Medical liability

The dilemma of litigations

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ABSTRACT

Objective: Most if not all of the physicians are ill prepared when it comes to facing a medical litigation. Having witnessed that first hand on numerous occasions made me decide to write on this issue to offer some insight and advice on the matter as it is obvious no one is immune in the medical profession. In addition, the number of medical litigation cases is on the rise. There is no doubt that the matter is of great importance not only to doctors, medical and dental students but also to other health care workers.

Methods: The data of the cases submitted to the Medico-legal committee of the Ministry of Health, Riyadh, Kingdom of Saudi Arabia from various parts of the country for the period 1420 through to 1423 H (1999-2003) were examined and analyzed. A total of 2223 cases were referred to the various committees over the past 4-years for considerations.

Results: Obstetrics lead the way in being the most litigation prone medical specialty. Surgery takes the second place followed by internal medicine pediatrics being the fourth in order of frequency. The other specialties are some where in between. Least number of malpractice lawsuits were filed against the dental profession.

Conclusion: Litigations can not be totally prevented but it could be limited to only the legitimate ones.

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Litigation is a symptom of discontent perceived or real. Up until a decade or so ago the litigation phenomenon was not that common in this country but not any more it seems. Gone are the days when doctors were blindly trusted. Nowadays they are frequently questioned on all aspects of patients' care; at times, even their motives are not beyond reproach. Most if not all of the physicians and for that matter all health care workers in this country are ill prepared to deal with it. In this information age, scrutiny of all aspects of medical care has become the norm. The profession has to be mindful of this reality and change practice habits accordingly. The fact of the matter no one is immune and we have seen over the years that the very best among us face litigations of some description. The odds are for more of the same in the future. We attempt to look at the problem from various points of view and examine ways that might help lessen the likelihood of this ever happening.

Methods. At the outset, it must be stated that the author had no control on the data collection process or how it was constructed. It is provided by the main medico-legal committee (MLC) of the Ministry of Health (MOH), Riyadh, Kingdom of Saudi Arabia where the data from various other MLC of the different parts of the KSA are compiled. Another important point these numbers do not reflect the total cases of medical litigation in the country. It is probably just the tip of an iceberg

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representing cases that made it to the MLC in the various parts of this country. Most of the litigations are dealt with a lower level and only a selected number makes it the MLCs particularly those dealing with blood money, indemnity or compensation. A simple look at the figures will speak for itself and reveals the point already made that this problem is on the rise. In the period between 1/1/1420 (April 18 1999) through to 29/12/1420 (April 5 2000) the number of cases referred to the various MLCs was 440. The following year the number went up to 496 an increase of around 13% and after that to 569 an increase of 15%. The number has jumped to 718 cases for the year 1423 (2002/2003) an increase of 26%. One can certainly appreciate the degree of increase; the figures are up in leaps and bounds.

Results. The average increase in the number of cases is around 21% annually. Obstetrical practice takes the lion share 27% of the cases filed are due to alleged malpractice in this specialty. The rest of the breakdown is as follows general surgery claimed 17%, specialized surgery another 17%, orthopedics 6%, internal medicine 13%, pediatrics 10%, anesthesia and intensive care 4%, dentistry 2.5% and others that include radiology laboratories and blood banks around 3.5% **(Figure 1)**. It is interesting to note that most of the litigations are filed in the city of Jeddah, KSA Dammam, KSA takes the second place while Riyadh is in the third place. The least number of cases are filed in the Al Qassim, KSA. Female physicians are less likely than male physicians to generate complaints, necessitate risk management interventions, or provoke lawsuits. The MOH hospitals and small clinics particularly those out side of the main cities of this country form the bulk of the hospitals that are mentioned in these litigations constituting 45% of them. The private hospitals are second for providing the grounds for discontent contributing 30% of the caseload. The rest are as follows privately owned small clinics account for 11%, the military hospitals 5%, private specialized polyclinics are in somewhat better position they account for 4%, specialized hospitals 3% and the least number of cases is from the university hospitals contributing a meagerly 1.5% to this group **(Figure 2).** Negligence was proved in only 36% of cases indictments were issued accordingly. The rest were acquitted. These decisions can of course be appealed to the Board of Grievances within 60-days of receiving the MLC ruling.[1] This is usually resorted to when the plaintiffs feel that they did not get a fair decision by the committee.

