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Evaluation of the drivers of high medico-legal claims and proposition of legal teaching approaches for curriculum transformation

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1 Introduction

Access to healthcare services is a constitutional obligation which is enshrined in s 27 of the Constitution of the Republic of South Africa, 1996. Though it is subject to limitations in terms of s 36 of the Bill of Rights, it is one of the basic human rights that must be respected, protected, promoted and fulfilled by the state. Since South Africa has a dual healthcare system consisting of the public and private healthcare sectors, the former caters for 80 per cent of the population while the latter caters for 15 per cent of the population.[1] The mines, independent companies, private general practitioners (GPs) and the South African Military healthcare services cater for the remaining 5 per cent of the population. Therefore, no one may be refused emergency medical treatment by any healthcare provider, health worker or health establishment when a need arises.[2] Health establishment refers to the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient

1 Dolamo & Peprah *Contemporary issues in health service management* (2011) 66; Kruger 'Universal Health Coverage, National Health Insurance, and Sustainable Workforce in Challenges' in van Niekerk, Jones, van den Heever &Kruger (eds) *Medical ethics: The South African context* (2022) 34.

2 S27(3) Constitution of the Republic of South Africa, 1996; S5 National Health Act61 of 2003.

or outpatient treatment, diagnostic or therapeutic interventions, nursing or any other health services.[3]

1.1 Medical malpractice and negligence

The healthcare sectors provide the same services varying from the most basic primary healthcare to hi-tech and highly specialised healthcare services, but the quality of services is different.[4] Thus, a poor quality of service usually leads to a number of claims being filed against the healthcare service provider. Since these claims are based on instances of medical negligence or malpractice, they are referred to as medico-legal claims (MLCs). Even though medical 'negligence' and 'malpractice' are frequently used interchangeably, there is a thin line between the two concepts. The most distinguishing difference is intent.[5] However, both concepts occur during the exercise of medical practice where a health practitioner has a duty to apply appropriate treatment or care in order to prevent any form of injury or harm to the patient.

The term 'malpractice' means a failure of a health practitioner to use the degree of skill or care that should ordinarily be exercised in a situation.[6] Basically, medical malpractice is a broad concept that includes both intentional and negligent wrongful acts or omissions.[7] These two forms of fault or blameworthiness namely, intention (*dolus*) and negligence (*culpa*), are required especially for liability. On the contrary, negligence is a failure to use proper care when doing something that an ordinary prudent person would use under the same circumstances.[8] It is as a serious misconduct by health practitioners which may cause serious harm or injuries that may lead to death.[9] A health practitioner refers to any person including but not restricted to medical practitioner, medical specialist, dentist, dental specialist, medical biological scientist,

3 S1 National Health Act.
4 Arhete and Erasmus 'Healthcare service delivery: a literature review' in *The 25th International Conference for Management of Technology* (2016) 488.
5 Obaro 'Legal imperatives of medical negligence and medical malpractice' 2022 *NJM* 600.
6 Blackwell *The essential law dictionary* (2008) 306.
7 McQuoid-Mason 'What constitutes medical negligence?' 2010 *SA Heart* 248.
8 Blackwell 333.
9 Shang-Feng et al 'Medical malpractice in hospitals – how healthcare staff feel' 2023 *Front Public Health* 1.

psychologist and a student, registered with the council in a profession registrable in terms of the Act.[10]

1.2 Costs and increasing MLCs

Generally, MLCs are costly to the healthcare service provider as they can amount to several millions of rands. Though MLCs for delictual liability often cost a fortune, the courts may award the claimed amounts depending on the nature of the malpractice. For instance, in *Pietersen v MEC for Health, Province of Gauteng* 2021 ZAGPJHC 807 case, a plaintiff claimed an amount of R23 million for general damages, loss of earnings and future medical costs and assistive devices including a dwelling suitable to her special needs due to the negligent medical treatment as a result of medical negligence suffered at Helen Joseph Hospital, Johannesburg.[11] However, the High Court ordered a total amount of R9 988 860 in respect of the plaintiff's general damages (R3 million), medical expenses, assistive devices and adjusted living space (R5.062 million) and total loss of earnings (R1.92 million).[12]

When handling the MLCs, there is no section in the Constitution or applicable legislation hence, the common law is applicable.[13] Thus, the law of obligations (delict and contract) is applied in courts.[14] Under this law, an *obligatio* or obligation between the two parties is created where the wrongdoer has an obligation to make compensation for the damage suffered whereas the prejudiced person has a corresponding right to claim compensation. However, many rules under the common law, such as the 'once and for all' rule, lump sum award, *res ipsa loquitur* and so forth, have been perceived as boons to the increasing number of MLCs.[15] Therefore, the increasing number of MLCs experienced in both health

