this information is not available.

Budgeting for claims

To date, there has been a common misconception by PDoHs that they are not allowed to budget for medico-legal claims because they are deemed 'fruitless and wasteful' expenditure in terms of the Public Finance Management Act and by the Auditor-General. The logic of this is that the definition of wasteful expenditure includes losses that are caused by the failure to apply reasonable care. As such, most PDoHs pay claims from their already allocated health budget, placing planned service delivery at risk as the available budget shrinks in-year.

However, the latest SALRC report has confirmed with National Treasury and the Auditor-General: South Africa that this is not necessary and in fact **PDoHs can budget for claims to better protect service delivery funding** during the year.[1] As a result, the reduction of service delivery funding that often happens currently to make cash available for claim pay outs is unnecessary and creates a vicious cycle of claims, which reduce service delivery funding which then subsequently reduces quality, making the system vulnerable to patient safety incidents.

A 2022 judgment arising from the Makhanda High Court clearly articulated that the misconception that claims cannot be budgeted for is incorrect and in fact, a failure to budget for known liabilities constitutes financial mismanagement.[22] This judgment may provide closure at last on this issue and support the budgeting of medico-legal claims across the country.

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

The recommendations in this section are based off the Western Cape's dedicated medico-legal unit, existing material in the public domain and a review of the information in the SALRC report. The intention is to clearly map out a recommended structure for these units such that other provinces might be able to replicate this. The Western Cape has the capability to calculate provisional payments and manage these risks because of its dedicated medico-legal unit team.

Error! Reference source not found. illustrates the claims paid against the contingent liabilities. As mentioned above, contingent liabilities are treated differently across provinces and as such these figures may not be comparable on a like-for-like basis. They are, however, the

only available data currently.

Table 1: Total claims paid and contingency liabilities per province: 2020/2021

Province	Total Claims Paid (R'000)	Contingent Liabilities (R'000)	% Share of total contingent liabilities	Total claims paid as a proportion of claims paid plus contingent liabilities
EC	R920 981	R38 842 976	32%	2%
FS	R3 484	R4 525 725	4%	0%
GP	R392 126	R21 710 437	18%	2%
KZN	R115 933	R26 417 906	22%	0%
LP	R79 233	R11 939 335	10%	1%
MP	R18 632	R 9 543 268	8%	0%
NC	R 34 327	R1 689 178	1%	2%
NW	R44 479	R5 582 950	5%	1%
WC	R131 729	R80 400	0%	62%
Total	**R1 740 924**	**R120 332 175**	**100%**	**1%**

Albeit difficult to compare, it is evident from Table 1, that the Western Cape has a higher Total claims paid proportion (62%) and lower contingent liabilities (R80 400) in comparison to the other provinces. It is envisaged that the existence of the medico-legal unit in the Western Cape strengthens the province's legal system which leads to such results. The lower contingent liabilities reflect that the province receives few claims without merit as the ones that are submitted tend to be with merit therefore allowing the Western Cape to settle.

Purpose of a dedicated unit

The dedicated unit should be set up such that **all medico-legal claims for the province go through the unit.** The value add of this approach is that the unit's team start to become claims experts in this space. The idea is to build institutional knowledge and expertise around the types of claims that come in, previous settlements, and building of relationships across the health, legal and patient environments to support sustainable and just pay outs, where appropriate. A uniform application of decision-making principles would lead to coherent calculations of provisional liabilities. The main purpose of the unit is therefore to ensure where the health system has been negligent, injured parties are offered a just settlement that is grounded in best clinical practice and is financially sustainable for the province. The provincial treasury and auditor-general have been satisfied with the WC's set up thus far and have agreed to allow them a three-year budgeting timeframe, which allows for better planning.

Critical to the unit's success is the ability to build trust. The team needs to develop trust between co-workers and management, as well as trust that the main purpose of the unit is to deliver a just settlement to both the injured party and the province. Trust relates to the belief that someone (particularly someone with more power than you) will ensure that your best interests are seen to.[23] Trust is important for health systems because they are by their nature multi-dimensional, complex and interrelated and require engagement across many different areas and levels.[24] The body of research that focusses on the 'software' within a

health system (values, norms and relationships), gives us evidence of the role of trust in a system and suggests that trust is a key determinant for high performing teams.[25]

The medico-legal space epitomises the complexity and inter-relatedness of health systems. Some of the stakeholders involved include: the patient; the provider; the health facility; the district or provincial head office; lawyers; medical experts and actuaries. Ultimately, for PDoHs to improve quality and reduce claims, they are hugely reliant on trusting and productive relationships between all these stakeholders.