Discussion. There is paucity of information when it comes to published material regarding liability issues in this country. The 10-years indexed local literature has very few references to that except for Al-Hajjaj[2] a set of guidelines for the practicing physicians. More recently Ajlouni[3] reviewed the subject of values, qualifications, ethics and legal standards in arabic (islamic) medicine. The article touched on legal matters in Islam and how the rules governing the quality control of health care delivery system were developed. In previous articles Ajlouni[4,5] wrote on informed consent and medical records. The fact that physicians were found liable and damages were awarded in 36% of the cases is remarkable. It is interesting to note that medical malpractice plaintiffs prevail in significantly fewer suits in 31.9% in Japan.[6] A similarly low success rate for plaintiffs in medical malpractice suits was observed in the United States of America (USA) 28% and Germany 10%.[7] It is worthwhile to mention that in spite of that the USA medical liability systems are in or near a state of crisis in many states. Doctors, hospitals, nursing homes and other health care providers and facilities are restricting their practices or closing their doors rather than face continued ruin from out-of-control lawsuits and gargantuan jury awards. Decisions in these litigations were reached by a judge unlike the western legal system where a lay jury passes verdicts that call for outrageous awards. In our system the awards are governed by the Sharia law and are not left to the temperament of the members of the committees. This in itself speaks for how impeccable the islamic legal system is. Obstetric practice leads the way in being the source of most cases. This comes as no surprise since obstetrics is the leading cause in most of the instances worldwide. In fact in the USA a considerable number of obstetricians have limited their practice to only gynecology.[8] The more recent data however suggests that primary care physicians are becoming more vulnerable in the USA and perhaps worldwide[9] and may indeed in the future reverse the lead that obstetrics always had. General surgery accounted for 17% of the litigations. Specialized surgery like neurosurgery and others were responsible for another 17% of the cases. If one lumps up all the branches of surgery together, they would account for 34% of the entire caseload in this country therefore becoming the number one litigation-prone specialty in this country. Since data are not well kept in general let alone on each specialty in particular no one will be in a position to find out for the time being which specialty in surgery is most litigation prone in this country. The literature suggests that neurosurgery leads the way in surgical practice particularly in the USA and even in Europe.

Scope of the problem. The fact is data on medical litigations are poorly kept that makes it extremely difficult if not downright impossible to retrieve the material for analysis, trends pattern and

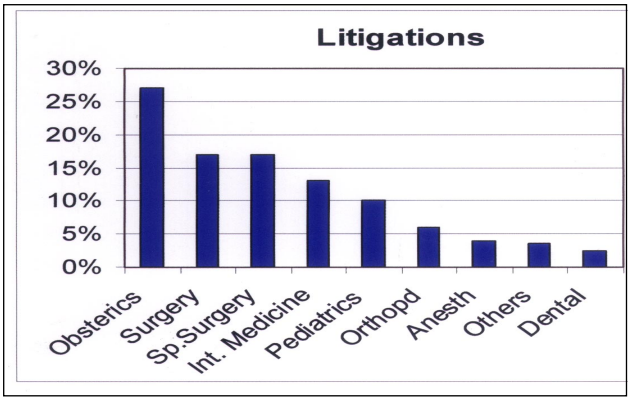

Figure 1 - Shows the different categories of the cases. Sp - specialized, Int - internal.

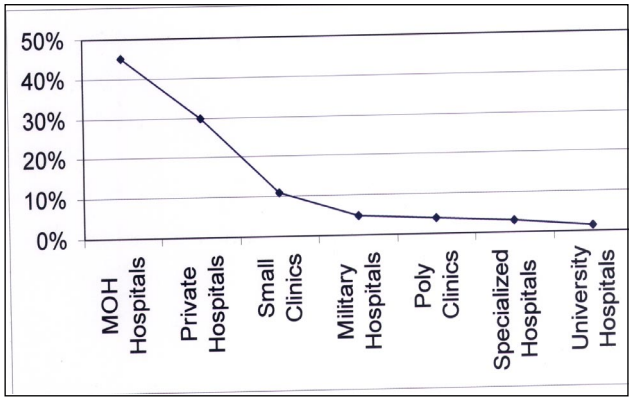

Figure 2 - The incidence of litigations in the various health care facilities. The Ministry of Health system takes the lead in litigations as compared with other health care facilities. MOH - ministry of health