10 S1 Health Professions Act 56 of 1974.
11 *Pietersen v MEC for Health, Province of Gauteng* 2021 ZAGPJHC 807.
12 *Pietersen v MEC for Health, Province of Gauteng* para 22.
13 Wessels 'Chapter 16. Excessive litigation for harm arising from medical malpractice in South Africa: Reasons, consequences and potential reform' in Bach-Golecka (ed) *Compensation Schemes for Damages Caused by Healthcare and Alternatives to Court Proceedings: Comparative Law Perspectives* (2021) 371; South African Law Reform Commission 'Discussion Paper 154 (Project 141) MLCs (2021)' https://www.justice.gov.za/salrc/dpapers/dp154-prj141-Medico-Legal-Claimspdf (accessed 17 January 2025).
14 Neethling, Potgieter and Visser *Law of Delict* (2014) 3.
15 Qual 'A Survey of Medical Malpractice Tort Reform' 1986 *William Mitchell Law Rev* 436.

sectors was described to have reached the crisis level because it was not in keeping with the generally known trends of medical malpractice.[16]

1.2.1 Private sector

Medical Protection Society (MPS), the world's leading protection organisation for health practitioners reported the claim escalation which were brought against medical practitioners in the private sector between 2009 and 2015 where claim sizes increased annually by over 14 per cent.[17] The data also indicated that the MLCs cost doubled over a period of two years where claims that exceeded R1 million increased by approximately 550 per cent while claims over R5 million increased by 900 per cent.[18] This impelled the MPS to raise subscription costs.

1.2.2 Public sector

Whittaker reported MLCs increase from 2014/15 to 2018/19 for each Province (Fig 1.1A) and a total number of claims for all Provinces (Fig 1.1B).[19] Though the number of claims fluctuated in each Province, the EC showed the highest total number of claims (2381) during the entire period. While the lowest was reported in the NC (136). Though Fig 1.1B indicates a decline in MLCs during the financial year 2018/19, it was not significant because the contingent liabilities escalated during that period (Fig 1.2B), to indicate the importance of the value of each claim.

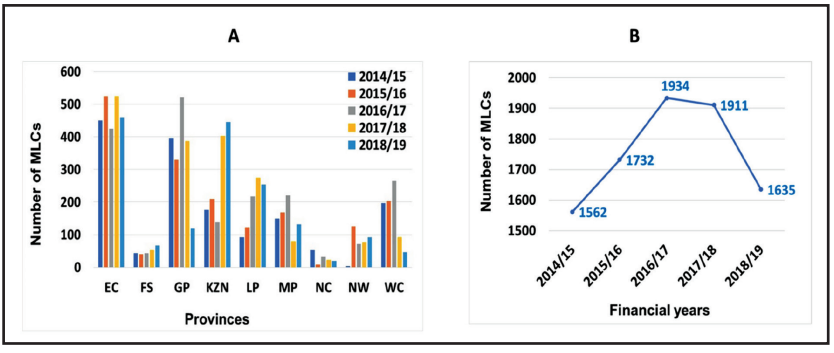
16 Maphumulo and Bhengu 2019 *Curationis* 3. Maphumulo and Bhengu 'Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review' 2019 *Curationis* 2-3.

17 MPS 'Challenging the cost of clinical negligence: The case for reform – 2015' https://medicolegal.org.za/uploads/accredited_journals/AJ_challenging-the-cost-of-clinical-negligence---the-case-for-reform_56eac1f8abb6e.pdf (last (accessed 17 January 2025).

18 Malherbe 'Counting the cost: The consequences of increased medical malpractice litigation in South Africa' 2013 *SAMJ* 83.

19 Whittaker *Medical Malpractice in the South African Public Sector* (2021) 15.

Figure 1.1: *Number of MLCs during financial years 2014/15-2018/19 (a) Claims for each Province (b) Total claims for all Provinces. Data obtained from Whittaker.*[20] *Abbreviations: EC, Eastern Cape; FS, Free State; GP, Gauteng; KZN, KwaZulu-Natal; LP, Limpopo; MP, Mpumalanga; NC, Northern Cape, NW, Northwest; WC, Western Cape*

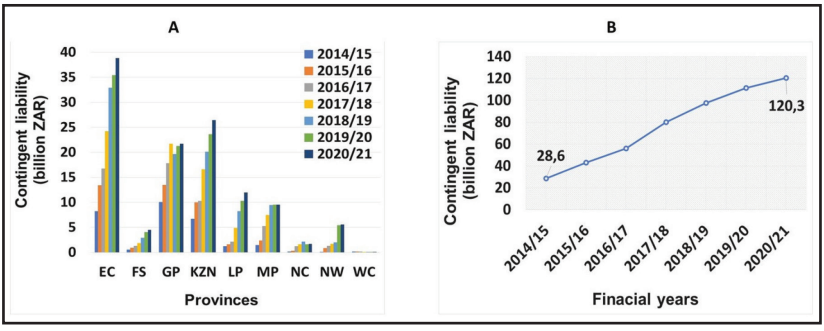


The EC showed the highest contingent liability growth during financial years 2014/15 and 2019/20, while WC had the lowest liabilities (Fig 1.2A).[21] Otherwise, the total MLCs have been increasing at an alarming rate during the entire period in the country as illustrated in Fig 1.2B, and the total year-on-year increase was 8.2 per cent.