Lastly, medico-legal claims in South Africa are generally very litigious and there are "structural incentives" that drive up quantum and the legal costs/fees, such as the practice by plaintiffs and defendants to set up teams of experts against each other, and contingency fees charged by plaintiffs' attorneys. Law reform is needed to compel parties to share and disclose information sooner and to cooperate to resolve matters in a timely manner. The establishment of these dedicated units may help propel this reform forward by the units requesting information in a more organised and structured manner.

Funding of the unit and claims

The unit needs to have a budget attached to it both for its organisational structure and for the payment of claims. This will reduce the reliance on service delivery funding and help the PDoH to be able to pay claims out more timeously. The recommendation is that the unit is funded from budget programme 1 (Administration)† because the MEC's office budget falls into this programme. As mentioned, claims are directed at the MEC and so there is some logic in housing this unit and claims budget in the same place.

There is sufficient data for PDoHs to recommend a starting budget that will at least cover overdue payments from previous years. In time, as these overdue payments are settled, the unit could work towards paying current claims due and reducing expenditure on interest. The other benefit of a dedicated budget is to remove the risk of 'unauthorised expenditure' which currently happens when claims have to be paid out but there is insufficient budget and as such accruals are created to make these payments. This is in breach of the Public Finance Management Act and places the accounting officer in breach of their duties in terms of the Act.

Responsibility and authority of the unit

By providing the unit with a dedicated budget, the unit is set up with delegations to spend and authorise decisions. This is crucial to the unit's success. For all claims that arrive at the unit, the team can decide to either attempt to settle or mediate the claim or go to court.

The uniform rules of court require parties to indicate why the matter cannot be mediated when they institute legal proceedings. This requirement was put in place to try and encourage parties to first mediate before approaching a court. The fact that a Department

† PDoHs are made up of eight budget programmes, each dealing with a different level or aspect of health care delivery.

of Health attempted to settle/mediate (with prejudice) would likely limit the extent of the costs awarded to the plaintiff/patient if successful. The mediation must be done by a separate third party, which will incur cost, but this cost is far less than the associated costs of going to court.

Mediation has been shown to be an effective method for managing medico-legal claims, and can coexist in a fault-based system without requiring legal reform.[26] Mediation can reduce the quantum of the claim, through trust-building between claimants and the clinicians, and the exclusion of the courts and their associated legal fees.[26,27] Mediation is successfully used in many high-income countries and its use or the exploration of its use has also grown in middle-income countries such as Malaysia[27] and Nigeria[28] as well, as they grapple with rising claims within a fault-based system. To successfully mediate, the unit's team must be able to offer compensation requisite to the injury and have clear reporting lines to do so without wasting excessive time on a long bureaucratic authorisation process.

The Public Finance Management Act (PFMA) and internal policies for any State entity require that expenditure that falls within certain financial brackets be authorised by more than one person - depending on the amount at varying degrees. The same principle applies to the Road Accident Fund (RAF) when settling claims or even when there is a court order directing RAF to pay out - depending on the amount, the RAF still must follow the PFMA authorisation process for the funds above a certain level. This is an integral internal 'checks and balances' system that aims to prevent abuse of processes and corruption.

Part of the value of mediation for the injured party is the speed with which compensation is made (the courts can often take months or years to conclude depending on the complexity of the case). The principles of mediation are practiced in settlement negotiations, which can occur at various stages from pre-summons, when summons is served (in which case the plea is held in abeyance whilst investigation or expert advice is underway), or after an expert report is received from the plaintiff. An agreed approach to settlement principles is important – for example, in cases when a precedent needs to be set, when the legal costs outweigh the claim, or if the judge is sympathetic to the plaintiff. While upholding the PFMA regulations, it is imperative that the unit's authorisation process be streamlined as far as possible.

For claims that go to court, the unit is then responsible for gathering the evidence and preparing the PDoH for the case. Much has been written about the role of electronic health records in safeguarding a health system from nefarious claims. Most South African PDoH's do not yet have this in place and as such early retrieval of medical records from health facilities becomes crucial to defending the State. The unit should therefore have strong relationships with all health facilities in the province to support this documentation being shared- this is another area where trust is paramount. Facilities and providers will only feel comfortable to share this information if they believe that the unit is not looking to 'punish' them. Where facilities run 'morbidity and mortality' (M&M) meetings‡, it is recommended that the documentation and findings are shared with the medico-legal unit as a preventative measure should a claim arise from these M&M cases. Since many patients start

‡ M&Ms are a clinical governance tool used to learn from incidents where patient outcomes were worse than anticipated. Most medico-legal claims arise from injuries rather than death and as such, a focus on morbidity cases would likely support a PDoH with the necessary documentation and early warning system to better identify potential cases and intervene before notice of a claim.

off with a request for information in terms of the Promotion of Access to Information Act (PAIA) so that they are able to formulate their summons, this unit should have sight of these requests for information as that is where the claims begin.

