

MEDICAL ETHICS

Managing risks in surgical practice: a necessity

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The bi-annual seminar of the South African Medico-legal Society was held recently on the topic of "Management of medico-legal risks and costs in surgical practice in South Africa". The invited speakers were Dr Liz Meyer of the Medical Protection Society (MPS) and Adv Graham van der Spuy of the Cape Bar. Some of their excellent contributions follow in this report. Everyone who attended left the conference left more aware of the many risks of surgical practice and the possible legal consequences.

A survey in the USA showed that 22% of medical practitioners experienced a lawsuit resulting from surgery gone wrong as the most stressful event in their lives – more so than divorce and death. It impacts heavily on a medical practitioner to be involved in a medico-legal case, and it is always a good idea to avoid such an experience since a good outcome is not always possible.

The concept of risk management is therefore a concept surgeons should get used to in surgical practice. It is not only the way in which a surgeon practises that minimises the risks, but also a specific knowledge and awareness of what is going on in medico-legal cases. Orthopaedic surgeons should stay informed of these cases by reading the MPS publication to become more aware of what **can** go wrong and of what **has** gone wrong.

A nationwide survey in Australia showed, however, that a breakdown in communication between the surgeon and the patient accounted for two-thirds of all malpractice litigations in that country. The motives spurring patients on to proceed with litigation were the following, in order of priority:

1. the desire to find out what went wrong, and the belief that litigation was the only way to find out
2. the desire to get even with the doctor who maltreated them

3. the need to prevent the same thing from happening again
4. the need for compensation.

It is therefore very important that surgeons learn how to communicate with their patients in a proper manner. As early as 1979, the Medical and Dental Council reported that 95% of their cases were communication issues and that 41% of the patients indicated that they would not have sued the doctor if everything had been explained in all honesty. In the Dutch medico-legal literature 9 out of 10 patients indicated that they would not have sued if the doctor had communicated with them properly. It is therefore a myth that the doctor should not inform the patient of problems that he encountered during the operation and that led to certain complications.

When complications arise, the surgeon should deal with them optimally. This means that the surgeon should recognise the problem in time and establish a course of action. An objective second opinion is always a good idea as it removes subjectivity from the problem that needs to be solved. Establishing a plan of action is as important as carrying out that plan.

The need to spend time with the patient and the patient's family is of the utmost importance. When there are complications, the surgeon must approach the patient and the family with the utmost humility. Adv Van der Spuy even described the ideal reaction to this tragic situation as **bombarding the patient and the family with attention** and stressed that the surgeon needs to spend a lot of time with the patient in these circumstances. A lot of don'ts were discussed as guidelines, especially not to follow the suggestions of *Huisgenoot* and *Cosmopolitan*. The good surgeon always stays in contact with his medical fraternity by attending congresses and workshops and taking the time to read specialist journals.

The MPS therefore advocates a **safe apology**, meaning that one can mention complications to the patient without admitting to any guilt or negligence. If something goes wrong during an operation, it is usually a chain of events that occur, not an isolated event. This emphasises once more the importance of accurate clinical notes. There is a correlation between good clinical records and good practice. To give the legal representative a proper chance to defend you, your clinical records should be very accurate and unaltered. Having no clinical records of a procedure is a recipe for disaster, and records that are too good to be true can also trip you up.

If something goes wrong during an operation, the best approach is, without exception, to sit down and write down everything from start to finish, even if it takes the whole night. Making photocopies of the file at that stage, even of the nurses' records, for your own clinical records is the best way to go. The problem is that a case does not always come before the court soon after the complications have happened. It may even happen as long as 10 years after the event. In those late cases, one can be sure of not remembering everything any more, and being left with very cryptic and inaccurate notes will not help.

Although the workload of private and public practice forces the surgeon to keep notes short, one should make adequate notes to cover the main events. With hindsight, one can usually see clearly what went wrong, but that is not always the case when things are happening. Good clinical records help your legal team to defend you in the best possible manner.