actual size of the problem. Lack of accessibility hinders adequate evaluation of disputes and the development of appropriate risk management strategy. This issue will have to be addressed at some point in time. The new policy of computerizing the various departments of the ministries will go some way in alleviating the problem keeping data more easily accessible. This will obviously take some years to complete and to train the staff to be able to handle data analysis. There are some concerns regarding the invasion of privacy that this technology might bring.[10] With the MLC, data are in a somewhat better shape as they are court documents although there is a lot of room for improvement. The increased rate of litigation stems from fact people are becoming more aware of good medical care and are demanding it. Looking at the problem from various angles in order to see the reason behind this unprecedented increase in these cases can be helpful. The MOH hospitals and small clinics are fertile ground for litigations. It is not very difficult to understand why. Out side the main cities of this vast country most of the health care is offered through the MOH system. The majority of these facilities are manned by under-trained physicians and surgeons usually at the levels of registrars and senior registrars. The other significant point is that a considerable number of them do not speak Arabic thus making good relationship with the patients very difficult to attain. In addition to that, these doctors are working with under-staffed and ill-equipped hospitals and small clinics. It is no wonder therefore that these individuals do not perform that well and are the source of much discontent. The private hospitals contribute a considerable portion of lawsuits. Their track record is the same whether they are in a major city or a small town. The bottom line rules at these institutions and it is their overriding concern. They are known to cut corners and try to manage with less than ideal conditions for the sake of reducing their operating cost. The same goes on for the small clinics and the like. A considerable number of them especially those away from major cities do not meet the standards of any health care facility. It is sometimes difficult to understand how some of these facilities were able to get a license to open as a hospital, or even a small clinic in the first place. It is only fair to state that the licensing body at MOH has to bear its fair share of the responsibility. It is interesting that in some of the remote areas of the country some of these privately owned hospitals and small clinics operate without ever obtaining a license. A few are even ordered to close only to re-open at a later date again unlicensed. It is no wonder that mistakes do take place leading to litigations under that kind of setup. In such instances, it is only fair to apply the full force of the regulations to those offenders and some of them are repeat offenders. It seems that what would work best is a heavy financial fine that would cut right in their profit margin and make them think twice before ever considering re-opening for business. The other point of equal importance is what would make someone decide to sue his doctor. On many occasions, the reasons can be traced to some misunderstanding, lack of communication or to both of them. The patient or the family, or both, feel that they were sidelined and that the doctor did not explain plainly the information needed. The doctor did not take the time to see the patient regularly. Attitude has a lot to do with the decision to sue. All of this could probably be avoided by having a good rapport with the patient and the family. Taking time to explain, alleviate anxiety and try to be very patient with them. It is of course demanding on the individual but this part of the price paid to be in this profession. In spite of these efforts, one should not

be surprised when some patients would still choose to litigate and try to collect for alleged damages. If the doctors took the steps outlined the plaintiffs chances of convincing the MLC judge are pretty slim.

Recommendations. Being a serving member of the MLC makes me in a position to offer some insight. In addition having had my graduate training in the USA where litigation is the way of life can perhaps make me even in a position to offer some advice too. As fearing, the nightmare of malpractice and litigation in every aspect of medical care is the norm for any physician in that part of the world. It resulted in a pattern of medical practice that is referred to by some observers perhaps inappropriately as defensive medicine. It is fair to say that in the USA medical practice is generally tense and the effects are felt in both medical schools and the training centers throughout the country. The amounts awarded for punitive damages are astronomical. On the plus side, having doctors on the edge at all times may have contributed to a quality medical care that is second to none. Based on the experience gained by serving in the MLC these are some of the areas that frequently formed the contentious point of most litigations. The advice offered is based on the actual pitfalls observed in looking at some of the cases and formed the ground of lawsuits. 1. The number one enemy of most physicians is tunnel vision. In order to avoid that the patient should be assessed as whole otherwise valuable information could be missed. The tendency to look at the patient from one's specialty point of view may be acceptable when one is working in a large medical center that has every specialty but even then one has to be alert for other co-existing conditions. Out there in the peripheral hospitals where excellent help is usually lacking one should assess the patient from all aspects and leave no stone unturned. 2. Poor documentation is enemy number 2 and is unfortunately very rampant in the profession particularly in small hospitals, clinics and even specialized polyclinics. It is wise to remember that the name of the game is documentation and more documentation. The patient's chart or file can be looked as a legal document that could be used at any time in a court of law for or against you. One has to decide which side does he want it to be on? With that in mind, the importance of documentation cannot be over stressed. 3. The sicker the patient the more comprehensive and detailed should be the progress notes. One should not leave any thing to memory. Every aspect of the management has to be documented in order for it to be admissible in a court of law as evidence for the doctor's defense. In fact with the personal computer (PC) being so readily available one perhaps could enter additional details in the PC regarding those seriously ill patients since the space in the chart is usually limited and it is easier to type than actually write for most of us. These details can be easily retrieved in case of need. 4. In looking after critically ill patient one should make it a routine to consult with more colleagues and no one should feel any embarrassment in doing that. In many parts of the developed world, it is the hospitals bylaws to seek other opinions for critically ill patients. 5. One should always try to be current in the knowledge base. It is the best way to gain both confidence and respect specially when dealing with the well-informed patients and their family members. 6. If one works in emergency rooms or covers intensive care units then it becomes a must then to be certified in basic and advanced cardiac life support (ACLS). It is amazing to see how the basic tenets of cardiopulmonary resuscitation are not followed and many mistakes are made in managing cardiac arrests. This is particularly the case in small towns, villages and surprisingly privately owned hospitals. Small clinics are notorious for mismanaging CPR. This is a very important issue and we believe that no renewal of license to practice should be allowed without certification in ACLS. In fact it would not out of place to have all practicing doctors be certified in ACLS. With some licensing bodies in the USA, it is requirement. 7. All emergency room physicians and general surgeons who look after trauma certification in Advance Trauma Life Support (ATLS) is a must. An ACLS certification for surgeons would be highly desirable and would indeed border on being a must. The mismanagement of trauma forms the bulk of the MLC particularly when it leads to death or disability and the question of compensation arises. 8. If one is working in an under equipped and poorly staffed facility is faced with a patient who is difficult to look after under those conditions and it is not possible to transfer the patient to a better equipped center. It is indeed a must to document the management and the patient's response to it. In addition, document all the efforts made for transfer in patient's chart. Keep the relatives fully informed make them feel that you are very concerned and doing your best. In addition, one could also write in the chart what could have been achieved under an ideal medical setup. This could prove very useful if the case ever goes to court. 9. Surgeons are common targets for litigations the problem can often be traced in many instances to poor communications with the patients or his family. One should take time and explain what the surgery would entail and even describe the potential complications. Explain it in lay terms it is a lot easier to talk regarding complications before they happen so that the patient can make an intelligent decision. This is particularly important in specialized procedures like those of cardiac or neurosurgery surgery.