20 Whittaker 13.

21 National Treasury 'Provincial Budgets and Expenditure Review: 2015/16-20 Whittaker 13. 2022/23' 64; SALRC (2021) 19.

Figure 1.2: ***Contingent liability as at 31 March 2021 (a) Liabilities for each Province (b) Total liabilities for all Provinces. Data obtained from SALRC.***[22]



1.3 MLCs mitigation strategies

As there is no legislation that addresses MLCs, the common law, alternative dispute resolutions and Health Professions Council of South Africa have been employed as mitigation approaches. However, these approaches are not effective as MLCs continue to escalate at an alarming rate. Hence, new strategies are urgently required.

In response to the increasing MLCs, the Department of Health and the Minister of Justice and Correctional Services requested the South African Law Reform Commission (SALRC) to conduct an investigation into these claims[23] While this investigation to find appropriate reforms is still ongoing, this study aims to evaluate the drivers of high MLCs in the country, how medico-legal issues are being taught and to propose teaching methods to be considered in curriculum transformation.

2 South African healthcare setting

The national health system is the system within the country in which the individual components finance, provide or deliver health services.[24] It consists of the public and private healthcare sectors, also called health

22 SALRC (2021) 19.
23 SALRC (2021) v.
24 S1 National Health Act.

establishments, which provide the population with the best possible health services that can be afforded by the available resources.[25] The private health establishment serves less than 20 per cent of the population, [26] and every establishment must have an insurance cover to indemnify a user for damages due to medical negligence of employees.[27] While the remaining 80 per cent is served for free by the public health establishment.

2.1 The most common drivers of increasing MLCs

2.1.1 Indemnity insurance premiums in the private health sector

As already indicated, the increasing claim size of over 14 per cent and under 14 per cent were reported during 2009-2015 period for medical and dental claims, respectively.[28] Since there is no further update in this regard, these values are expected to have risen by virtue of the malpractice crisis.

Despite the majority of medical negligence cases being instituted against four medical professions namely, obstetrics and gynaecology, neurosurgery, neonatology and orthopaedics,[29] there has been a sharp increase of professional indemnity premiums for obstetricians and gynaecologists.[30] Moreover, a whopping 573 per cent sharp increase in the cost of indemnity insurance for private specialists in neurosurgery were reported between 2005 and 2013, while the premiums for obstetrics increased by 382 per cent.[31] Due to the malpractice crisis which is dire, these days many medical practitioners are reluctant to specialise in any medical field especially, obstetrics and gynaecology.

25 S2(a) National Health Act.
26 SALRC (2021) 384.
27 S46 National Health Act.
28 MPS 'Challenging the cost of clinical negligence: The case for reform – 2015' 15.
29 Motsoaledi 'Doctors call for lawyers to get out of hospitals' 2015 *SAJBL* 5.
30 Taylor and Cleary 'A retrospective, observational study of medicolegal cases against obstetricians and gynaecologists in South Africa's private sector' 2021 *SAMJ* 661.
31 Motsoaledi 2015 *SAJBL* 5.

2.1.2 Underprivileged infrastructural settings of academic hospitals

Approximately 80 per cent of the population relies on the state public hospitals for healthcare services. Unfortunately, these hospitals are used as training institutes for medical practitioners since they are mostly attached to the universities. Apparently, the state hospitals are not conducive as training institutes by virtue of their poor infrastructures, lack of accountability, bad record keeping systems and healthcare associated infections.[32] Furthermore, the junior medical practitioners provide most healthcare services.

2.1.3 Practice of defensive medicine

Defensive medicine is described as a clinical action taken by clinicians during patientcare primarily to protect the clinician against some adverse outcome.[33] Such actions include unnecessary ordering of diagnostic tests, procedures and making more patient referrals. Its goal is in contrast with the medical practice of serving the patient's interests.[34] Since it is popular among specialists in critical surgery such as general surgery, orthopaedics, gynaecology and neurosurgery,[35] about 84.8 per cent neurosurgeons were found to be more likely to engage in defensive medicine.[36] In addition, defensive medicine was said to be gaining momentum in the country as a result of the medico-legal risks that led to unnecessary surgery and an exodus of specialists.[37]

32 Klopper 'The Public Health Medical Negligence Claims Conundrum' (accessed 17 January 2025) 1; South African Medico-Legal Association 'Proposal for Future Medical Education – Becker' https://medicolegal.org.za/SubmissionToThePresident/2.5.8-Proposal%20for%20future%20medical%20education%20-Becker.pdf (accessed 17 January 2025) 1.

