Medical Litigation – How to Reduce Our Risk

By Dr T Thirumoorthy

INTRODUCTION

Medicine is far from being a perfect science. Medical and human biological processes are too complex to predict outcomes with any certainty. Thus even the best doctors can make the worst mistakes.

Mistakes occur in medical practice daily. Fortunately most mistakes do not harm the patient.

When harm is perceived or results after a medical encounter, the present system of remedy is a medical litigation. Recent trends in Singapore show a rise in claims, medical litigation cases and the average pay out per case from $50,000 in 1997 to $75,000 in 1999. The total amounts for claims settled also increased from $557,000 in 1997 to $1.3 million in 1999 as reported by the Medical Protection Society (MPS), which insures 70% of doctors in Singapore.

Management of medical litigation must be based on a broader healthcare risk management program which must be built into daily medical practice.

Healthcare risk management involves:

i. Reporting and analysis of accidents and incidents to prevent recurrences.
ii. Prospectively reviewing the existing system such as equipment, policies, procedures, personnel competence and training, and eliminating the deficiencies.
iii. Educating healthcare personnel on appropriate practice, work habits and skills in minimising medical errors. Adopting a "Safety First" approach.
iv. Resolving patient complaints.
v. Facilitating legal defence.

From the individual practitioner's point of view, a 3-point strategy in managing the risk of medical litigation can be summarised as:

1. Primary Prevention - Attitude and systems must be in place to minimise mistakes and reduce risk.
2. Secondary Prevention - Dealing with complaints and mistakes timely and effectively.
3. Tertiary Prevention - Documenting defences and thorough preparation to go to court.

UNDERSTANDING LITIGATION

The legal basis for medical litigation can be classified as:

i. Failure to diagnose
ii. Failure to treat
iii. Failure to refer
iv. Failure to inform
v. Complication of medication or surgery

This reminds us as medical practitioners that we owe an ethical and legal duty of competent care to our patients to diagnose accurately, treat appropriately with timely referral, and continuously communicating with our patients. The law requires and the patient expects us to practise within our competence with the patient's safety uppermost in our minds - do no harm.

Underlying all litigation exists:

i. An injured patient - Technical error and competence issues.
ii. An angry patient - Patient-doctor relationship and communication issues.

Studies have shown patients usually cite 3 main reasons for pursuing medical litigation, namely:

i. The doctor did not tell me what was going to happen.
ii. I want to make sure this does not happen to someone else.
iii. I want financial compensation for my injury.

RISK REDUCTION STRATEGY

For the individual practitioner this paper encapsulates the approach and practical points to risk reduction and medical litigation using the 7Cs Model.

1. Constant vigilance
2. Communication
3. Competence
4. Clinical records
5. Consent
6. Careful prescribing
7. Confidentiality

1. Constant Vigilance

- Mistakes do occur in medical practice and thus a mindset of "Safety First" is essential. Think safe. Be safe.
- Imbibe the culture of professionalism as the basis of daily practice - competence, ethics, service and accountability.
- Acquire basic knowledge and skills in medical ethics and health law.
- Understand our legal responsibilities and endeavor to fulfill them daily.
- Most importantly, acquire and maintain a valid medical protection insurance. Develop a relationship with your medical defence organisation (MDO).
- Adopt a proactive approach to preventing medical litigation.

2. Communication

It has been shown by several studies that up to 70 - 80% of all medical litigation claims are related to failure of communication. The 4 common types of communication problems cited are:

i. Patients felt deserted when things had gone wrong.
ii. Patients' views were devalued.
iii. Poor information delivery.
iv. Patients' perspectives not understood.

A major barrier to communication is medical arrogance and not taking the time to explain. In the doctor-patient relationship, the art of getting your message across effectively to build confidence and trust is a vital part of being an effective physician. Acquire good communication skills:

- Communicate effectively with patients, family, staff and colleagues.
- Be available when needed. Be helpful.
- Good communication is active listening and not interrupting.

