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Ethics

Avoiding malpractice litigation and defending claims of negligence

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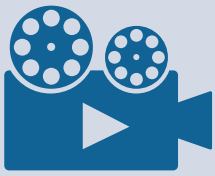
Dr Graham Howarth
Head: Medical Services in Africa
Medical Protection Society



Are you up-to-date?
A critical part of any defence (click here to watch video)

Introduction

In South Africa, medicolegal complaints and claims often arise from the failure of the clinician, pharmacist or allied health professional to fully appreciate their legal and professional responsibilities, problems with clinical management or systems and resourcing, and communication failure. 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.

KEY MESSAGES

- Medical negligence is a legal concept that implies failure to attain a reasonable standard of care
- Failure to manage patient expectations, or mismanaging the informed consent process, is a common pitfall giving rise to malpractice litigation
- The absence, or poor quality, of medical records makes defence of litigation very difficult
- For successful litigation, the claimant has to prove a duty of care towards them, a breach of standard of care and that the harm claimed is unequivocally a direct result of the alleged negligence.

The concept of negligence

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 a patient is considered reasonable by a responsible body of his/her peers, a court is unlikely to find him/her guilty of negligence. In cases of proven 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 and that damage was suffered as a result of that negligence.[1]

At the eighth annual congress of the Faculty of Consulting Physicians of South Africa, 14-16 June 2019, Dr Graham Howarth represented the Medical Protection Society (MPS) in hosting a workshop considering pitfalls to avoid for litigation and the core features of the litigation process.

What are common problems in defending medical malpractice litigation?

Dr Howarth points out that depending on the field of medicine being practised, doctors may be more vulnerable to different types of complaints. These may be real or perceived delays in diagnosis or be therapy related - an act where something has gone wrong or an omission where something hasn't been done.

Many Health Professions Council of South Africa (HPCSA) complaints arise as a result of charging for special investigations, with a common patient misperception

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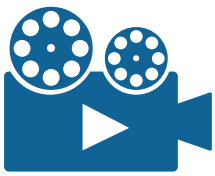
being that these are included in the consultation fee. Communicating all details of the costs or charges a patient will have to meet is part of the informed consent process (Table 2), which is both a statutory obligation under the National Health Act and important for managing the expectations of the patient. Consent is patient-specific and can depend on individual circumstances such as lifestyle, age and/or occupation. Any competent adult can refuse treatment, and all adult patients are presumed competent unless proved otherwise.[2]

Table 2. The informed consent process

Minimum requirements of the informed consent process[3]
• Details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated
• Uncertainties about the diagnosis, including options for further investigation prior to treatment
• Options for treatment or management of the condition, including the option not to treat
• The purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure, including common and serious side effects
• For each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes that may be caused or necessitated by the treatment
• Advice about whether a proposed treatment is experimental
• How and when the patient's condition and any side effects will be monitored or re-assessed
• The name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team
• Whether students will be involved, and the extent to which they may be involved in an investigation or treatment
• A reminder that patients can change their minds about a decision at any time
• A reminder that patients have a right to seek a second opinion
• Where applicable, details of costs or charges that the patient may have to meet.
Important factors to consider when obtaining a patient's consent[4]
• Take the patient's particular circumstances into account when discussing options including the risks, benefits, cost and expected outcome of each option, as well as the option of doing nothing
• Check the patient's understanding. If the patient lacks decisional capacity, obtain it from someone whom the law recognises as a valid substitute
• Be careful not to place the patient under pressure to choose a particular course of treatment
• Be transparent about any financial interest you might have in a recommended healthcare facility.

… it may be more difficult to defend doctors in South Africa for a variety of reasons; … one of the major factors is poor medical record-keeping



Informed consent: the burden of proof is on you
(click here to watch video)

Good record-keeping – key to defending malpractice litigation

Of MPS cases in South Africa, just under 50% are settled successfully in favour of the practitioner, a lower rate than in other countries. Dr Howarth is of the opinion that it may be more difficult to defend doctors in South Africa for a variety of reasons; although he feels that one of the major factors is poor medical record-keeping. He dispelled the myth that if there are no notes, then a patient cannot successfully sue the practitioner. "The absence of notes makes defence very difficult."

The nature of negligence claims means that it can often be years before a case is heard and fully resolved. In South Africa, the limitation period for bringing a claim of clinical negligence is three years from the date of knowledge – that is, the date on which a patient becomes aware of a problem.[5] The case may only get to court many years later and the judge must rule on a balance of probabilities, determining which story is the most likely. The claimant will be the first to give evidence, with their memory of the event deemed to be based on a unique event in their life compared to the doctor's, who sees many patients and whose memory of the long-ago interaction may not be as reliable.

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"The absence of notes makes defence very difficult"

The doctor will give evidence based on their notes - contemporaneous evidence from the time of the treatment or incident in question.