33 Bester 'Defensive practice is indefensible: how defensive medicine runs counter to the ethical and professional obligations of clinicians' 2020 *Med Health Care Philos* 414.

34 As above.

35 Kakemam et al 'The occurrence, types, reasons, and mitigation strategies of defensive medicine among physicians: a scoping review' 2022 *BMC Health Serv Res* 2.

36 Yan et al 'International Defensive Medicine in Neurosurgery: Comparison of Canada, South Africa, and the United States' 2016 *World Neurosurg* 53-61.

37 Klopper 'The Public Health Medical Negligence Claims Conundrum' (accessed 17 January 2025) 1.

2.1.4 Contingency fees

Contingency Fees Act 66 of 1997 makes it possible for everyone to enforce their rights particularly when medical negligence is alleged. Since this Act is based on a 'no win no fee' principle, many people recognised and considered their democratic rights after South Africa attained democracy in 1994. Hence, courts are mostly flocked with cases that have no merits for litigation. Most of such cases are as a result of legal practitioners who unlawfully solicit medical malpractice work via touting at various healthcare facilities under the guise of 'no win no fee' principle to conscientize patients about their constitutional rights.

2.1.5 Health Professions Council of South Africa (HPCSA)

HPCSA is the regulatory body for the health professions in South Africa. In 2014, it was accused of several misconducts including but not limited to maladministration, irregularities, mismanagement, poor governance, unfair processes during professional conduct enquiries and failing to provide guidance when resolving challenges that affect the healthcare profession.[38] After the Minister appointed a Ministerial Task Team to investigate the allegations, the HPCSA was found to be in a state of multi-system organisational dysfunction which fails the organisation to deliver in accordance with its objects and functions in terms of the Health Professions Act.[39]

3 Teaching of medico-legal issues

3.1 Medical schools

Medico-legal issues arise unexpectedly when health practitioners are off the guard. These cause psychological shock that leads to depression

38 HPCSA MTT Report 'report of the ministerial task team (mtt) to investigate allegations of administrative irregularities, mismanagement and poor governance at the health professions council of south africa (hpcsa): a case of multi-system failure' Microsoft Word – HPCSA MTT Report – Final Version – Submitted_21.10.2015 (accessed 17 January 2025) 7.

39 HPCSA MTT Report 11.

that has a serious impact on medical practice.[40] It is not surprising that most health practitioners lose confidence when faced with medico-legal issues as some would go as far as closing their practices to evade lawsuit and adverse publicity, particularly after losing a case, that may harm their reputations and livelihoods. Furthermore, undergraduate training on medico-legal issues has been limited while knowledge on medical negligence and ethics remained poor. But then, in 1997 the Health Professions Council of South Africa (HPCSA), as the regulatory body that oversees the education and training of all health practitioners in South Africa, introduced mandatory ethics training for qualified medical practitioners.[41] This was part of redress from the apartheid regime that pervasively influenced the academic training of undergraduate students. Hence, all schools of medicine in the country were strongly encouraged to teach medical ethics. In order to promote professional and public confidence, the HPCSA assists the medical schools to achieve the anticipated standards to ensure compliance of the graduate's performance with the national norms[42]

According to Kirchner,[43] legal ethics is described as a set of ethical rules. Whereas in the medical field, ethics is concerned with ethical issues resulting from medical practice and other interventions that involve humans.[44] Basically, these are ethical principles that govern the actions of healthcare practitioners in their respective professions. They include but not limited to duties to patients; duties to society; duties to the healthcare profession; national patient's rights charter; seeking patient's informed consent; confidentiality: protecting and providing information; guidelines on patient records and guidelines withholding and withdrawing treatment.[45] Therefore, health practitioners who lack

40 Singh et al 'Knowledge, practices and attitude of healthcare professionals towards medico-legal aspects in clinical practice: Results of a questionnaire-based survey' 2019 *MedPulse Int J Gynaecol* 46.

