Can private obstetric care be saved in South Africa?

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This article examines the question of whether private obstetric care in South Africa (SA) can be saved in view of the escalation in medical and legal costs brought about by a dramatic increase in medical negligence litigation. This question is assessed with reference to applicable medical and legal approaches. The crux of the matter is essentially a question of affordability. From a medical perspective, it seems that the English system (as articulated by the Royal College of Obstetricians and Gynaecologists) as well as American perspectives may be well suited to the SA situation. Legal approaches are assessed in the context of the applicable medicolegal framework in SA, the present nature of damages and compensation with reference to obstetric negligence liability, as well as alternative options (no-fault and capping of damages) to the present system based on fault. It is argued, depending on constitutional considerations, that a system of damages caps for non-economic damages seems to be the most appropriate and legally less invasive system in conjunction with the establishment of a state excess insurance fund.

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The sustainability of private obstetric care will soon be under threat. Claims inflation leads to increasing indemnity costs, which means that private obstetric indemnity cover will probably be unaffordable by the end of the decade. This not only has serious consequences for private obstetricians and private parturients of the future, but there are also serious public health sequelae. As obstetrics is the vanguard of the threat we are concentrating on private[1] obstetrics, but private neurosurgery and spinal surgery face similar imminent threats.[1]

Invariably there is an unhappy story behind every case of litigation involving obstetric care where a child has been compromised. As these children now often survive, and then live longer as a result of sophisticated expensive care, obstetric claims are inevitably extremely high value and run into millions of rands. While an individual obstetrician may be at relatively low risk of having a claim of the magnitude of an obstetric claim, the claim's value can be so high that a single individual could not afford to compensate a deserving claimant. The financial risk has to be transferred to an insurer or shared by a not-for-profit indemnifier.

Those accepting the financial risk of obstetric claims require sufficient reserves to meet future administrative and claims costs. Insurers are already avoiding the market and, as a result of claims inflation, not-for-profit indemnifiers are becoming progressively unaffordable as their subscription rates reflect actuarially calculated obstetric risk. Based on the claims inflation and subsequent subscription inflation, there are concerns that indemnity for obstetric risk will be unaffordable by the end of the decade.[2]

Obstetricians who are not indemnified would be poorly advised to continue practising obstetrics. A single case would leave them financially ruined, and a deserving patient would be inadequately compensated. Additionally they may be precluded from practising by regulation or by the private hospital where they deliver – it is unlikely that private hospital groups would knowingly allow an obstetrician who is not indemnified to deliver at their facility.

Patients will continue to fall pregnant and require delivery. If they cannot deliver in private facilities, they will have to deliver in state facilities. This will increase the workload of already heavily burdened state facilities by an additional 10% nationally, but inevitably more in the urban areas where private patients tend to reside, which already act as referral centres for rural state patients. Not only will the increased workload shift across to state facilities, but the obstetric liability will move from private care to the state. Already overburdened facilities will have to cope with patients who expect private healthcare and the system will be placed under even more stress – probably increasing the litigation burden on the state.[3]

Who are the potential losers here? Private patients are unlikely to be endeared by the prospect of delivering in state facilities. Private obstetricians' income may fall. Already busy state facilities will be placed under increased strain, and this burden will be disproportionately placed on units that already accept referrals from urban areas. State patients will be inconvenienced; their labour wards will become busier with an influx of demanding patients. There is likely to be an increased litigation burden that will further disadvantage state patients, as the state does not budget independently for litigation and every rand spent out of the health budget is a rand no longer available for healthcare or to improve facilities. Private patients, private providers, public patients, public providers, policymakers and politicians all have a vested interest in resolving the problem.

Medical approaches

The intuitive response from the medical profession is to blame and vilify lawyers. Lawyers will rightfully argue that obstetricians are responsible for the predicament in which they find themselves. There is either a problem with the care offered by individual obstetricians, or

there is a problem with the system rendering the care. In reality, a relatively small number of repeated errors lead to most preventable adverse outcomes.

The model of private intrapartum obstetric care delivery has been described previously and consists of remote obstetricians reliant upon the expertise of labour ward staff of varying qualification and quality.[1] While the obstetrician is ultimately responsible for the patient, the obstetrician being remote precludes the model from being considered a consultant-led service as described by the Royal College of Obstetricians and Gynaecologists (RCOG). Although midwives may be primarily responsible for the labouring patient's admission and first-stage care, the model is also not that of a midwife obstetric unit.

