MEDICO-LEGAL DECLARATION

NATIONAL DEPARTMENT OF HEALTH

DR T CARTER
DEPUTY DIRECTOR- GENERAL: HOSPITALS,
TERTIARY HEALTH SERVICES AND WORKFORCE DEVELOPMENT

DATE: 23 OCTOBER 2016
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<th>PROVINCE</th>
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• 23% of doctors identified medico-legal litigation as their most stressful life experience.

• Of all anaesthetic sub-specialities the obstetric anaesthetist is the commonest to retire from work due to medico-legal concerns.

Canada
• Doctors who perform childbirth duties are becoming increasingly scarce. Data from the American College of Obstetricians and Gynecologists (ACOG) projects a shortfall of between 9,000 and 14,000 obstetrician-gynecologists in the next 20 years, and an ACOG survey found that 1 in 7 obstetricians has stopped delivering babies.

• Could we ever have envisioned a point when women approaching childbirth might have trouble finding an obstetrician to deliver them? : **Dr. Richard E. Anderson is chairman and chief executive officer of medical malpractice insurer The Doctors Company and past chairman of the department of medicine at Scripps Memorial Hospital in La Jolla, Calif.**
On 9 and 10 March 2015, a Medico-Legal Summit was held with various delegates representing the public and private health sectors, medical and legal professions, in order to discuss and find solutions to the medico-legal crisis facing the health system in South Africa.

After the Medico-Legal Summit, the Minister appointed a Ministerial Task Team to consolidate all the recommendations of the various Commissions, and to compile a Declaration that will pave the way forward in resolving the problem.
• On 15 March 2016 the Minister approved and signed a Declaration developed by the Ministerial Task Team that should pave the way to effectively address medico-legal litigation that threatens the vision of Government of achieving a long and healthy life for all South Africans.

• The Declaration addresses the main areas of Patient Safety, Administration and Legal front that needs to be adequately addressed to improve medico-legal litigation in South Africa.
CONVERSION OF MINISTERIAL TASK TEAM TO AN ADVISORY COMMITTEE

• The mandate of the Ministerial Task Team has been broadened to such an extent that the Task Team has become an Advisory Committee to the Minister.

• Minister approved the conversion of the Ministerial Task Team to a Ministerial Advisory Committee on 20 June 2016.

• The Implementation Plan focuses on the main areas of Patient Safety, Administration and Legal front and identifies immediate, medium and long term actions that should be executed to implement the Declaration.
The Ministerial Advisory Committee has developed a proposed Implementation Plan for the approved Declaration for the Minister’s consideration and approval.

Upon approval of the Implementation Plan the Ministerial Advisory Committee will visit the Provincial Departments of Health to communicate the Plan to ensure implementation of the Plan.
KEY ROLE PLAYERS

– Senior Management within the National and Provincial Departments of Health
– Clinical Managers
– Nursing Managers
– Senior Clinicians
– Registrars
– Clinical Expert Teams
– South African Law Reform Commission
– Office of the State Attorney
A long and healthy lifestyle for all South Africans

Improved quality of health care
Universal Health coverage achieved through NHI
Re-engineering of Primary Health Care (incl NCDs)

Improved human resources for health
Efficient Health Management Information System for improved decision making

Improved health facility planning and infrastructure delivery

Health care costs reduced

Reduction in medico-legal litigation
• There is a need for greater focus on Clinical Governance in specialist training.

• The Medico legal summit proposed 3 focus areas:
  1. Patient safety.
  2. Improved Administration.
  3. Legislative reform.
Reducing the cost of medical negligence

1. There is a need for greater focus on Clinical Governance in specialist training. Clinical governance must be uniformly implemented.

2. A culture of patient safety and medical accountability must be enforced.

3. Development and implementation of safety checklists

4. There must be a renewed focus on patient safety in the education and training of all health professionals.

5. Adherence to standard operating procedures and scope of practice.

6. The referral of patients must occur at an early and appropriate time.

7. Reliable, complete and accurate medical records
Reducing the cost of medical negligence

3

- Empathetic explanatory communication must be routine. Communicating with the patient and any form of communication is another positive step towards establishing a relationship with the patient.

- We also believe one answer lies in effecting ‘good practice’ combined with “therapeutic alliance” with the patient. The latter implies sharing of information with the patient to increase her/his empathy with the doctor or using reverse empathy, empathy being defined as a positive cognitive attribute leading to ‘feeling with’ the patient and understanding her/his/his perspectives as a separate
Reducing the cost of medical negligence

1. Poor knowledge of the Law
2. The poor knowledge of the law by most medical staff: In a whitepaper on Legal Knowledge, Attitudes and Practice at the Queen Elizabeth Hospital in Barbados, 52% of senior medical staff and 20% of senior nursing staff knew little of the law pertinent to their work. Doctors is often acknowledged widely.
3. “If a doctor reaches the standard of a responsible body of medical opinion, he is not negligent.”
Reducing the cost of medical negligence

• The modern medical practice must be safe and peer reviewed, practiced with sense and honed to be delivered humanely. A holistic attitude to patients rather than defensive medicine is promulgated.

• Good clinical practice with good communication and developing a relationship with patients that enhances the humanity of medical practice at times of maximal stress is essential.
THE END

THANK YOU