EDITORIAL

Medical malpractice litigation: Is there an alternative?

Litigation against orthopaedic practitioners is alive and well, if only in the eyes of the legal profession. Orthopaedics has been in the forefront of many medical innovations over time but none as unfortunate as the case of Charles Lowell which made history by spawning the first medical malpractice litigation crisis in the USA. The unfortunate attending orthopaedic surgeon in this case was mercilessly hounded by a pack of eager legal vultures for failing to reduce an obturator dislocation of the hip in 1821. This account is interestingly documented in an article by Herndon in which he chronicles the growth of the litigation industry over the following decades.[1]

Since that time the number of complaints against practitioners leading to legal action has continued to grow. This is not surprising as we know that societal expectations will change with changing circumstances. The increased affluence of the post-Second World War era fuelled development and improved capability which in turn generated increased expectation for quality and quantity of service; demands which were handsomely embraced by the medical profession. However a changing economic climate and a relentlessly elevated expectation have led to the inevitable reaction. Quantity has prevailed over quality. Novel avenues of revenue generation and over-servicing are exploited. More time is spent on income generation than ensuring patient satisfaction. More fertile soil is exposed to the seeds of malpractice claims. With a not-so-subtle-slap-in-the-face Khan *et al* even suggest that apart from the changing expectations of the public, a growing legal services industry also plays an active role in the increase in litigation.[2] Driven by the fear of litigation, enormously costly defensive practice has emerged.[3] Additionally, patients are further compromised by exposure to complications associated with unnecessary tests and procedures.[4]

Despite the continued growth in this sector not all complaints against practitioners have sufficient substance to 'stick'. Generally most complaints do have some grounds for complaint but only a small percentage proves to be due to 'negligence'. This figure is difficult to extract from the literature and has been stated to be under-reported by Ohrn *et al*.[5] Taken at face value it would appear that the threshold for the public to lodge complaints is somewhat low. While many have termed minor complaints as frivolous, when analysed critically they frequently highlight a fundamental problem, namely one of a 'failure to understand'. Failure to understand can arise for two reasons. First, the lay public often misunderstands the difference between negligence, adverse events and error, either personal or systemic, when a medical injury occurs. Recent appreciation of these distinctions has sparked an active debate, in medical and legal circles in particular, seeking alternatives to litigation for dispute resolution.[6] Secondly, and most disturbing, is the sad failure of our own practitioners to get messages across to their patients. How does an uninformed individual know if an error has occurred if they have not been enlightened as to what may be expected? The more informed the public is, the more likely it is that the rate of complaint would match the finding of negligence.

In discussing appropriate oversight and control systems, argument has been proffered that punitive measures against individuals serve no useful purpose, and in fact do not work. A recent case that illustrates this point was where a practitioner accused of malpractice reached an out-of-court settlement which included the withdrawal of the complaint. Issue resolved? Not really. Had the practitioner been sent for inquiry the overwhelming likelihood was that a guilty verdict would have been reached and the practitioner sanctioned. Under our current legal system the complainant is silenced by a pecuniary award, paid for by you and me (via MPS or MDU), with only a miniscule portion coming from the guilty practitioner who probably learns nothing from the experience and continues to practice as before. Arguments are mounting against litigation as the appropriate oversight system, citing that it is costly, that most of the money spent accrues to the legal teams, and it is cumbersome without necessarily reaching the desired goal, which includes fairness in righting the wrong. In addition, the plaintiff will only succeed in the event of negligent practice being proven against the practitioner but will have no protection or compensation when an inherent error has occurred. Some have argued for changes in the tort system such as a shift of liability from physician to enterprise, while momentum is increasing for the introduction of health courts, no fault compensation, and, not only in medicine, towards arbitration and mediation.[7] Current thought has seen a shift from blaming the doctor for all the ills and ails that befall a patient to an appreciation that some avoidable errors will occur.

The call for change is strong. But what are the alternatives? They are:

- Measures to reduce or prevent occurrence of errors
- Improvement of patient education and communication
- Changes in the system for dealing with complaints

Error reduction

We are human. And we work in systems (not of our own making) that have boundaries that are not ideal. It is here where possible changes should be, and are being, introduced so that systems are designed to eliminate or minimise the human error component. The Surgical Safety Checklist was introduced under the auspices of the WHO to reduce system errors for patients undergoing surgery[8] and is a system of checks and balances to eliminate errors.

Without them it is easy to conceive how for example wrong side surgery, or wrong patient surgery can occur in a busy unit with overworked and fatigued staff working under pressure to complete a never-ending stream of tasks. Through ensuring accurate communication and interaction with all involved in the management of patients, the safety bar is raised and the Checklist serves as an excellent example of an initiative to address a systemic error.