The system is vulnerable; medical involvement is remote, nursing care is of varying qualification and quality, and there is no uniformity of process.[4]

Liability is complicated by the fact that obstetricians are independently indemnified while the employer of the labour ward staff is vicariously liable for their acts or omissions. Indeed, the high caesarean section rate, justified as a response to increasing litigation, is perhaps an acknowledgement of the frailties of the current system.

The English system as advocated by the RCOG, using both qualified midwives and doctors, including consultants, in the labour ward, will be well understood by virtually all medical and nursing staff. It is the system that is utilised, to a greater or lesser extent, in the training of undergraduate and postgraduate medical and midwifery personnel in South Africa (SA). Regulatory changes and an appetite by private hospital groups to adopt the model would be necessary to implement any system compatible with RCOG recommendations.[5] Labour ward doctors, including obstetricians, would no longer be independent contractors but private hospital employees. Understandably this approach may not be appealing to many obstetricians currently in private practice.[6]

An approach utilised by the largest private obstetric healthcare provider in America may be more applicable to private practice in SA. The Hospital Corporation of America does not employ doctors and may be the most appealing approach both to SA obstetricians and SA private hospital groups. Since the inception of the programme there has been an improvement in outcomes, a dramatic decline in litigation claims, and a reduction in the primary caesarean section rate. Importantly the approach has been amenable to expansion beyond the initial pilot and sustainable. Claims frequency continues to fall despite an increasing claims frequency nationally.[7]

The basic principles and subsequent additions are set out in Table 1. The approach utilises well-described risk management tools.[8] When confronted with so many interventions, it is difficult to identify the interventions most likely to have made a significant difference. It is interesting to note that a relatively small number of repeated errors lead to most preventable adverse outcomes. Uniformity of process and clearly defined unambiguous practice guidelines would assist in decreasing the number of repeated errors.[9]

Perhaps two points are particularly salient. Firstly, if the current care system cannot do the job, then trying harder will not make it work; changing the system of care will. Secondly, the changes could not be coerced and were dependent upon pure leadership.[10] An organisation, perhaps either private hospital groups or the South African Society of Obstetricians and Gynaecologists (SASOG), would to have to take the leadership role.[11]

While changes to the medical system may alleviate the problem, these changes would take a considerable time to implement and it would be even longer before the benefits would be such that they would influence subscription rates. Even the American model considers the possibility of 24-hour labour ward obstetricians. One very quick solution would be for the private hospital groups to employ obstetricians and implement either another or the English or American models described.[12] As employers the hospital groups would be vicariously liable for the acts or omissions of their employees – the obstetricians. Instead of transferring obstetric liability to the state, it could be transferred to the private hospital groups.

Legal approaches

The medicolegal framework

Any legal assessment of the posed title of this article should be approached with reference to the guiding medicolegal framework consisting of the supreme Constitution of the Republic of South Africa,[13] the common law, the applicable healthcare legislation, and consideration of applicable medical ethics.[14] Any solution to the posed title, viewed from a legal standpoint, will have to resonate in the legal framework in the context of legal compliance. It is also evident that complex health problems (as the present topic under discussion) have remained largely unsolved in the 21st century and are indicative of conflicts between public interests and individual rights as part of evolving health crises in many countries (including SA). The regulation of healthcare practitioners, the determination of liability for clinical negligence and the issue of funding and costs pose specific challenges. It is to be noted that without adequate funding there can be no access to justice for the victims of clinical medical negligence. Funding and costs (inclusive of compensation) go hand-in-hand as together they determine the

Table 1

Principles and additional points of the redesigned system

- Uniform process and procedure.
- Every member of the obstetric team should be required to halt any process that is deemed to be dangerous.
- Caesarean delivery is best viewed as a process alternative, not a source of outcome or a quality endpoint.
- Malpractice is best avoided by reduction in adverse outcomes and the development of unambiguous practice guidelines.
- Effective peer review is essential to quality medical practice.
    - Expansion of online provider education/communication programme.
    - Ongoing process standardisation.
    - Development of national quality metrics.
    - Elective early term delivery.
    - Prevention of post caesarean venous thromboembolism.
    - Perinatal/neonatal collaboration.