41 Moodley 'Teaching medical ethics to undergraduate students in post-apartheid South Africa, 2003–2006' 2007 *JME* 673.

42 Sims et al 'Medical education, reflections and perspectives from South Africa: a review' 2025 *BMC Med Educ* 5.

43 Kirchner 'Legal Ethics Education in Germany' 2015 *IJIL* 104.

44 Laurie, Harmon and Dove *Mason and McCall Smith's law and medical ethics* (2019) 2.

45 HPCSA 'Ethical guidelines for good practice in the health care professions' https://headroom.co.za/wp-content/uploads/2020/03/HPCSA-Ethics_Booklet-03_2020-1.pdf (last access: 11-05-2025).

ethical knowledge tends to make risk-management decisions which are not based on facts but their own beliefs. Nonetheless, any deviation from the ethical principles, a health practitioner may incur malpractice liability for (1) healthcare negligence; (2) assault in an event where he performed medical or scientific experiments without a patient's informed consent; (3) violation of privacy due to unwarranted disclosure of medical information; (4) unnecessary performance of medical procedures and diagnosis; (5) breach of contract for not performing as per the contractual obligation.[46] Though the malpractice liability against the medical students are rare, these may exist during their clinical rotations around their final years of the study. Hence, it is important that they comply with medical ethics at all times.[47] Despite medical ethics being taught at medical schools, the number of medico-legal claims continues to rise.

Nevertheless, change in curriculum was dire after South Africa attained democracy in 1994. However, three educational themes were the driving forces towards curriculum transformation in the medical schools, namely, 1) introducing student-centred learning covering problem-based approaches; 2) shifting model of illness from bio-scientific to biopsychosocial; 3) exposure to community-based learning opportunities.[48]

3.1.1 Student-centred learning

As opposed to the traditional teaching strategy where teachers give lectures while the students listen, the student-centred approach provides a platform for students to participate by talking, sharing ideas, issues and concerns with the teachers and fellow learners regarding the academic subject. Since student-centred learning is an active learning approach, it allows students to be responsible in contributing to a meaningful teaching and learning process. The fact that students are not being spoon-fed, they learn to be independent and take full responsibility for

46 Oosthuizen and Carstens 'Medical Malpractice: The extent, consequences and causes of the problem' 2015 THRH 272.

47 Wong and Balasingam 'Teaching medical law in medical education' 2013 *J Acad Ethics* 130.

48 Seggie 'MBChB curriculum modernisation in South Africa – growing doctors for Africa' 2010 *AP J Health Prof Educ* 10.

the learning process. While the teacher acts as a facilitator and resource person.[49]

For the problem-based approach, students are often assigned into working groups during the learning process where they are given clinical problems to discuss, ask clinical questions and solve the problems[50] Thus, they often use videos, readings, lecture notes or journals as learning materials to evaluate, synthesize and analyse the problem until it is solved. This task may take about 2 hours to be completed, following which the students make a summary of the knowledge acquired in a form of concept map.[51]

Although the student-centred approach is quite popular, it has flaws because it focuses on learner as an individual and the implementation is associated with several problems[52]

3.1.2 Shift from bio-scientific to biopsychosocial model of illness

Bio-scientific approach is based on a structural conceptualisation of pain. Its role is to find a source of pain and target the responsible tissues to address it.[53] However, one of its drawbacks is the principles and methods that are based on chemical-based pharmacological intervention. Moreover, this approach has limited success since pain is not linked to any changes in patho-anatomy. Whereas bio-psychosocial model does not consider the disease or pain as a linear product of an organic lesion,[54] but as a holistic approach which takes into account the biological, psychological, and social factors when handling healthcare particularly pains and diseases.

49 Sreelakshmamma 'Challenges of student-centred learning: a note' 2020 *RJELAL* 114.

50 Yusof et al 'Student-Centred Approach in Medical Education: A Review of the Teaching-Learning Activities and the Perceptions of Educators on the Students Engagement and Performance at the Faculty of Medicine and Defence Health, National Defence University of Malaysia' 2022 *Adv hum biol* 104.

51 Yusof et al 2022 *Adv hum biol* 104.

52 Sreelakshmamma 2020 *RJELAL* 114.

53 Mescouto et al 'A critical review of the biopsychosocial model of low back pain care: time for a new approach?' 2020 *Disabil Rehabil* 3270.

54 Telles, Stoyanov and Rocha 'How to define today a medical disorder? Biological and psychosocial disadvantages as the paramount criteria' 2022 *J Eval Clin Pract* 1195–1196.

3.1.3 Community-based learning

Early exposure to the community settings promotes more meaningful learning for the students. It may enhance socio-behavioral aspects of the students in understanding the influence of health complications in daily context.[55] Even though the students focus on their tasks rather than patient during training, it is important that they have sufficient contact with the patients to ask them how they are feeling before providing healthcare. Thus, they need to have an effective engagement with local communities to fully understand all determinants of health on individual patient namely, how patients live and work; socio-economic status; the cause of patient's illness; the influence on their recovery; what is needed to keep patients well; and helping them exert power over their health and determinants of health.[56] This is a global health practice which is learned in the community.