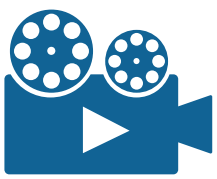
The primary function of medical records is to facilitate continuity of care and good-quality medical records are essential for safe and effective healthcare. These should enable a reconstruction of the essential points of each patient contact and be comprehensive enough to allow a colleague to carry on where the original practitioner left off; being characterised as comprehensive, contemporaneous, comprehensible and accurate (Table 3). Poor record-keeping is in itself evidence of poor clinical practice - it is substandard practice to keep substandard records. In the event of a claim or complaint, the practitioner will be starting from a weakened position if records are poor or non-existent. With poor or no records, it is much easier for the court to prefer the patient's evidence in respect of what actually happened.[6,7]

Pitfalls in medical record-keeping that can compromise patient safety or lead to medicolegal problems include failure to record negative findings, the substance of discussions about the risks and benefits of proposed treatments, drug allergies or adverse reactions and the results of investigations and tests. Other common problems include illegible entries, not reading the notes when seeing a patient and altering notes after the event.[4]

The practitioner is innocent until proven guilty; however, it is advantageous to be able to prove innocence

Table 3. Principles of good record keeping[4,7,8]

Absolute minimum necessary for each patient's records[8]
• Personal (identifying) particulars of the patient
• The biopsychosocial history of the patient, including allergies and idiosyncrasies
• The time, date and place of every consultation
• The assessment of the patient's condition
• The proposed clinical management of the patient
• The medication and dosage prescribed
• Details of referrals to specialists, if any
• The patient's reaction to treatment or medication, including adverse effects
• Test results
• Imaging investigation results
• Information on the times that the patient was booked off from work and the relevant reasons
• Written proof of informed consent, where applicable.
Medicolegal and risk-management perspectives on record-keeping[4]
• Include all important positive and negative findings from the consultation with the patient. Information about the presence or absence of certain signs or symptoms at different stages in the course of a patient's illness is not only important for forming a picture of the development of the patient's condition, but can be crucial in defending any future medicolegal challenges
• Differential diagnoses, including reasons for ruling out (or preferring) a potential diagnosis
• Details of discussions with the patient about the risks and benefits of proposed treatments, including the risks of no treatment, costs and any information given to them in this regard (e.g. patient information leaflets)
• Any advice or warnings given to the patient – e.g. not to drive while taking certain medications
• Arrangements for follow-up tests, future appointments and referrals made
• Any instructions or advice given to the patient. It is particularly important to make a note of any instructions about what to do if symptoms change, persist or worsen, such as returning for another consultation.



How good are your records? (click here to watch video)

Core features of the litigation process

Although different healthcare practitioners may face different types of medicolegal claims, the principles of litigation remain the same, regardless of the nature of the complaint. Dr Howarth maintains: "The litigation process itself is straightforward."

The central tenet of litigation is burden

This CPD accredited programme was written for *deNovo Medica* by Glenda Hardy
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of proof – the practitioner is innocent until proven guilty; however, it is advantageous to be able to prove innocence. In a criminal case, the burden of proof remains the responsibility of the state; in a civil case it is the claimant's responsibility.

Duty of care

The first requirement of medicolegal litigation for the claimant is to show that the practitioner had a duty of care towards them. In cases where covering for a colleague or phoned in an emergency setting, duty of care is initiated upon handover or answering of a call, provided that the practitioner has been informed of the patient. It is not necessary to have consulted with the patient if there is the anticipation that the practitioner is available for care. Dr Howarth states that the MPS has never pleaded duty of care in defence.

Breach of duty of care

In a given situation, what is the standard of care anticipated from the practitioner? What would a reasonable practitioner do under the circumstances? David McQuoid-Mason, Professor of Law at the University of KwaZulu-Natal, proposes: "The test is whether a reasonably competent practitioner in the defendant's position would have foreseen the likelihood of harm and taken the steps to guard against it." Guidelines can be useful in that they furnish a standard of care against which the average practitioner should be judged.

Professor McQuoid-Mason considers medical negligence to mean that the practitioner has failed to exercise the degree of skill and care expected of a reasonably competent practitioner in that particular branch of medicine. It is the responsibility of the claimant to prove this breach of standard of care.

Causation

Causation is often the most difficult argument that the claimant must prove. This inherently implies that the harm claimed for has unequivocally occurred as a direct result of the negligence. Without proof of causation, a claim will not be successful.

In South Africa, a doctor can be found guilty of culpable homicide in the case of negligence if the judge is convinced beyond reasonable doubt that death was a foreseeable outcome. The most important factor in this scenario is the judge's determining the extent of negligence.

Damages

A practitioner may be found guilty based on one of the abovementioned elements, but not necessarily another. For the practitioner to be found liable for damages, the claimant must establish that there was a duty of care, that the duty was breached and that the breach was responsible for the adverse outcome. Quantum arguments then revolve around the value of the damages.

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Click on reference to access the scientific article

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