bigger picture – namely the financial context in which the specialist physician operates. This economic reality should also underpin the patient's or health user's right to healthcare in an integrated and accessible health system.[15] Interpreted as equal access to necessary healthcare facilities (private or public), the notion of access to care (in context, and including reproductive healthcare) raises various fundamental questions within the obstetrician-patient relationship. Clearly access to healthcare includes the absence of unjust discrimination in the rendering of obstetric care and begs the question of whether funding and costs (or capping or absence thereof) will negatively impact on the level, quality and availability of obstetric services a patient would constitutionally and ethically be entitled to. Access to healthcare (reproductive healthcare) is therefore dependent on the quality assurance of obstetric care as amplified by proper funding and costs in cases where damages are claimed based on clinical obstetric negligence.

The present nature of damages and compensation in SA law: Liability and compensation based on fault

In terms of the Law of Obligations (contract and delict), the same medical negligence may constitute both a breach of contract and delict. Liability for medical negligence is firmly rooted in a system based on fault. Therefore a plaintiff-patient may rely on the breach of contract or alternatively on delict. Only pecuniary damages (patrimonial damages) may be recovered in contract, while pecuniary and non-pecuniary (non-patrimonial) damages may be recovered in delict. Recoverable pecuniary damages include medical costs (past as well as future), loss of income (past and future earnings), maintenance, etc. The ambit for recoverable non-pecuniary damages includes not only compensation for actual physical pain, but also shock, discomfort and mental suffering, disfigurement, loss of amenities of life and disability, and loss of expectation of life – called loss 'for pain and suffering'.[16,17] It is also possible to claim for detectable psychiatric injury, provided that there was actual psychological injury caused by medical negligence and the psychological harm is significant.[18-20] The calculation of non-pecuniary damages is more often than not complex and controversial, and in this regard the courts are, in principle, guided by policy considerations and comparable precedent.[21,22] Provision is also made in the Apportionment of Damages Act[23] for instances of contributory negligence. In addition, SA law makes provision for a so-called 'contingency fee' conditionally allowed since 1999 in terms of the Contingency Fees Act.[24] Pivotal, however, is the rule which serves as the most powerful deterrent against medical negligence litigation, namely that the patient-plaintiff runs the risk that an order of costs will be made against him/her if the case fails. It is also to be noted that punitive damages (as known in the USA) are not awarded in cases of medical negligence in SA.[25] In addition, the advent of the Consumer Protection Act[26] (in the context of healthcare services) has also contributed to patients (as consumers) asserting their rights to compensation in an already litigious society, specifically in the context of obstetric negligence.[27,28]

Alternative options to the present system, based on fault

Various options in response to systems, based on fault, have been postulated (inclusive of dispute resolution, the establishment of special medical negligence courts, adjudication by way of expert screening panels, mediation,[29] periodical or staggered pay-outs[30] and defensive professional training).[31-33] In an attempt to curtail the meteoric rise in legal and insurance costs emanating from medical negligence litigation, it is specifically the implementation of a substantive no-fault system and/or the statutory capping of compensation that have received considerable attention in some countries.[34] In addition, there is the radical option for government subsidisation by way of the establishment of a state excess insurance fund thereby providing victims of medical negligence a *quid pro quo* for the potential loss of complete compensation.[30] The focus of the discussion here will be on the no-fault system and the capping of damages as possible sustainable or substantive options for obstetric negligence in SA.

The no-fault option

Medical no-fault schemes (where provision is made for compensation for medical and other injuries independently of liability) were first introduced from the 1970s in the Nordic countries (Sweden 1975, Finland 1984, Norway 1988 and Denmark 1992) and as part of the comprehensive accident compensation scheme introduced in 1974 in New Zealand.[30,35,34] Birth injury no-fault compensation schemes were established in the 1980s in the US states of Florida and Virginia.[36,37] No-fault legislation was introduced in Austria in 2001 and a no-fault component was included in the new medical injury scheme in France in 2002, while Belgium followed suit in 2007 and Poland in 2011 (under the influence of the Swedish scheme). In Japan a new scheme was introduced in 2009 to deal with obstetric injury involving severe brain damage. An obstetric injury scheme, similar to that in Japan, was recommend for England and Wales in 2003, but was not carried through to the subsequent legislation.[37]

