SASCI

South African Society of Cardiovascular Intervention

SUBMISSION BY

the South African Society of Cardiovascular Intervention (SASCI)

on the

South African Law Reform Commission

Discussion Paper 154

Project 141

Medico-Legal Claims

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INTRODUCTION

1. South African Society of Cardiovascular Intervention (SASCI) is a voluntary non profit organisation of cardiologists, scientists, and allied professionals with the purpose to advance the development of cardiology and coronary revascularisation and to provide minimally invasive, image-guided diagnosis and treatment of cardiac medical conditions. It also acts in an advisory capacity to funders; industry; members and the government on matters relating to interventional cardiology. The latter is a branch of cardiology that deals specifically with catheter-based treatment of heart diseases and includes procedures such as angioplasty and Trans Aortic Valve Implantation (TAVI). The society is also a key enabler of CPD accredited education in interventional cardiology. SASCI is a Special Interest Group affiliated to SA HEART Association.

2. SASCI would hereby like to formally thank the South African Law Reform Commission and all role-players in preparing a well-researched, reasoned and documented discussion paper on medico-legal claims. In addition, SASCI would also like to thank the SALRC for the opportunity to communicate our comments on the discussion paper.

3. For the sake of brevity, clarity and uniformity, our views/comments will be communicated under the same headings used in the discussion paper.

4. The views, opinions and ideas expressed in this document are those of SASCI, who is an affiliate organisation to SA Heart Association, who in turn is affiliated to the SA Medical Association.

COMMENTS

5. Our views and comments on strategies to reduce medico-legal claims include, but are not limited to, statements expressed under a heading, which are some of the SALRC recommendations, as indicated in bold, and in bold and italic font (for specific proposals) below:

A. Strategies to reduce medico-legal claims

Evidence-based development of policies and clinical guidelines in all disciplines.

6. SASCI supports this recommendation.

7. As both a provider and a funder of healthcare, SASCI do not believe that the National Department of Health ("NDoH") is the appropriate body to set these evidence-based guidelines. Its decisions may be driven by budgetary constraints. It is therefore the strongly view of SASCI that such policies and guidelines be exclusively determined by the respective medical fields or their respective professional bodies, such as the South African Heart Association. This could be provided into an independent body such as that proposed by the Health Market Inquiry ("HMI"), in the form of the Supply-Side Regulator for Health.

8. In amplification of the above, strong reliance may be placed on the skills and experience of the practitioners, as per Rule 21 in the *Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act, 1974*, which states that:

> *A practitioner shall perform, except in an emergency, only a professional act -*
> *(a) for which he or she is adequately educated, trained and sufficiently experienced; and*
> *(b) under proper conditions and in appropriate surroundings.*

9. Pronouncement of what would be the "correct", i.e. evidence-based way of treating patients, can therefore only be made by healthcare professionals registered under the Health Professions Act, 1974. For inappropriately trained or unregistered persons to do would, be tantamount to a criminal offence under that Act.

10. SA Heart, and SASCI follow the European Society of Cardiologists ("ESC") Guidelines, when treating patients. In so doing, the treatment of South African patients in the field of cardiovascular disease aligns with the highest international standards.

Necessity of referral pathways

11. We agree that such referral pathways are necessary and that it should be regulated through policies/guidelines which are issued by the NDoH under guidance form the appropriate professional society.

There is, however, such a document that were issued by the NDOH in 2020.[1] This document, however, does not address referrals in the private sector. It was also, to the best of our knowledge, not circulated for comment and seem to not be implemented at all.

12. This attests to an important issue in the health sector – where there are legislative and policy frameworks, those however remain, largely unimplemented, and a key driver of medico-legal issues arising in the sector.

13. As healthcare professionals dealing with emergencies often (e.g. suspected heart attacks and the likes), it is imperative that the NDoH develop polices/guidelines on the management of emergency treatment specifically. We wish to stress that these proposed guidelines should be different from best practice guidelines.

14. In addition, it is the strong view of SASCI that the NDoH should develop an efficient patient transport system. Such a system may either be provided by the state or privately funded. A current problem with patient transport services is that, apart from being insufficient ,many, if not all, private ambulance services have a vested interest in a respective hospital or hospital group to which a patient is admitted. The provision of a national ambulance transport system , available via an UBER style service , should be urgently considered (see below).

15. In essence, what we propose is that:

    a. Patient transport be immediately available;

    b. Patients be taken to the appropriate and suitable medical centre, depending on the patient's medical conditions and the availability of resources; and

        i. Where a patient is not taken to the nearest and/or best centre of excellence by patient transport, good reasons must be provided.

[1] https://www.knowledgehub.org.za/elibrary/referral-policy-south-african-health-services-and-referral-implementation-guidelines.

16. A possible example of broadening the access to patient transport services is to consider a concept introduced in Kenya. The Kenyan start-up Capsule is set to launch Flare, a mobile solution that aggregates available ambulances into a single system and allows patients or hospitals to request emergency help using their smartphones.[2]

Morbidity and mortality meetings ("M&M meetings") & clinical governance committees

17. Our view is that such M&M meetings ought to be implemented practically and be strongly encouraged, alternatively made mandatory, subject to the size of a facility or minimum size of the facility or department, and dependent on the disciplines involved at a specific facility.

18. For example, M&M meetings should be strongly encouraged for cardiologists in a hospital, and be held on a monthly basis. However, dermatologists would, for obvious reasons, not have such a meeting.