Called to testify what one should do. There is usually plenty of time to be prepared. It is wise to review the whole case beforehand specially one's role in the case. Write down specific dates and events in order to remember important details before the judge. That is where notes written on one's PC that were alluded too earlier can come in handy. The legal system demands accuracy in all aspects. One is allowed to review the patient's chart at the MLC to refresh the memory or to point out to a relevant documentation. One could probably consult with an attorney to prepare the affidavit or have an attorney represent him or even attend with him. In general very few doctors resort to that. It is a good idea to be brief and to the point avoiding unnecessary details and repetitions. It is acceptable to quote the relevant literature to strengthen one's position. It is allowed to bring some of these articles along to have the quotes cited in the affidavit and to form a reference for the case. It is permissible to give the affidavit in writing and it could be entered in the record as such.

Role of health care facilities. The old saying goes an ounce of prevention is better than a pound of cure applies to the health care facilities too. The ideal situation is to prevent litigations from ever starting rather than to fight it afterwards. Prevention entails expenditure but the benefits that improvements could bring would in no doubt justify the cost. The role of the hospital, clinics and small clinics would complement that of physicians in reducing the risk of litigations and its aftermath. One is often surprised by fact that basics in safe health care delivery are lacking in many institutions making them justifiably vulnerable for litigations. Most of these facilities operate without a set of guidelines for delivery of health care. Policy and procedures should be in place for all expected emergencies like cardiac arrest etc and even the unexpected community-wide disasters. There are any number of cases where basics of safe CPR were not implemented. Attention should be focused on keeping good medical records. Poor history and physical examination is another point of major concern. Poor record keeping is endemic and not enough attention is given to documentation of the various procedures carried out for the patient. It is a fact worth repeating the medical chart is a legal document; make it work for you not against you. The health care facilities should have a system of checks and balances to assess its own performance. Critical review of performance should start from within. This can be achieved by defining the level of privilege of each physician and by setting up committees to look into morbidity and mortality and to look into any legitimate concerns of the patients and their families. These facilities should also encourage the physicians on their staff to be certified in both by ACLS and those covering emergency services should be certified by ATLS. Continuing medical education CME is definitely needed in order to keep up with leaps in medical care. It is time to re-visit the consent for treatment and surgery and make it more comprehensive and even consider adding clauses regarding potential complications and risks. A lot is being said regarding having liability insurance for doctors. That is a personal choice and this is not certainly the forum to offer any advice for or against it. It is clearly not the substitute for the improvement suggested. Insurance alone without changing the root causes of litigation would result in only higher premiums as time goes on. One has to remember that insurance companies are in the market to make money and not to loose it. They understand that the margin for profits is way above any potential payouts. The history of the insurance industry clearly shows that any compensation that they pay today would ultimately translate into higher premiums for the insured tomorrow.[11]

In conclusion, there is no doubt that the increase in the number of litigations is a sign of the time. Treating the cause of discontent would greatly help prevent the problem from ever starting. Having a good relationship with the patient and the family goes a long way in fostering harmony and content. The fear of being sued will in doubt make physicians more careful in their practice. It will force doctors to update themselves and stay current in their knowledge. In spite of its ill effects litigations will translates into better patient care. The amount of mental anguish that no one can put a price tag on is understandable. Loss of freedom in the shape of ban on travel on some may just be the incentive to the procrastinators to embark on the improvement. The aim of course is prevention as the first step in the long quest for perfection of medical care.

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