Staffing the unit

The head of the unit needs to be someone with exceptional people skills who can build trusting relationships across multiple stakeholders. It is helpful if this person also has a clinical background, but clinical advisors can be used to support the head for clinical decision-making. The head should be hands-on and technically competent to be able to engage at a high level with all stakeholders. Someone with a background in the health sector is critical.

Under the head of the unit, we recommend a cadre of clinical advisors who are clinicians and allied health professionals. Allied health professionals in particular are valuable given their knowledge of disability and rehabilitation requirements. This gives them insight to advise on the quantum of settlements. Nursing professionals are familiar with the structure of a patient file and would be able to interrogate and interpret records, and understand when the correct information is complete in the file or needs to be requested. The number of these should be dependent on the number of claims dealt with annually but the minimum would be a clinician and one allied health professional (occupational/physio/speech therapist). While clinicians cannot form part of the defence team, they are very useful as part of the dedicated unit.

A legal professional with experience working with medico-legal cases should also form part of the unit and provide support by appraising the legal documentation and providing feedback on the legal merits of the claim. The legal professional/s is critical as they would be an important resource for the State Attorney in getting the matter trial ready. This in-house capacity will provide the PDoH with the technical capacity to review claims from a legal standpoint. Most provinces are reliant on the State Attorney's (SA) office for that function currently which has not historically worked well given (a) time pressure, (b) the fact that these offices are already burdened with large workloads in other areas and (c) the distance between PDoH and the SA office.

The unit should also have administrative assistance to support with the large paperwork load inherent in the legal environment. It is also recommended that all claims, irrespective of outcome, are captured electronically in a searchable format such that the province can begin to build a claims database to better manage and monitor claims. In time, this database would allow the staff to search particular categories and types of claims, easily view past settlements and generate fair estimations based on evidence. This electronic system would also protect the PDoH from nefarious or fraudulent claims, where it would be easy for the system to pick up if the details were similar to a previous case, which many provinces report as a common problem. Lastly, this system would also allow the unit to run more efficiently, reducing the manual labour involved in comparing and benchmarking cases and reduce the unit's reliance on institutional memory of the staff.

Conclusion

The recommendations for the set-up of provincial dedicated medico-legal units do not differ materially from the current medico-legal unit within the Western Cape, who have done well to manage their medico-legal claims. Additions and elevations have been suggested based on research done from existing material in the public domain and a review of the information in the SALRC report. Although these suggestions may mean a substantial cost in setting up a new unit, it should result in a streamlined process which would prevent cases from slipping through the cracks and is protective from corruption. It would also require electronic systems to manage paperwork load and the number of claims, however, the PDoH would become capacitated to better manage claims and defend itself. Lastly, the unit will still need to go through the usual PFMA checks and balances which could slow down decision-making. However, opportunities for mediation and settlement outside of court are increased due to early detection and management.

References

1. South African Law Reform Commission. Project 141: Medico-legal claims [Internet]. 2021 [cited 2022 Aug 30]. Available from: https://www.justice.gov.za/salrc/dpapers/dp154-prj141-Medico-Legal-Claims.pdf

2. South African Law Reform Commission. Project 141: Medico-legal claims [Internet]. 2017 [cited 2022 Sep 10]. Available from: https://www.justice.gov.za/salrc/ipapers/ip33_prj141_Medico-legal.pdf

3. Actuarial Society of South Africa. SUBMISSION ON: THE SOUTH AFRICAN LAW REFORM COMMISSION DISCUSSION PAPER 154 PROJECT 141 MEDICO-LEGAL CLAIMS. South Africa: Actuarial Society of South Africa; 2022.

4. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health 2018;6(11):e1196–252.

5. Chakraborti C. Systemic Negligence: Why It Is Morally Important for Developing World Bioethics. Dev World Bioeth 2015;15(3):208–13.

6. Jhaveri S. Constructing a Framework for Assessing Public Authority Liability in Negligence: The Role of Public Law Norms, Private Law Norms and Policy Arguments [Internet]. 2011 [cited 2023 Feb 9];Available from: https://papers.ssrn.com/abstract=1829743

7. Reason, J. Human error: models and management. British Medical Journal 2000;320(7237):768–70.

8. Farrell, Ann-Marie, Devaney, Sarah, Dar, Amber. No-Fault Compensation Schemes for Medical Injury: A Review. SSRN [Internet] 2010 [cited 2022 Sep 6];(January). Available from: Farrell, Anne-Maree and Devaney, Sarah and Dar, Amber, No-Fault Compensation Schemes for Medical Injury: A Review (January 20, 2010). Available at SSRN: https://ssrn.com/abstract=2221836 or http://dx.doi.org/10.2139/ssrn.2221836

9. Devaiah, Vishwas H., Rai, Shivkrit. The need for healthcare reforms: is no-fault liability the solution to medical malpractice? Asian Bioethics Review 2019;11(1):81–93.

