

Medical Negligence Suits: Risk Management

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Summary

Medical negligence suits have become an issue of concern for doctors as well as for the health service departments. The main objectives of medical malpractice law are to compensate patients who are injured by negligence and to improve the quality of medical care. The amount of money and time spent on these cases may not be an effective allocation of social resources to minimize patient safety. Though physicians generally win more malpractice suits, much time and money are spent and results in much stress to those concerned. There are certain controllable events in practice that render a physician more or less vulnerable to malpractice claims. Attempts by physicians to understand and prevent unwanted situations that can lead to litigation is important. The risk factors for medical negligence suits are discussed. The practice of good medicine will be the best form of risk management.

Key Words: Medical negligence, Medical malpractice, Risk management

Introduction

Medical negligence is the failure of a health-care provider to exercise the ordinary care and skill that a prudent, qualified person would exercise under similar circumstances. When a patient is injured by such malpractice the fairness of any compensation will depend upon the country's legal system. Medical malpractice actions have two main objectives: quality control and compensation for physical and emotional harm.

Medical negligence has been recognized more than 4000 years ago. The Babylonian king Hammurabi promulgated a law that provided that a physician whose patient lost an eye as a consequence of surgery should himself lose his

hand. Ancient Egyptians provided for banishment or death as the physician's penalty for malpractice, and the Romans also assessed similar penalties.

The traditional physician-patient relationship, based on mutual respect, has begun to fade; and a business model with customer and provider slowly, but steadily, emerged in its place. As the public's knowledge of patients' rights increases, inappropriate medical action resulting in harm is now commonly perceived in some countries as an opportunity for financial compensation.

Americans file claims more than 10 times as often as their British counterparts do. Many reasons have been offered to explain this difference: different legal systems and rules, access to

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attorneys and courts, method for paying medical expenses, the existence of a National Health Service in the UK, and the use of different complaints procedures. The highest number of medical negligence case reporting in Europe is in Ireland.

The "information age" is making physician-profiling information, including malpractice-claims data, more easily accessible to the public. A growing number of US states are interested in making use of new technology to increase consumer awareness¹.

In Malaysia it is not possible to exactly identify the number of medical accidents that occur each year in our clinics and hospitals and the number that are litigated because official statistics are not available. It is estimated that the number of litigation may be around 20 to 30 cases per year². The amount of compensation awarded in Malaysia is nowhere near the awards made by American juries or the English courts. This is partly due to the position taken by the government. Our Prime Minister Dr Mahathir has said that amendments (made to Civil Law Act in 1984) were necessary to prevent Malaysia from becoming "a litigious society" like some Western nations. The other reason being the judicial climate in Malaysia, which had subscribed strictly to the 'balancing interest' of both doctors and patients.

The problem of medical negligence suits is not common in Malaysia yet, but it is slowly picking up. This article will look into ways of reducing medical negligence suits.

Medical Malpractice Suits

To prevail in a medical malpractice suit, the plaintiff (the person who brings the suit) must demonstrate 4 key elements to the judge. These concepts are well known to most medical personnel, but it is worthwhile to re-iterate them here. They are, in order:

(1) the physician had a duty to treat or otherwise provide a service to the plaintiff (i.e., a physician-patient relationship had been established).

- (2) The physician breached that duty to the plaintiff. This usually requires the introduction of medical expert testimony to demonstrate the physician fell below the "minimally acceptable standard of care."
- (3) This breach of the appropriate standard of care proximally caused the plaintiff harm.
- (4) Finally, although seemingly obvious, actual damages must be suffered by the plaintiff, and they must be proven with specificity (i.e., quantified in some way)³.

Magnitude of the Problem

The recent medical malpractice "crisis" has seen skyrocketing liability premiums and increasing fear of liability. According to the U.S. General Accounting Office, insurance premiums cost medical providers between \$4.86 and \$9.2 billion annually, and defensive medicine costs the health care industry from \$4.2 to \$12.7 billion a year⁴.

According to the National Audit Office, clinical negligence claims cost the National Health Service UK £235 million in 1996-97, an increase of about 17% over the previous year. The UK Medical Protection Society (MPS) fields about 1400 calls every month from doctors worried about possible clinical negligence claims. An estimated 35 out of every 1000 general practitioners may actually face demands for compensation. There has been a 13-fold rise in the number of medical negligence claims of all kinds over the past 10 years⁵.

The billions of dollars spent on the malpractice system annually may not be an effective allocation of social resources to minimize patient injury, maximize patient safety, and compensate injured patients.

Studies have shown that less than 2% of injuries caused by negligent actions in a hospital setting lead to claims being filed and fewer result in payment⁶. On the other hand, some claims are filed although there was no negligence, but most do not lead to payment⁷. It has been noted by one insurer that payments were made on only 43% of the claims filed, of which 21% were considered defensible⁸.