3.1.4 Other learning methods that are currently used

In addition to the above-mentioned drivers of curriculum transformation, the medical school curriculum included the outcomes-based learning; employment of an integrated, systems-based method to the study of basic sciences; the use of computer-based technologies where appropriate while continuing with tutor-student interaction; compliance with ethical standards, professional values and human rights to convey the moral and ethical responsibilities.[57]

The curriculum transformation had several drawbacks. For instance, some staff/faculty members who were taught before democracy are reluctant to embrace the change as they continue to support the traditional system.[58] The outcomes-based education, case and problem-based learning, student-centred, peer-assisted and small group learning and patient-centred education were some of the teaching methods that were used. Some of the clinical trainings such as bedside teaching,

55 Claramita 'Community-based educational design for undergraduate medical education: a grounded theory study' 2019 *BMC Med Educ* 2.
56 Biswas 'Implementing a practical global health curriculum: the benefits and challenges of patient-based learning in the community' 2020 *Front Public Health* 2.
57 Seggie 2010 *AP J Health Prof Educ* 10-11.
58 Seggie 2010 *AP J Health Prof Educ* 11; Sims et al 2025 *BMC Med Educ* 7.

ward rounds, tutorials and simulations occur on clinical platforms at the healthcare facilities. Moreover, these trainings are conducted in various decentralized platforms with different types of investments to equip students with skills and workforce competence to be considered fit-for-purpose.[59] Since mostly occur at the hospitals with inadequate resources and inevitable competition between medical, nursing, physiotherapy students among others, the training changed to population-based and interprofessional education so as to provide for a workplace based learning with practical experiences.

3.2 Law schools

Since few universities in the country teach medico-legal issues as part of medical law at the undergraduate and postgraduate levels, they employ the following methods during teaching and learning;[60]

3.2.1 Interactive learning

This method of learning allows students to participate during teaching and learning through meaningful activities to make the learning experience more dynamic. Typical examples of interactive learning techniques include discussions; games and simulations, project-based learning, and online learning platforms. The latter is used by most universities that teach medical law to encourage flexible access for a diverse student body to interact with the learning material.

3.2.2 Lectures

Lecture method is the oldest teacher-centred approach where a lecturer decides on the learning content which may include case law, legislations

59 Van Staden 'Investing in health professions education: A national development imperative for South Africa' 2021 *S AP J Higher Educ* 232.

60 Bhabha 'Towards a pedagogy of diversity in legal education' 2014 *Osgoode Hall LJ* 59-108; Deventer ES 'Methods to use when teaching legal ethics in South Africa' 2021 *Obiter* 312-335; University of Pretoria 'University of Pretoria Yearbook 2023' www.up.ac.za/yearbooks/2023/pdf/module/PBL%20813 (accessed 17 January 2025); University of the Western Cape 'Faculty of Law Programme: Foundations of Medical Law' https://law.uwc.ac.za/programme/foundations-of-medical-law/#:~:text=Medical%20law%20is%20a%20popular,for%2010%20ETHICS%20CPD%20points (accessed 17 January 2025).

and other materials. Lectures are effective means of introducing new subjects and explaining ideas, principles and rules. Since they do not require students to be actively involved in the process, students learn by listening to the lecturer and taking notes for better understanding. Otherwise, narrated lectures are used to cater for the employed and working students so as to have access and engage with the learning content at their own time.

3.2.3 Videos and films

This method of teaching can emotionally and intellectually engage the students to discuss about the problem that is depicted in the videos and films. The images and verbal statements shown on films and videos stimulate students' interests, draw their attention, and help them to understand concepts more easily. Although this method may be luxurious, other platforms such as YouTube may be considered.[61] Nonetheless, some universities prefer using online videos especially for the employed and working students to engage effectively with the learning content.

3.2.4 Cases and court judgments

The judgments are provided for the students to read, interpret and analyse so as to learn the fundamentals of critical reasoning, thinking and application of the law relevant to the specific case. They also learn how a court of law or tribunal previously dealt with a particular situation.

3.2.5 Experiential learning

This method focuses on learning through experience where students have an opportunity to acquire hands-on experience via community service projects, undergraduate research, clinics, simulations and internships amongst the others. Since they learn through doing and reflecting on real-world, they are presented with tools to apply legal principles to medico-legal issues.

61 Deventer 2021 *Obiter* 328.

4 Training of legal practitioners in handling complex MLCs

When handling complex MLCs, students are trained on strategies used to settle the disputes either outside or in court as discussed in the following subsections.

4.1 Mechanisms for settling the disputes outside court

There are two mechanisms that students are being taught namely, alternative dispute resolution (ADR) and HPCSA.

4.1.1 ADR

ADR processes include arbitration, determination by an independent third party or expert, mediation, negotiation and doing nothing.[62] Teaching and learning equips the students with relevant knowledge and skills to navigate and utilize the ADR processes within the South African legal context. But due to cost-effectiveness of the lecturing as a teaching method, many universities utilize this approach,[63] videos, project-based learning, discussions and case law.