10. World Bank. Medical malpractice systems around the globe : examples from the US - tort liability systemand the Sweden - no fault system [Internet]. Washington, DC; 2017 [cited 2023 Feb 9]. Available from: https://documents.worldbank.org/en/publication/documents-reports/documentdetail/797831486996063182/medical-malpractice-systems-around-the-globe-examples-from-the-us-tort-liability-systemand-the-sweden-no-fault-system

11. Zinn C. Australian government tries to solve doctors' indemnity crisis. BMJ 2003;327(7406):72.

12. Bibb G. How the crisis unfolded [Internet]. Australian Medical Association (NSW)2017 [cited 2022 Sep 6];Available from: https://www.amansw.com.au/how-the-crisis-unfolded/

13. Cardoso R, Zarin W, Nincic V, Barber SL, Gulmezoglu AM, Wilson C, et al. Evaluative reports on medical malpractice policies in obstetrics: a rapid scoping review. Syst Rev

2017;6(1):181.

14. Saha K, Shetty D. Are large compensation payouts for negligence good for medicine in India? BMJ 2014;349:g5229.

15. Kassim,Puteri Nemie Jahn, Najid, Khadijah Mohd. Medical Negligence Disputes in Malaysia: Resolving through Hazards of Litigation or through Community Responsibilities? International Journal of Humanities and Social Sciences [Internet] 2013 [cited 2023 Feb 9];7(6). Available from: https://zenodo.org/record/1330463#.Y-SxMXZBy5c

16. Iyioha I. Medical Negligence and the Nigerian National Health Insurance Scheme: Civil Liability, No-Fault or a Hybrid Model? African J Intl & Comparative Law 2010;18(1):46–77.

17. South African Lancet National Commission. Confronting the right to ethical and accountable quality health care in South Africa: A consensus report [Internet]. Pretoria: National Department of Health; 2019 [cited 2022 Sep 6]. Available from: https://bhekisisa.org/wp-content/uploads/2019/07/620a9eb9-final-sa-lnc-report.pdf

18. Blecher M, Kollipara A, Maharaj Y, Mansvelder A, Dav én J, Gaarekwe O. Health spending at a time of low economic growth and fiscal constraint. South African Health Review 2017;2017(1):25–39.

19. Taylor B, Waart J van, Ranchod S, Taylor A. Medicolegal storm threatening maternal and child healthcare services. South African Medical Journal 2018;108(3):149–50.

20. Roytowski D, Smith TR, Fieggen AG, Taylor A. Impressions of defensive medical practice and medical litigation among South African neurosurgeons. South African Medical Journal 2014;104(11):736–8.

21. Whittaker, Gregory. Medical Malpractice in the South African Public Sector [Internet]. Actuarial Society of South Africa; 2021 [cited 2022 Oct 10]. Available from: https://www.actuarialsociety.org.za/convention/wp-content/uploads/2021/09/Gregory-Whittaker-MedicalMalpracticeInTheSouthAfricanPublicSector-FullReport.pdf

22. THE HIGH COURT OF SOUTH AFRICA, EASTERN CAPE DIVISION, MAKHANDA. Case No: 2091/2021. 2022;

23. Hall M, Dugan E, Zheng B, Mishra A. Trust in physicians and medical institutions: what is it, can it be measured, and does it matter? The Milbank quarterly [Internet] 2001 [cited 2023 Feb 9];79(4). Available from: https://pubmed.ncbi.nlm.nih.gov/11789119/

24. Gilson L. Trust in health care: theoretical perspectives and research needs. J Health Organ Manag 2006;20(5):359–75.

25. Aragon TJ, Garcia BA. We will be the best at getting better! An introduction to population health lean. 2017 [cited 2023 Feb 9];Available from: https://escholarship.org/uc/item/825430qn

26. Claassen N. Mediation as an alternative solution to medical malpractice court claims. South African Journal of Bioethics and Law 2016;9(1):7.

27. Khan HA, Bastiampillai A, Mon SW. Mediation as a Suitable Dispute Resolution Method in Medical Negligence Cases: Special Reference to the Malaysian Position. Social sciences & humanities 2020;28(3):2309–23.

28. Ehikhamenor E, Obani P, Azodo C. Application of Alternative Dispute Resolution (ADR) in trauma care in a Nigerian tertiary hospital. International Journal of Medicine and Biomedical Research 2017;6:74–85.