Another problem that one encounters as the reason for court cases against surgeons is incompetence. A previous article in which I cautioned surgeons to stay within the boundary of their field of expertise is applicable here.¹ If you are not competent to do the operation, you have no defence when things go wrong. Yes, there is a surgical learning curve for every surgeon, but one should know when to operate and when to get proper assistance or to refer a case.

If a patient is referred there should not be unnecessary delays, for instance a spinal case presented with a sequestered disc at the L2-3 level, but doctors failed to diagnose the accompanying cauda-equina syndrome. Basically, it took too long to make the proper diagnosis and too long to

give the patient the proper treatment. This was partly due to the red tape of patients with severe problems being referred to public hospital and then referred back to private practice, while a proper clinical examination of the patient would have revealed the problem at a much earlier stage.

There are six Cs that summarise a good surgical clinical practice, namely Consent, Competence, Compassion, Consultation, Communication and Clinical records.

Some very interesting statistics of the Medical Protection Society were made available. At present the MPS in South Africa has about 18 000 paying members. The members paying the highest fees are the obstetric and gynaecologic surgeons, who pay more or less R95 000.00 per year. The second highest fees come from the spinal surgeons, who pay about R75 000.00 and the average orthopaedic surgeon, who is not involved in very high-risk surgery, pays about R45 000.00 a year.

The number of cases dealt with by the Health Professional Council of South Africa increases dramatically every year. As far as the MPS is concerned, the numbers of claims are not increasing so much as the amount of the payouts. Last year almost 1 400 files were opened for MPS cases, but this number will be topped this year. Luckily, about half of the cases disappear with time and about 60% of the rest of the cases are defended successfully. Payouts in respect of claims amounted to R17 million in 2007, and R30 million was spent defending the claims, including payment for the opinions of medical experts.

The MPS needs to have a reserve for all the outstanding claims. At this moment, there are 700 outstanding claims for which the MPS keeps R350 million in reserve as cover.

The highest settled claim to date was about R8 million for an obstetric and gynaecologic claim, but close on its heels followed an orthopaedic spinal case of about R6.4 million. It was paid out when an injection into the spinal cord left the patient paralysed. Although the doctors involved may express a desire at the preliminary meeting to settle the claim early, an early settlement is not always possible because the plaintiffs' lawyers are not always prepared to accept such a settlement. It has happened quite often that a case of malpractice is filed just before the date a claim expires after a period of 3 years.

The best expert witness for the defence is a fair and objective expert. A fair expert does not totally condemn the actions of the surgeon involved, and should mention this in his report. Presenting the right evidence in court cases is what wins court cases, not the cross-examination, as is often thought. Good expert witnesses stick to their own field of expertise and do not change their mind in court. To qualify as an expert, one needs to be considered very knowledgeable, and not just because of knowledge of the subject, but also because of one's own experience with that type of problem. It is therefore always wise to have one's own statistics at hand to explain the reason why a certain opinion is presented based on one's own experience.

There are difficult surgical procedures that should not be performed by any surgeon who does not do a certain number of these a year. If you do not perform enough of that type of operation, you are not competent enough and the same goes for an expert witness voicing an opinion about a certain complication being acceptable or unacceptable for that procedure.

There should be a better, active system of peer review. Although discussed numerous times in the past, there is no properly functioning system of peer review at this moment. The professional bodies of the surgical discipline should take that responsibility upon themselves and should make an effort to improve on that system. Peer supervision is quite a natural phenomenon in the elephant world, where younger bulls are disciplined by an older one that takes them to task.

There is a lesson to be learnt almost everywhere, but future generations should take those lessons to heart and not forget them.

This article was not submitted to an ethical committee for approval. The content of this article is the sole work of the authors. No benefits of any form have been derived from any commercial party related directly or indirectly to the subject of this article.

Reference

1. Van den Bout AH. Know the boundaries within your scope of practice. *SAOJ*, Winter 2008;7(3):28.

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