MEDICAL MALPRACTICE LITIGATION

PITFALLS IN SOUTH AFRICAN PRACTICE TODAY

“Even if you are among the world’s best physicians, litigation and HPCSA complaints don’t go away... any patient can sue or complain about anyone and anything; and they do.” – Dr Volker Hitzeroth, commenting on the complex medicolegal web of clinical practice in South Africa

Introduction

South Africa has witnessed a sharp increase in medical malpractice litigation. This increase has been ascribed to a number of factors, including normalisation to global trends, increasing public awareness of patient rights and deliberate targeting of the public by medical malpractice attorneys. In addition to an increased number of clinical negligence complaints, the value of financial compensation claims is rising significantly. Technological advances and increased life expectancy affect claim size, particularly for catastrophic claims such as birth defects and brain injury. Most of these increases have been seen in the riskier specialties such as obstetrics, spinal surgery, neurosurgery and neonatology.

Negligence is a legal concept. It does not necessarily mean neglect or wilful misconduct, but a failure to attain a reasonable standard of care. If a doctor’s management of the patient is considered reasonable by a responsible body of peers, a court would be unlikely to find him or her guilty of negligence. In cases of negligence, the only remedy available in law is financial compensation. Before damages are payable, however, the claimant must prove that they were owed a duty of care, that there was a breach of that duty of care and that damage was suffered as a result.

KEY MESSAGES

- A sharp increase in both the number and value of negligence claims has occurred in South Africa
- Even if not directly responsible for an adverse incident, all members of the health care team may face medicolegal consequences
- Common South African medicolegal problems have arisen from failure to appreciate legal responsibilities, problems with clinical management, systems and resourcing, and failure of communication
- Common triggers for malpractice complaints in South Africa include billing and account issues, manner and attitude, disparaging colleagues, and communication gaps in handover to colleagues
- Comprehensive record-keeping is essential and is the best defence in any malpractice litigation
- Medical malpractice litigation may have many negative consequences for the individual practitioner and the health care system
Patients and doctors tend to approach a consultation with markedly different agendas, a situation that can easily lead to misunderstandings, frustration and disappointment unless the needs of each party are met. Disappointed patients are far more likely to sue when the outcome of clinical care fails to meet expectations.1

At the sixth annual congress of the Faculty of Consulting Physicians of South Africa (May 2017), Dr Volker Hitzeroth discussed the current local context of medical malpractice litigation. He considered the role of the specialist consultant physician in a patient’s journey as part of a greater health network.

From a referring GP in the community, the patient travels to an ER centre at a hospital, to the admission ward, to the consulting physician. The physician consults with pathologists, radiologists and other colleagues. The patient is then discharged and followed up. An adverse incident anywhere along the path of this journey may have medicolegal implications for any, or all, of those who were involved with the management of the patient, even if not directly responsible or even present at the time of the incident.

Common medicolegal problems in South Africa

According to the Medical Protection Society (MPS), most incidents giving rise to medicolegal problems in South Africa fall into one of four categories.2

Failure to appreciate legal and professional responsibilities

Key responsibilities of a health care practitioner at all times:

- Act in the best interests of patients;
- Respect patient confidentiality, privacy, choices and dignity;
- Maintain the highest standards of personal conduct and integrity;
- Provide adequate information about the diagnosis, treatment options and alternatives, costs associated with each, and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making;
- Keep professional knowledge and skills up to date;
- Maintain proper and effective communication with patients and other professionals;
- Except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment, from the patient’s next of kin; and
- Keep accurate patient records.

Problems in clinical management

- Do not deviate from accepted practice embodied in evidence-based guidelines unless there are very good reasons for doing so. These reasons must be documented contemporaneously in the medical record;
- Do not undertake tasks beyond your competence, unless emergency intervention is required and you are the only (or most experienced) doctor available;
- Ensure that sufficient help and equipment are available for any procedure undertaken, and for the management of all foreseeable complications;
- Medication errors are commonly caused by inadequate knowledge of patients and their clinical conditions, inadequate knowledge of medication, calculation errors, illegible handwriting on prescriptions, confusion regarding the name of the medication and poor history-taking.