The main arguments for no-fault compensation are considerations of fairness; speedier resolution of cases; lower administrative and legal costs than court action; the increased certainty for complainants on the circumstances in which compensation is payable and increased consistency between claimants; the reduced tension between clinicians and claimants; and the greater willingness by clinicians to report errors and adverse events.[38] Critics of no-fault compensation argue that overall costs will be higher than under a tort system; that it will open the floodgates to compensation payments and fuel a compensation culture; that disputes about causation remain, even if fault is removed; that disputes about the amount of damages remain, unless there is a tariff-based approach; that it is difficult to distinguish injury from the natural progression of the disease in some cases; that explanations and apologies are not necessarily provided in a system that focuses on financial recompense alone; and that a no-fault system, in itself, does not improve accountability or ensure learning from adverse effects.[38] However, Ken Oliphant, former director of the European Centre of Tort and Insurance Law in Vienna, Austria, correctly states that it seems that no-fault liability schemes are back on the reform agenda internationally, even if only a limited number of countries have actually implemented such schemes.[38,34]

The capping option

Proponents of damages caps have argued that damages caps benefit consumers by reducing the rate of increase in health insurance.[39] Ultimately the question to be posed is whether victims of medical negligence are sufficiently compensated for the smaller amount of

expected damages by a reduction in the cost of healthcare. Research indicates that damages caps are the most controversial aspect of medical negligence reform.[39] Central to the debate, emanating mostly from the USA, is the constitutionality of damages caps as policymakers expect liability insurers to give effect to the passage of caps by reducing premiums in response to their improved risk exposure and ability to predict their payouts.[39]

The research of authors Kelly and Mello [40] indicates that in the USA there have been five major constitutional grounds for challenging medical liability for reform:

- Damages caps have been challenged using the open-courts guarantee contained in many state constitutions.
- Damages caps have been said to violate the right to trial by jury.
- Damages caps have been perceived to violate both federal and state equal protection guarantees.
- Damages caps have been challenged using due process provision in federal and state laws.
- Damages caps are occasionally challenged in terms of the doctrine of the separation of powers.[30]

It is specifically in the context of non-economic damages that legislative caps were introduced in a number of states in the USA (ranging from a total cap of a minimum of $250 000 to a maximum of $500 000, with courts in some states having the authority to increase the maximum cap to $1 million).[40]

Although the constitutionality of damages caps in the USA has been successfully challenged in a minority of states,[41-43] comprehensive research[39] indicates that this issue has now largely been resolved in the sense that rigorous empirical analyses conducted since 1990 found that malpractice premiums, in principle, are lower in the presence of damages caps. However, the effects of damages caps on the practice of defensive medicine, the subsequent increase in the availability of doctors in certain locations and the cost of healthcare to consumers are less clear. Some researchers state that the evidence about damages caps' effectiveness remains mixed and concerns about their equity implications persist.[40,44]

The possible introduction of damages caps for medical negligence (in the context of private obstetric negligence) in SA will undoubtedly, by analogy to the experience in the USA, also face constitutional challenges, specifically with reference to the equality clause,[45] access to courts provisions,[46] and the doctrine of the separation of powers.[47] Taking the cue from the salient American law it may be stated that, traditionally, in terms of equal protection clause challenges, experience has taught that challenges in this regard arise as a result of so-called differential treatment of plaintiffs in medical negligence cases. The differentiation translates into pitting plaintiffs in a medical negligence action against plaintiffs in other personal injury cases (who can obtain full recovery) – in the words of author Gfell: 'the equal protection argument against damages caps becomes fairly obvious: those who suffer the most severe injuries will go without full compensation for their non-economic damages, while those who suffer relatively minor injuries from other personal injury will be entitled to full recovery of non-economic damages'.[30] It is, however, to be noted that mere unequal treatment in terms of legislation is not *per se* unconstitutional. This will also be the case if section 36 (the limitation clause) of the SA Constitution is invoked and such limitation is reasonable and justifiable in an open and democratic society.[47] In terms of the access-to-courts provision in our Constitution (militating against a system of damages caps), it is trite law that all victims of medical negligence should have the right to have justifiable disputes settled by a court of law or, where appropriate, by another independent and impartial forum.[47,48]

Conclusion

In our view, private obstetric care can be saved in SA – it remains a matter of affordability. It is to be noted that the issue is not about the merits of the medical negligence case (which will be served well by the current applicable substantive medical law), but rather about the quantum of damages, and more in particular non-economic damages to be awarded for obstetric negligence. One solution, in our opinion, from a medical approach, points to the importation of the English system advocated by the RCOG as discussed above.