While physicians generally win more malpractice suits than they lose, their success rate is decreasing. Furthermore, the time needed by physicians to resolve these claims is increasing⁹. Although distressing, physicians must recognize that claims arise for any number of reasons that may or may not be related to their negligence. Furthermore, despite their eventual exoneration much time and money are needed and much stress results from these suits they "win."

Risk Management

Why do some physicians experience one or more claims during their careers and others do not? The central question is whether or not identifiable aspects of medical practice are associated with increased vulnerability to claims. The assumption among risk managers is that certain controllable events in practice tend to render a physician more or less vulnerable to malpractice claims¹⁰. The majority of errors in medicine are not the fault of individual care providers but are the result of more systematic problems¹¹.

To tackle medical error head on, therefore, we need "new" research teams with expertise from organizational managers, human factor engineers, and other industries, such as aviation and manufacturing sectors that have already been successful in reducing errors. We also need additional expertise from lawyers, not to litigate lawsuits, but to assist in developing legal protection for those who report and process information about medical errors and events.

Unfortunately, one of the major reasons we know so little about the epidemiology of medical near misses and errors is because of our current legal system. The potential for litigation deters physicians and other care providers from furnishing information that could reveal mistakes in the system, because this information also could be used against them in a lawsuit. Errors should be learned from, not covered up. Using punitive reports of malpractice claims to educate physicians may only perpetuate the underreporting of errors and make it more difficult to collect the

information necessary to make patients safer. The role of data within malpractice databases, therefore, may be more useful as one source of data for health care team leaders to set priorities and to the "new" health care research discipline that will understand the environment in which medical error occurs and the proper methods to alleviate the stresses.

Relationship Between Malpractice Suits and Error

Most studies indicate that most 'malpractice' suits have little relationship with error, especially in the hospital setting. Indeed, most errors do not result in litigation. Conversely, most litigation has very little to do with errors, merely unfortunate outcomes and, as has become increasingly clear, failure of communication between doctor and patient.

A study was done in US, where an anesthetist did peer-review in all cases with adverse outcome. Surprisingly none of the 13 cases in which a disabling injury was caused by deviations from the standard of care, as determined by peer review, resulted in legal action; none of the 18 cases involving legal action were found to be caused by human error on the part of the anesthesia provider. More striking in the study, however, is the finding that patients who are victims of disabling injuries resulting from deviations from the standard of care are often not compensated by our legal system¹². Attempts by physicians to understand and, it is hoped, prevent unwanted situations that can lead to litigation are paramount. A better understanding of why patients sue may also enhance quality of care and better outcomes. Patients have a high expectation of a successful outcome and are more inclined to sue for an unsatisfactory outcome. A bad outcome is not evidence of malpractice, although some studies have suggested that a bad outcome is frequently seen in patients who bring litigation^{13,14}.

Risk factors for Medical Negligence Suits

Communication: Failure of communication between doctor and patient has been identified as

one of the factors responsible for the suits. Doctors who fail to communicate adequately with patients and families are much more likely to be involved in a professional liability action than those who communicate successfully, no matter how unfortunate the clinical outcome¹⁵. As an increasing number of studies demonstrate that 'malpractice' suits and practice below the accepted standard have only a weak correlation, and confirm that the real problem is communication, an increased emphasis is being placed on communication skills in colleges of medicine and training programmes. In colleges a new movement known as 'professionalism' is being advocated and communication skills are stressed as a major part of this initiative.

Informed Consent

Before the performance of any procedure, the patient should be fully informed of the benefits, risks, and potential side effects of the procedure. The proper standard is "what information would the reasonably prudent person need to know before having this procedure? This includes informing the patient of common but minor complications and those that are rare but potentially serious. All truly informed consent by patients includes knowing the consequences of doing nothing (i.e., no procedure or test at all).

For most routine laboratory work, radiographs, etc, written consent is not required. However, for virtually any invasive procedure, and for many types of medical therapy, documentation that the patient has been informed of the risks and benefits of the procedure or therapy will often serve as an excellent defense for the physician if treatment is unsuccessful or complications ensue.

The doctrine of informed consent has been recognized in Malaysian courts. The Judge in a recent court case held that, 'it is common ground that there is in law a duty on a doctor to warn the patient of any material risk in undergoing or foregoing surgery or treatment'¹⁶.

Record Keeping

It is important to have proper recording of all the cases for future reference. Electronic Medical Recording (EMR) has been widely used in developed countries and some of the third world countries. An advantage of EMR is that systems can be designed to automatically remind physicians of pending laboratory or radiographic results, flag abnormal results for specific attention, automatically generate notices to patients who are "no-shows" for appointments, and suggest appropriate health screening given the patient's age, sex, demographics, etc.