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- Give time for the patient to digest the information given. Reflect back to the patient.
- Pre-warn and discuss with the patient on fees and cost of medication. Do not ambush the patient with an unexpected bill.
- Train your clinic staff to communicate politely, effectively and professionally.
- Develop a network of peers, specialists and hospital doctors with whom you can refer, discuss and consult.
- Do not practise in isolation.
- Do not raise expectations unreasonably.
- Do not guarantee results or safe outcomes.
- Do not be overconfident. Do not oversell.
- Avoid telling the patient that a procedure is simple, routine or without problems.
- Address the patient's concerns and answer all questions asked. Failure to answer questions gives the perception to the patient that the doctor is aloof, uncaring and arrogant.
- Guard against callous or sarcastic comments to patients or about your colleagues.

3. Competence

- Keep updated in knowledge. Attend CME programs.
- Improve practice skills.
- Do not use treatment or do procedures that you have not been fully trained in.
- Practise within your competence.
- Actively look for alarm signs with each encounter.
- Refer timely and appropriately.

Initiate and offer a second opinion when diagnosis is uncertain or treatment response does not meet your patient's or your own expectations.

4. Clinical Records Management

- The medical records must be recognised as legal documents. Good medical records are our best defence in medical litigation.
- Record the date, time and relevant points and events legibly.
- Ensure all reports, letters and laboratory results are reviewed before filing.
- Never obliterate, alter, erase or destroy records inappropriately. The appropriate way to correct an error is to draw one line through the incorrect entry, initial it and date it with the time the correction is made. Note the reason for the correction and chart the correct information.
- In the eyes of the law "what is not documented was not done".

Good Records is Good Defence
Bad Records means Bad Defence
No Records means No Defence

A physician is believable to the courts to the extent that what is said is verified by the medical records. The court works on the premise that most people cannot remember accurately details about an event many months or years later. So if the record is silent or contradicts the verbal testimony, the court will find it difficult to believe the doctor.

5. Confidentiality

- Medical confidentiality should be imbibed into the culture of good clinical practice by doctors and all persons handling medical records.
- Observe the principles of medical confidentiality when writing notes, speaking on the phone, sending a fax or email and writing reports.
- Avoid discussing patients' case histories in public places like corridors, lifts or hospital canteens.
- Gossiping about patients' case histories is incompatible with good medical practice.

6. Careful Prescribing

- Write all prescriptions legibly with clear instructions on frequency and duration.
- Record allergies clearly on case notes.
- Check allergies with patient before prescribing.
- Train dispensing staff to be professional.
- Answer questions and phone calls on possible adverse drug reactions and give clear instructions to patients.
- Educate patients on what to expect with medications and treatment.

7. Consent

- Respect the patient's desire to make his own decisions with regards to his health and illness - principle of patient autonomy.
- Involve and communicate with the patient in all stages of decision-making - treatment, investigations, surgery and nature of follow-up.
- Provide information on options available and discuss effectiveness (outcome), safety, cost and convenience (patient preference).
- Do not underestimate or overestimate your patient's ability to understand medical facts.
- Give time for the patient to decide on the options.
- Respect the patient's desire to refuse certain treatments.
- Consent is an ongoing clinical process and not just signing a consent form.

CONCLUSION

Until the development of alternate dispute resolution in medicine, medical litigation has been described as a disease with a potential for epidemic proportions and to be destructive to a healthy doctor-patient relationship. This could lead to adversarial postures and defensive medicine.

Medical litigation is costly, lengthy and distressing to all parties. Even if the doctor wins the case he has lost in many other ways.

Accepting this reality is important. Even the best doctors can make the worst mistakes - such is the nature of medical practice. There are practical ways of preventing this epidemic and main-taining a harmonious doctor-patient relationship. Placing the patient's safety first (do no harm) and recognising our own limitations physically, mentally and emotionally (do no harm to thyself physician) is the first step. ■