From a legal approach, it is submitted that the only viable and substantive options, as indicated from international perspectives, are the establishment of a no-fault compensation system, or the introduction of a system of damages caps for non-economic damages only – both systems, as discussed, offer distinct advantages and disadvantages. The most recent comparative research pertaining to no-fault systems indicate that if no-fault is to displace liability systems based on fault, this should be accompanied by additional mechanisms to ensure the goals of prevention and accountability. To date there is insufficient evidence to assess whether the steps taken in jurisdictions where no-fault systems were introduced (e.g. New Zealand and the Scandinavian countries) have been effective, specifically with regard to the promotion of patient safety. On the other hand, however, there is no clear evidence that the substitution of a liability system with a no-fault system has had a detrimental effect on patient safety.[48]

In the context of the question posed in this article, however, the economic realities and the unprecedented rise in obstetric negligence in SA, a considered system of damages caps for non-economic damages (non-patrimonial damages) only, seems to be the more appropriate and legally the less invasive option. The adoption of such a limited system will still ensure access to the courts in terms of the substantive merits of the law pertaining to the case, but will undoubtedly curtail the quantum proceedings. In addition, this option may be further enhanced by government subsidisation by way of the establishment of a state excess insurance fund (or 'top-up' fund) which could cover any shortfall in compensation in deserving cases of obstetric negligence. It goes without saying that the introduction of a system of damages caps will have to withstand constitutional muster.

References

1. Howarth GR. The threat of litigation: Private obstetric care – quo vadis? South African Journal of Bioethics and Law 2011;4(2):85-88.
2. Malherbe J. Counting the cost: The consequence of increased medical malpractice litigation in South Africa. S Afr Med J 2013;103(2):83-84. [http://dx.doi.org/10.7196/SAMJ.6457]
3. Bateman C. Medical negligence pay-outs soar by 132% – subs follow. S Afr Med J 2011;101(4):216-217.
4. Hoffman DN. The medical malpractice insurance crisis, again. Hastings Center Report 2005;35(2):15-19. [http://dx.doi.org/10.135/hcr.2005.0022]
5. Clark SL, Belfort MA, Byrum L, Meyers JA, Perlin JB. Improved outcomes, fewer cesarean deliveries, and reduced litigation: Results of a new paradigm in patient safety. Am J Obstet Gynecol 2008;199:105,e1-7. [http://dx.doi.org/10.1016/j.ajog.2008.02.031]