Systems and resourcing problems

The most common systems failures are:

- Failure to pass on important information;
- Failure to arrange appointments, investigations or referrals with the appropriate degree of urgency;
- Failure to review the results of investigations;
- Failure to arrange follow-up and monitoring;
- Mislabelling, misfiling and failure to check labels.

Communication failure

Keeping people informed in the interests of continuity of care must be balanced against the need to maintain...
Confidentiality, and both these issues should be borne in mind when sharing relevant information about patients. Issue clear and unambiguous instructions when prescribing medication to be administered by other members of the health care team and document the administration of drugs and infusions (name, time, dose).

Common triggers for South African malpractice complaints

Dr Hitzeroth has formulated a list of triggers for problems he commonly encounters in the South African setting.

Billing and account issues
One of the most important aspects of a practice is the billing department, which is very commonly neglected. Account disputes may trigger a malpractice claim, particularly if the patient is unhappy or dissatisfied and perceives the problem as remaining unresolved. Ensure billing is in order. Respond to problems as soon as possible.

Manner and attitude
During a consultation, be aware of your words, manner and attitude while interacting with the patient, including any physical contact during an examination. Always follow up calls, messages and requests for meetings and make comprehensive notes. Ensure administrative staff are aware of the appropriate manner for and requirements of patient interactions.

Disparaging colleagues
Don’t disparage colleagues. Always be honest and objective. If you don’t know the facts, say that you don’t know the facts.

Communication gaps in handover
Ensure that the handover is not rushed, with properly documented notes.

Pitfalls to practice
“When we hear facts that challenge us, we selectively amplify what suits us, ignore what does not and reinterpret whatever we can.”

Dr Hitzeroth presented a number of fictional examples of common scenarios that might occur in medical practice in South Africa, with specific learning points, to highlight the common litigation pitfalls of informed consent, consultation with colleagues and recording of all contacts (See cases 1-7).

Informed consent
South Africa’s National Health Act obliges practitioners to tell patients of the range of diagnostic procedures, treatment options, risks, costs and consequences of each in a language the patient understands and that takes into account their level of literacy. This also includes the right to refuse health services and an explanation of the implications, risks and obligations of refusal. It is also necessary to consider a patient’s expectations. Many claims and complaints arise from patients feeling disappointed as a result of an experience or outcome being different from what they were expecting. Document the substance of these interactions, including the date, time and who was present.

Consultations with colleagues
Document the substance of consultation sessions with colleagues (formal, informal, academic ward rounds, weekend handover), including the date, time and who was present.

Record all contacts
Document the substance, date, time of and participants in all contacts: nursing instructions, telephone calls, ER referrals and follow-up of urgent test and screening requests, family contacts and ward rounds.

Clear, objective and contemporaneous
medical records are essential to defend a malpractice claim. Common problems with record keeping that may compromise patient safety include failure to record negative findings, drug allergies and adverse reactions or the results of investigations and tests; not recording the substance of discussions regarding treatment; illegible, unsigned or undated entries and altering notes after the event.

### Consequences of complaints

Ideally, a healthy tension between the medical and legal professions should lead to an overall improvement in quality of health care and help to reinforce and possibly define standards of care that are evidence-based. Patient dissatisfaction may result in a combination of a financial compensation claim, HPCSA inquiry, complaint to the hospital where one practises, inquest, criminal charges and complaints on social media.

There are many negative consequences to claims of negligence. Most MPS members who had experienced untoward incidents in their practice found that negligence claims shook their confidence and eroded their job satisfaction. Negligence claims can have the same emotional impact as a major illness, loss of a loved one or a severe career setback. Reported clinical manifestations include irritability, headache, insomnia, difficulty with concentration, clinical depression and suicide. Communities with smaller populations may be deprived of access to specialist care and expertise; a practitioner may not be able to perform sufficient clinical procedures to justify the cost of indemnity. Therefore, he or she will move to a bigger community or stop practising medicine altogether. Aspiring practitioners may be deterred from high-risk specialties or from the medical profession altogether, with a resultant health systems capacity shortage.