19. Clinical governance must not be dictated to by Designated Service Providers (as it is easily susceptible to manipulation); clinical governance should be based on standards set by each respective hospital group.

Better record-keeping and standardisation thereof

20. A central failure that could be immediately addressed namely, the lack of proper record-keeping, and hence the inability to justify one's actions in the health sector, is the non-promulgation of regulations in terms of section 10 and section 90(1)(g), which should standardise requirements for recordokeeping and discharge reports for all facilities and practices.

21. In SASCI's view this goes beyond just record-keeping, and includes registries. Also this was an important recommendation of the HMI. We hold a very strong view that records and a registry be kept, by both the state and private sector, for every catheterization laboratory ("cath-lab") of what is being done, and what

[2] See https://disrupt-africa.com/2016/07/26/kenyan-startup-to-launch-uber-for-ambulances-app/

patient outcomes are. This is strongly encouraged as this concept would be both in the best interests of the patient and all medical practitioners.

22. The NDoH must mandate the keeping of such a registry and records by possibly promulgating a legislative provision to the National Health Act 61 of 2003 ("NHA"). The registry and records would effectively neutralise the power imbalance between funders and medical practitioners. The only statutory registries are those for cancer, which is understood to not be significantly successful, and the databases relating to notifiable medical conditions.

23. In the United States of America ("USA") and the United Kingdom ("UK") the impact of a cath-lab registry and records adds immense value as the entire clinical history all cardiovascular services can be established.

24. Other examples of the necessity for, and success of, registry and record keeping include:

    a. With the launch of the Transcatheter Aortic Valve Implantation ("TAVI") in South Africa, a register and records were kept with great success as this assisted cardiologists with a track record and success rate;

    b. South Africa has established a partnership to register and record ST elevation myocardial infarction ("STEMI") as part of a national project, with the aim of enhancing treatment to patients in the private and state sector.

Early detection and management

25. SASCI proposes a local and national complaints system and complaint management for all facilities and practices. We, however, propose that these bodies are independent health complaints committees. Although required as part of the Standards set by the Office of Health Standards Compliance ("OHSC"), their work and in particular the enforcement and therefore the increase compliance in standards, are severely hamstrung by budgetary constraints. This should be a key strategy, made mandatory, in all health facilities and practices,

as not only an "early warning", but also a strategy to intervene early on a systemic level to address possible health systems failings. The success of this would be greatly enhanced by the collection of data nationwide.

26. In our view there is also a need on the individual (non-systemic) front, to have experienced individuals (be it a combination of medical practitioners or highly skilled and experienced administrative staff) who can resolve the less serious complaints and expedite the resolution of same.

27. Complaints also ought to be categorised and assigned to specific areas, for example: the Road Accident Fund, Compensation for Occupational Injuries and Disease Act 103 of 1993 ("COIDA"), Office of Health Standards Compliance ("OHSC") to deal with the issues expeditiously.

Adverse events monitoring

28. We are of the view that these issues should ordinarily be addressed in an M&M meeting. We propose that the submission of an annual formal report to the NDoH, alternatively to Health Professions Council of South Africa ("HPCSA"), be strongly encouraged.

29. For medicines and medical devices, adverse event reporting relating to health products should be encouraged, and possibly simplified.

30. Significantly, patients should understand the risks inherent in healthcare service- and products provision, also to address unreasonable expectations of patients and their families.

Feedback from medico-legal cases and issues

31. SASCI agrees with this recommendation. In addition, we wish to state that if a matter concerns medical malpractice by a medical professional, feedback ought to be provided to the HPCSA, as it should guide the issuance of new policies, booklets or guidances.

32. It is also suggested that a register be kept of all successful alternative dispute resolutions in medico-legal cases. This would undoubtedly promote alternative dispute resolution approaches in such matters.

B. Legal solutions

Alternative dispute resolution (ADR) (mediation and arbitration)

33. We fully support mediation as a form of ADR. In support of this, we posit that mediation:
    a. is effective and expeditious and cost effective
    b. is, however, not always an option and ought to be adjudged on a case-by-case basis;
    c. should be made mandatory by either amending Uniform Court Rule 41A or legislation.

34. We are less enthusiastic about arbitration as a form of ADR, as it is similar to a court process with a "winner" and "loser".

Fast-tracking legal processes to save costs

35. SASCI supports the fast tracking of legal processes to save costs, as well as the extended pressure and emotional distress it causes for healthcare professionals, who are sorely needed in the health sector.

In-kind and/or capped compensation

36. SASCI supports this concept, as long as it is an option to have an issue resolved efficiently, expeditiously and subject to financial sustainability. The Road Accident Fund (RAF) has shown how easily a system can collapse if it is not financially sustainable.

Certificates of Merit to be obtained prior to a case

37. SASCI supports this concept. In addition, we support the filing of joint minutes by expert witnesses.

Redress systems

38. Although we would recommend that this concept requires regulation in the form of legislation, in our view this idea is not suitable for implementation in South Africa.

UK pre-action protocol, requiring processes, timelines, disclosures, attempts to avoid litigation

39. SASCI supports the various concepts that make up this proposal.

CONCLUSION

40. We hereby request that you kindly consider and accept SASCI's comments and views expressed in this document.

41. SASCI remains available to render any support, or supply any information required by the SALRC in this important work.

42. SASCI can be contacted at: 083 458 5954 and sasci@sasci.co.za