6. Ransom SB, Studdert DM, Dombrowski MP, Mello MM, Brennan TA. Reduced medicolegal risk by compliance with obstetric clinical pathways: A case-controlled study. Obstet Gynecol 2003;101(4):751-755. [http://dx.doi.org/10.1016/S0029-7844(02)03129-0]
7. Clark SL, Belfort MA, Dildy GA, Meyers JA. Reducing obstetric litigation through alterations in practice patterns. Obstet Gynecol 2008;112(6):1279-1283. [http://dx.doi.org/10.1097?AOG.0b013e31818da2c7]
8. Howarth GR, Bown S, Whitehouse S. The importance of comprehensive protection in today's healthcare environment. S Afr Med J 2013;103(7):453-454. [http://dx.doi.org/10.7196/SAMJ.7107]
9. Bateman C. Clumsy patient-friendly regulations could strip 25 000 of MPS cover. S Afr Med J 2010;100(10):696-697.
10. Royal College of Obstetricians and Gynaecologists (RCOG). Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. London: RCOG, 2007.
11. RCOG. Standards for Maternity Care. Report of a Working Party. London: RCOG, June 2008.
12. RCOG. London. Labour Ward Solutions. Good Practice No. 10. London: RCOG, January 2010.
13. Republic of South Africa. Constitution of the Republic of South Africa. Government Gazette 1996. www.gov.za/documents/constitution/1996/a108-96.pdf (accessed 13 March 2014).
14. Carstens PA, Pearmain D. Foundational Principles of South African Medical Law. 1st ed. Durban: LexisNexis, 2007;1-3:229.
15. Lewis C, Buchan A. Clinical Negligence. 7th ed. Haywards Heath: Bloomsbury, 2012:591-619.
16. Boberg P. The Law of Delict. 1st ed. Cape Town: Juta, 1984:516.
17. Coetzee L, Carstens P. Medical Malpractice and Compensation in South Africa. Medical Malpractice in Global Perspective. Berlin: De Gruyter, 2013:397.
18. Accident Fund v Sauls 2002 (2) SA 55 (SCA).
19. Barnard v Santam 1999 (1) SA 202 (SCA).
20. Clinton-Parker v Administrator Transvaal 1996 (2) SA 37 (W).
21. Corbett MM, Honey DP. The Quantum of Damages in Bodily and Fatal Injury Cases. 1st ed. Cape Town: Juta, 2010.
22. Corbett MM, Buchanan JL, Gauntlett JJ. The Quantum of Damages in Bodily and Fatal Injury Cases. 3rd ed. Cape Town: Juta, 1985.
23. Republic of South Africa. Apportionment of Damages Act 34. Government Gazette 1956.
24. Republic of South Africa. Contingency Fees Act 66. Government Gazette 1997.
25. Collins v Administrator Cape 1995 (4) SA 73 (C).
26. Republic of South Africa. Consumer Protection Act 68. Government Gazette 2008.
27. Ntsele v MEC for Health Gauteng Provincial Government, unreported Case nr 2009/52394 dated 24 October 2012.
28. Carstens PA. Judicial recognition of the application of the maxim res ipsa loquitur to a case of medical negligence. Obiter 2013;34(2):348-358.
29. Mulcahy L. Can leopards change their spots? An evaluation of the role of lawyers in medical negligence mediation. Int J Legal Prof 2001;8(3):203-224. [http://dx.doi.org/10.1080/09695950220141025]
30. Gfell KJ. The constitutional and economic implications of a national cap on non-economic damages in medical malpractice actions. Ind L Rev 2004;37(3):775-809.
31. Strauss SA. Doctor, Patient and the Law. 3rd ed. Pretoria: Van Schaik, 1991.
32. Studdert DM, Mello MM, Sage WM, et al. Defensive medicine among high risk specialist physicians in a volatile malpractice environment. JAMA 2005;293(21):2609-2617 [http://dx.doi.org/10.1001/jama.293.21.2609]
33. Pepper MS, Nöthling Slabbert M. Is South Africa on the verge of a medical malpractice litigation storm? South African Journal of Bioethics and Law 2011;4(1): 33.
34. Farrell A, Devaney S, Dar A. No-fault compensation schemes for medical injury: A Review: Interim Report (Scottish Government Social Research) 2010: 6-11.
35. Oliphant K. Medical malpractice and compensation: Comparative Observations in Medical Malpractice and Compensation in Global Perspective. Berlin: De Gruyter, 2013:522-523.
36. Siegal N, et al. Adjudicating severe birth injury claims in Florida and Virginia: The experience of a landmark experiment in personal injury compensation. Am J Law Med 2008;34(4):493-537.
37. National Health Service. Redress Act 2006, chapter 44. London, United Kingdom.
38. Stauch M, Wheat K. Texts, Cases and Materials on Medical Law and Ethics. London: Routledge, 2012:293.
39. Nelson LJ, Morrisey MA, Kilgore ML. Damages caps in medical malpractice cases. The Milbank Quarterly 2007;85(2):259-286.
40. Kelly C, Mello M. Are medical malpractice damages caps constitutional? An overview of state legislation. J Law Med Ethics 2005;33(3):515-527. [http://dx.doi.org/10.1111/j.1748-720X.2005.tb00515.x]
41. Moore v Mobile Infirmary Association 592 So 2d 156 (Alabama 1991).
42. Ferdon v Compensation Fund 701 NW 2d 444 (Wisconsin 2005).
43. Lebron v Golllieb Memorial Hospital No 2006 L 12109 (Illinois 2007).
44. Studdert DM, Mello MM, Brennan TA. Medical malpractice. N Engl J Med 2004 15;350(3):283-292 [http://dx.doi.org/10.1056/NEJMhpr035470]
45. Republic of South Africa. Constitution of the Republic of South Africa, Section 9, Government Gazette 1996.
46. Republic of South Africa. Constitution of the Republic of South Africa, Section 34, Government Gazette 1996.
47. Currie I, de Waal J. The bill of rights handbook. 5th ed. Cape Town, Juta, 2005: 229, 703.
48. Bernstein v Bester NO 1996 (2) SA 751 (CC) para 105.