Furthermore, negligence claims have direct and indirect effects on the cost of health care. Increased health practitioner indemnity costs or insurance premiums can translate into higher consultation fees. Payment of compensation reduces the state’s ability to finance health care, further destabilising an already overburdened and under-resourced health system. The practice of defensive medicine may result in additional or unnecessary diagnostic and screening tests and procedures and may also expose the patient to unnecessary risk.

### Case 1 – Telephone referrals and instructions

38-year-old female patient, known diabetic, presents to community GP with hypoglycaemia. Alleged negligence (delay in treatment) resulting in brain injury. Summons includes GP, ER doctor, physician and hospital. High claim. No documentation of substance or time of telephone communications between GP, ER doctor and the physician.

**Specific learning points**

- Document the substance of telephone referrals and instructions, including date, time and who the participants were.
- Once a physician has answered a call, they are responsible or partly responsible for the patient. If you are not available to take calls, leave a message with clear instructions as to who is responsible, with their contact details.
### Case 2 – ‘Midnight corridor’ consultation

37-year-old male nurse, chest pain with ECG, asks physician to ‘take a quick look’. Physician allegedly missed myocardial infarction. No records of this contact as it was not a consultation, and the physician did not formally consult with the patient. Moderate claim and social media complaint by the patient.

**Specific learning points**
- Physicians should create a practice file for odd or unusual contacts and consultations.
- Ensure there is a practice policy on how to manage informal interactions with colleagues and other involved parties. The policy should be clear and visible; and the physician should be comfortable enough to respond only within that boundary. Rather recommend formal routes of interaction through admission wards or appointments in consulting rooms.

### Case 3 – ‘Who did what, when?’

57-year-old male patient, hypovolaemic shock. Alleged negligent arterial line insertion during resuscitation, with subsequent compartment syndrome resulting in arm amputation. Moderate claim, HPCSA complaint, social media complaint by son against physician, ER doctor and surgeon. Nobody is able to say who inserted the line, due to poor record-keeping. Nursing notes are not comprehensive; the physician was not at the hospital at the time of insertion and yet the nursing notes imply, but do not state, that the physician performed the insertion.

**Specific learning points**
- Keep your own notes. When, where, what actions, by whom? Ideally, the resuscitation should be reformulated from clinical notes without having to rely on memory.
- Use a voice recorder for note-taking if this proves easier.

### Case 4 – Surgical complications

47-year-old male cardiac patient. Request from specialist surgeon for pre-operative assessment and optimisation by physician. Adverse incident during surgery results in brain injury, death. Physician, surgeon, anaesthetist and hospital all face high claim, HPCSA complaint, legal inquest into cause of death and criminal charges of manslaughter. Lack of informed consent documentation resulted in criminal charges of assault for the duration of the operation.

**Specific learning points**
- Ensure you are aware of the indemnity status of colleagues.

### Case 5 – ‘Bread-and-butter’: polypharmacy and co-morbidity

45-year-old female patient, 12 co-morbid conditions. Polypharmacy, drug interactions and/or side effects lead to renal (or liver or bone marrow) failure, ICU or transplant or death. Physician faces moderate claim, HPCSA complaint, social media complaint.

**Specific learning points**
- ‘Know your medicines’; check the SAMF or MIMS.
- Inform the patient and their family of potential side effects.
- Follow up by phone if concerned, listen and respond to concerns, return calls. Comprehensively document these interactions.
**Case 6 – Missed diagnosis**

69-year-old female patient, risk factors for stroke. Missed thrombolysis with subsequent stroke. Physician, ER doctor and radiologist face high claim and HPCSA complaint. Physician can’t recall what was explained to the patient and family, or when, and there are no notes.

**Specific learning points**

- Comprehensively document the substance of all interactions, making careful note of where, when and who was present.
- It is the physician’s responsibility to promptly follow up on the results of special investigations, particularly if they have been urgently requested.

---

**Case 7 – Missed diagnosis**

24-year-old male patient, acute-onset renal failure. Alleged delay in diagnosis has resulted in lifelong renal care, dialysis and transplant. Physician, pathologist, radiologist and hospital face high claim.

**Specific learning points**

- Respond promptly to results of special investigations.
- Look for causation and consult with colleagues. Consider a second opinion, further investigation and/or joint ward round. Keep records of these interactions.

---

**References**