Although Socratic method involves less lecturing but more interrogations in class where the teacher poses a number of thought-provoking questions to the students, some ADR lectures are semi-Socratic and require students to participate.[64] Furthermore, the South African Medico-Legal Association (SAMLA), a non-profit organisation which promotes excellence in medico-legal practice, offers a comprehensive range of courses and training programs to enhance the knowledge, skills, and understanding of medico-legal matters to the seasoned medico-legal practitioners and the newcomers.[65] The organisation also provides a lecture and mock trial on ADR with special emphasis on mediation.

62 Marnewick (2019) 51.
63 Deventer 'Methods to use when teaching legal ethics in South Africa' 2021 Obiter 329.
64 Rhodes University 'Alternative Dispute resolution' www.ru.ac.za/media/rhodes university/content/law/documents/courseoutlines2024/ADR.pdf (accessed 15 May 2025).
65 South African Medico-Legal Association (SAMLA) 'Empowering Minds, Elevating Practice: SAMLA Education & Training – Where Medico-Legal Excellence Begins' https://medicolegal.org.za/education-training/ (accessed 17 January 2025).

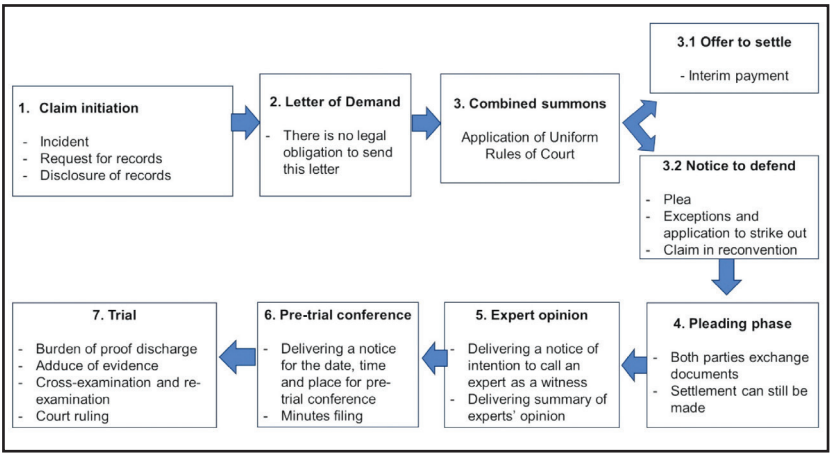
4.1.2 HPCSA

HPCSA was established by Health Professions Act 56 of 1974 and appointed by the court as an arbiter to settle a dispute according to the rules of law. Section 41-41 of this Act provides a professional conduct inquiry process which aims to discipline the health professionals after receiving a complaint, charge, or allegation of unprofessional conduct against them. Moreover, the regulatory body has general ethical guidelines for the health professions that need to be taught. These guidelines and the Health Professions Act have been used as learning materials while lectures, discussion, videos, project-based learning and case law are used as effective teaching methods in this regard.

4.2 Civil dispute system

This system is used to settle the disputes in court. As illustrated in Fig 1.3, the system has seven stages starting from claim initiation and ending with trial stage. These stages are based on national legislations including the National Health Act, Promotion of Access to Information Act 2 of 2000 and Supreme Court Act 59 of 1959. Therefore, the applicable teaching methods include lectures, project-based learning, videos, discussions and cases. Otherwise, these stages have been discussed in the following subsections.

Figure 1.3: Flow-chart of medical negligence claim in South Africa



4.2.1 Claim initiation

Subsequent to a malpractice incident at the health facility, the patient institutes a claim for compensation. At this stage, relevant procedures should be followed to gather clinical records as part of evidence. Based on these records, an attorney may advise on whether pursuing the claim is worth it.[66]

4.2.2 Letter of Demand

A Letter of Demand is a written request in terms of which payment or performance of a legal obligation is demanded.[67] It contains all the necessary information required to determine liability so that the defendant can decide whether to defend or settle the claim.[68] The actual demand for payment, time period within which payment must be made

66 Van Deventer and van Deventer 'Claiming for Medical Negligence in South Africa' (accessed 17 January 2025).
67 Pete et al *Civil Procedure: A Practical Guide* (2016) 711.
68 Pete (2016) 162.

and the consequences of not complying with the demand must also be stated in the letter.[69]

4.2.3 Combined summons

In an event where there is no response to the Letter of Demand, the claimant issues a summons, ordering the sheriff to command the defendant to enter an appearance to defend by a fixed day, in order to answer the claim made by the plaintiff. On receipt of the summons, the defendant has to decide whether to settle the case out of court or to defend at trial. If the decision is to defend, the students had to be taught all the processes including the plea, exceptions and application strike out and claim in reconvention.

4.2.4 Pleading

This stage involves a documentary exchange between both parties. Notably, both parties can still agree on settlement out of court.