Doctor–patient communication

My own experience in reviewing complaints against doctors in South Africa for the HPCSA is that by far the majority of these are based on a lack of communication between doctor and patient. Bearing in mind that not all dissatisfied patients actually lodge complaints, of 1 600 complaints evaluated, failure of adequate communication was identified as a component in about 1 200 cases. Major surgeon error like failure to act when the clinical state required action, iatrogenic damage caused by failure to protect structures, wrong side surgery, etc. are rare, probably around 2–5%. In my review the single most common problem that recurs throughout all surgical disciplines is the failure of patients to appreciate the consequences of surgery or the possibility of complications that may arise thereafter. Why did they not get the message? Whose responsibility is it to ensure that patients are intellectually aware and informed about the impending assault on their body? It is lamentable that this failure is not accepted as a serious oversight by the practitioner, or viewed with the same gravity as ignoring vascular compromise of a leg following a total knee replacement. It is all too easy to trim the time spent ensuring adequate communication with the patient in the interests of getting through the work for the day! To illustrate this I could not have chosen better words than those penned by an expert asked to review a case. The report ends as follows: 'Just as a personal comment, I find it sad that the information given by the plaintiff and that of the accused, do not match … most probably because the communication gap or statements are based on perceptions instead of facts.' Arguments that patients are 'difficult', that 'they can't understand' or that they 'forgot', carry no weight in defence of a practitioner where communication, both verbal and written, is required.

The seriousness of communication is aptly illustrated by initiatives introduced in recent times. The Australians have taken the concept of patient understanding to heart in no uncertain terms. Informed consent implies what it says; a visit to the Queensland Health website is worth the time spent.[9] They have designed individual consent forms for each procedure which ensure that the patient and the doctor spend sufficient time on that process that an understanding is inevitable. The randomised controlled study by Riess *et al* supports the value of communication by showing that a brief course of empathy training of physicians had a positive effect on patient care and resulted in fewer malpractice claims.[10] Perhaps this should become a compulsory component of our training programmes.

Changes to the system dealing with complaints

A major advantage of some of the alternative systems proposed to replace litigation is that more of the money spent will be directed at redressing the wrongs where help is needed and that this will benefit the health care system. The plaintiff is more likely to derive benefit without falling foul of legal technicalities.

In a significant mind shift, Solm suggests that whatever system operates it should ideally be one that ensures appropriate compensation for the medical injury, correctly identifies the error and learns from the adverse effects to build systems that eliminate errors.[6]

How far is this from the current pecuniary gain and punitive system under which we function?

Not all the parameters by which we are judged remain constant. Having moved away from an era of '… In my opinion …' by the so-called expert witness, Brenner *et al* concluded that not even the 'standard of care' is an accurate measure because it is premised on the notion of conformity, and they go on to suggest that an ongoing consensus 'committee on orthopaedic principles of negligence' should be established.[11]

The system should ensure appropriate compensation for the medical injury, correctly identify the error and learn from the adverse effects

There is no doubt that the current system for addressing complaints against medical practitioners is flawed. Some years back a colleague and I approached senior counsel for the Medical Protection Society with two suggestions to assist in attaining fairness in arriving at decisions in medicolegal matters. The first was to institute a panel of orthopaedic experts from which without fear or favour opinion for both the complainant and the defendant could be garnered. This was not viewed positively because it would not be possible to obtain the opinion that would be favourable to building and supporting 'the case'. The introduction of the AAOS Professional Compliance Program[12] in the US in 2004 is a positive move to control and 'police' the quality of opinion reported by experts and could be gainfully introduced here in SA as well. (Further information at http://www3.aaos.org/member/profcomp/profcomp.cfm.)

The second suggestion proffered was that a panel of orthopaedic experts be selected by the orthopaedic fraternity who would review each case and collectively decide on the merits thereof, before it reaches the litigation hyenas. This was rejected on the basis that the public would view this with distrust, seen as the medical profession conniving in a protectionist manner and would thus reject such a committee. This sentiment is also expressed by Stommbaugh (attorney) in his commentary in the article by Bernstein proposing changes to the tort liability system.[13]

Stommbaugh strongly supports the current legal system, showing just how polarised we are. How can a system written by lawyers, run by lawyers to the benefit of lawyers, win or lose paid by others, be better for the public?

Today I feel somewhat vindicated that these earlier suggestions have gained support. The HPCSA Preliminary Committees work exactly like our suggested expert panel. A preliminary appraisal of a complaint is made, on which a recommendation for further action is made. This makes the availability of 'justice' as this translates to fairness vastly more accessible to all. The call for and introduction of physician-based health courts and arbitration procedures, which operate in a similar way, is clearly a step in the right direction.

Change for the better is coming but until that happens: Avoid trouble. Spend more time being a doctor and not just a technician. Document everything. Embrace reforms on health care oversight systems that strive for better health care delivery, decency, honestly and fairness for all.

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