A serious potential pitfall exists regarding the review of laboratory and radiograph results. It is not uncommon for the busy primary care physician to request laboratory tests and/or radiographs for a patient, only to receive the results at a later date and frequently in piecemeal fashion. In many practices, laboratory or radiograph reports can be misplaced, misfiled, or simply placed in the patient's chart without the ordering physician's review.

Qualified Assistants

Through the legal concept of respondeat superior (literally, "let the master answer"), the physician is legally responsible for the actions of his/her employees, as long as the employee is acting in the scope of their employment. This raises many concerns for the primary care physician who employs nurses, laboratory or other technicians, or any other personnel (even nonmedical) in his/her practice. In a medical negligence case in India, a child had cardiac arrest after an unqualified nurse gave the injection without the supervision of the doctor. The insurance company refused to pay the compensation because the hospital engaged an unqualified nurse¹⁷.

It is the responsibility of the employer to assure that their staff are properly credentialed, trained, and certified, where appropriate, and/or legally required. An employer, who knowingly hires or retains a person with a background of criminal

behavior, repeated negligence, sexual predation, etc, will almost certainly be subject to liability in the event that a patient or family member becomes injured.

Complaints Board

An easily accessible complaints procedure to give patients and their families redress without resorting to expensive and protracted court cases should be there. "Often the patient just wants an investigation, an apology, and an assurance that it won't happen again, they are not looking for drawn-out cases in an adversarial environment". Such informal procedures in the UK had led to 93% of complaints against GPs being resolved without resort to court¹⁸. In Malaysia, Malaysian Medical Association and Malaysian Medical Council are the avenues for the patients and their families to complain about medical negligence. Now the Ministry of health is setting up an independent body to probe cases of medical negligence, comprising non-medical practitioners. The body will not only ascertain whether there has been negligence, it will also determine how the incident happened and also measures that will prevent any future recurrence¹⁹.

Medical Indemnity Coverage

All medical practitioners must ensure that they have adequate medical indemnity coverage. Whenever they change the place of practice or start doing new procedures they have to inform and make necessary amendments to their indemnity coverage. It is imperative that physicians maintain ongoing communication with

malpractice liability carriers, insurance agents, and/or risk managers.

Conclusion

We are more concerned with reducing errors in Medicine; as such quality assurance programs are set up to study ways and means to reduce the problems. However, a change in the culture of medical practice towards encouraging suggestions for improvement rather than being fearful of complaints and the consequences must be given priority.

Auditing medical records should be a more fact finding exercise rather than fault finding. Good clinical practice must always prevail because it would incorporate the moral philosophy of good medicine. The criterion of good clinical practice as stipulated by the law is that of a reasonably skilled doctor in his profession.

Physicians are encouraged to let the practice of "good medicine" be the best form of risk prevention. This obviously includes good communication with patients and their families regarding the risks, benefits, and possible complications of the planned medical regimen. Many physicians unfortunately take a cynical approach to the problem of medical liability and practice medicine with the goal of "not being sued" versus simply providing quality, cost-efficient care. The article has attempted to make the reader aware of the medical negligence suits and the risk areas so that appropriate risk management techniques may be employed to minimize risks.

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MCQ's : Medical Negligence Suits: Risk Management

1. The following statements regarding Medical negligence are true/false:
 - A. It is the failure of a health care provider to exercise ordinary care and skill.
 - B. It has been recognized more than 4000 years ago.
 - C. Medical negligence data are accessible to public in some states in USA.
 - D. Physicians wins more malpractice suits than they lose.
 - E. There are controllable events in practice that tend to render a physician more or less vulnerable to malpractice suits.

2. Regarding medical malpractice suits
 - A. They are hundred times higher in USA compared to Britain.
 - B. The highest number reported in Europe is in Ireland.
 - C. The number of litigation cases in Malaysia is around 100 per year.
 - D. In UK there is a 13-fold increase in suits in the last 10years.
 - E. Less than 2% of injuries caused by negligent actions in a hospital setting leads to suits.

3. To succeed in a medical malpractice suit the patient has to prove in the court that
 - A. the physician had a duty to treat.
 - B. the physician breached the duty.
 - C. appropriate standard of care was not provided.
 - D. the patient must have suffered damages.
 - E. the damages suffered must be proved with specificity.

4. The following statements regarding medical errors are true/ false:
 - A. The majority of errors are not the fault of the individual care providers.
 - B. Most malpractice suits have little relationship with error in the hospital setting.
 - C. Most litigation is the result of medical errors.
 - D. Study has shown that victims of disabling injuries resulting from medical errors are often not compensated.
 - E. Studies have shown that a bad outcome is frequently seen in patients who bring litigation.

5. The following are the risk factors for the medical negligence suits:
 - A. Failure of communication between doctor and patient.
 - B. Lack of informed consent
 - C. Poor record keeping.
 - D. Having unqualified nurses.
 - E. Employing one with sexual predation.