4.2.5 Expert opinion

Rule 36(9)(a) of the Supreme Court Act provides procedures to be followed before calling a person as a witness to give evidence. Otherwise, the parties must endeavour to appoint a single joint expert on any one or all issues in the case and file a joint minute of experts that relate to the same area of expertise.

4.2.6 Pre-trial conference

The purpose of this meeting is to bring together all experts involved in the case. A plaintiff receiving the notice of the trial date must within 10 days, deliver a notice where he appointed a date, time and place for a pre-trial conference as contemplated in the Uniform Rules of Court.[70]

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69 As above; Medical Protection Society (MPS) 'Inside a clinical negligence claim' https://www.medicalprotection.org/southafrica/casebook/casebook-january-2013/inside-a-clinical-negligence-claim#:~:text=The%20Letter%20of%20Demand%20sets%20out%20what%20the,so%20upon%20receipt%20of%20a%20Letter%20of%20Demand (accessed 17 January 2025).

70 S37(2)(a) Supreme Court Act.

4.2.7 Trial

The legal representatives of both parties have to present their side of the case in court. Again, the Uniform Rules of Court must be followed.[71] Furthermore, rule 39(8) of the Supreme Court Act provides that each witness must be examined, cross-examined or re-examined as the case may be by only one advocate for such party. At the conclusion of the evidence in trial actions, the judge may follow court processes before handing down the judgment.[72]

5 Proposed changes in legal pedagogy of medico-legal issues to be considered in the curriculum

5.1 Introducing medico-legal practice as a module

Although medico-legal issues content are covered under medical negligence and malpractice in medical law, it is not adequately discussed. Contrariwise, there is an increasing number of legal practitioners who pursue MLCs with no training in this *sui generis* type of law which prompted the Legal Education and Development (LEAD) to offer online training in medical law to all practising legal and candidate legal practitioners, non-practising legal practitioners and other related organisations that venture into the field of medical negligence.[73] Furthermore, professional organizations like SAMLA and South African Institute of Medicolegal Experts (SAIME) provide training on various medical law topics including but not restricted to medico-legal practice.[74] Medico-legal practice is a field where health practitioners work together with legal practitioners to serve justice. Since it is a broad field of study that is specific to medico-legal issues, it must be integrated into the undergraduate curriculum for legal studies preferably as a stand-alone module that will cover other topics that are not included in medical law.

71 S39(1) Supreme Court Act.
72 S39(24) Supreme Court Act.
73 LSSALEAD 'Medical law (Online Course)' https://www.lssalead.org.za/course/medical-law/ (accessed 17 January 2025).
74 South African Medico-Legal Association (SAMLA) 'Empowering Minds, Elevating Practice: SAMLA Education & Training – Where Medico-Legal Excellence Begins' https://medicolegal.org.za/education-training/ (accessed 17 January 2025); South African Institute of Medicolegal Experts (SAIME) 'SAIME Training)' https://saime.co.za/Training.html (accessed 17 January 2025).

5.2 Authentic or experiential learning

With this method of learning, students participate in tasks that reflect real-world and complex problem-solving activities that mimic the actual discipline context. For instance, the moots, mock, externships, negotiation, mediation and clinical experiences may be helpful in creating authentic learning environments.[75] Since the legal profession is currently experiencing ethical crisis due to non-compliance of legal practitioners,[76] mediation and clinical experience must be considered mandatory when teaching medico-legal issues. The former is offered as one of SAMLA courses to indicate that it can be incorporated in the ADR and all HPCSA professional conduct inquiry processes. Additionally, the clinical experience is covered under Practical Vocational Training. However, both mediation and clinical experience may have a significant role if they could be incorporated in all seven stages of the civil dispute system.

6 Conclusion

The first goal of the study was to evaluate the drivers of the increasing MLCs in South Africa. These were successfully evaluated, and five drivers were identified namely, 1) high indemnity insurance premiums; 2) underprivileged infrastructural settings of academic hospitals; 3) practice of defensive medicine; 4) contingency fees; and 5) HPCSA.

The second goal was to evaluate the teaching methods for medico-legal issues and to propose teaching methods for legal studies to be considered in curriculum transformation. Since medico-legal issues involve an intersection of medicine and law, various teaching methods in both fields of study were evaluated. However, only the teaching methods that apply to legal practitioner training were proposed for consideration. Due to insufficient medico-legal issues content covered in the medical law, an introduction of a stand-alone module that will focus primarily on medico-legal practice was proposed. Whereas mediation and clinical experience were proposed to be included as authentic learning for ADR particularly mediation, and HPCSA professional conduct inquiry processes.

75 Quinot and Greenbaum 'The contours of a pedagogy of law in South Africa' 2015 *Stell LR* 47.
76 Deventer 2021 *Obiter* 313.