News Release
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Five golden rules to reduce patient harm or risk

Johannesburg – Talk to any doctor who's faced litigation from a patient or their family, following an adverse event, and they'll tell you how emotionally exhausting the process is. Risk reduction in medicine or surgery, where mistakes amounting to negligence are an occupational hazard, is the best way of avoiding lengthy legal headaches.

The public and private healthcare sectors are dealing with billions in claims. The former faces a crushing R98 billion, which is currently being forensically assessed, and in the private sector, a major London-based local indemnity provider estimates the number of claims (across all disciplines) increased by 35% between 2011 and 2016.

Workshops and think tanks, plus legal reform measures, are making progress but some practitioners of higher risk specialties, such as obstetrics and gynaecology, are re-assessing their options. Over half of members belonging to the South African Society of Obstetricians and Gynaecologists (SASOG) believe they will stop providing obstetric services in the next five years, while a fifth of South African Society of Anaesthesiologists (SASA) members say they are "vulnerable to move or leave South Africa", according to surveys by the two groupings.

Getting the basics right

Solving the problem on a medico-political level is one thing, but there are basic measures a practitioner can follow to reduce litigation risks. We spoke to Dr Hlombe Makuluma, Medico-legal Risk Advisor at EthiQal, and the first South African provider of both occurrence-based and claims-made cover to doctors, about five basic measures that can assist a practitioner to reduce his or her medical malpractice litigation risk.

Here they are, in summary.

Ensure:

- diligent informed consent (proper patient communication and education, not just a signed form)
- first-rate record keeping (recording of not just the clinical information but also the discussion the practitioner has with the patient pertaining to his or her condition)
- confidentiality (by the entire care-giving team and support staff)
- availability (do not desert the patient when there is a complication or the patient is dissatisfied)
- communication with patients/family (their concerns, your bedside manner, active listening)

Falling down on one, all, or a combination of these can easily trigger litigation, making it more difficult to settle out of court or mitigate once in court. Cases can take up to ten years to resolve.

Diligent informed consent: Dr Makuluma says outlining the benefits and risks of suggested treatment, the consequences of following it or not, its alternatives, and the patient's right to refuse treatment are fundamental to proper informed consent. "Sufficient informed consent involves discussing the facts material to the particular patient and their condition (known as materiality). If, for example, a patient mentions that they are consulting a spiritual healer or herbalist, the risks associated with such consultations are to be noted," he says.

First-rate record keeping: According to Dr Makuluma, the biggest record-keeping slip-ups by healthcare practitioners are illegible writing, terse and sketchy notes, shorthand and abbreviations that are not universally understood, failing to record all aspects of treatment and discussions with the patient, and not filing all patient records (including radiology and pathology reports).

Confidentiality: "With confidentiality, the most common mistake is not securing express patient consent as to who doctors may share the information with. Most often a breach happens with support staff other than the doctor," he adds.

Availability: "When a patient is dissatisfied with an aspect of his or her treatment, or there's a complication, they want to discuss their concerns with the doctor who was involved. You cannot imagine how often their decision to take legal action stems from the unavailability of a practitioner. Making yourself available when these red flags start flying goes a long way to reducing the risk of litigation," he adds.

Communication: A closely linked aspect to availability is communication. Active listening, consideration of patient and/or family concerns, professional bedside manner and seeing the patient perspective here is crucial to mitigating downstream turbulence, stresses Dr Makuluma.

"Doctors need to stick to these basic principles and keep it simple. If they do that thoroughly, their risk of litigation and any harm to patients, could be significantly reduced, he adds.

(675 words)

Three illustrative case studies.

Record keeping

- A legal secretary with a strong family history of strokes showed mild symptoms at work. She consulted Dr SC who diagnosed anxiety and hypertension, prescribed medication and advised her to return should symptoms persist or worsen. Her employer referred her for a second medical opinion. This doctor diagnosed her as having suffered a slight stroke, prescribed medication and booked her off for three weeks. The legal secretary then suffered right hemiplegia, leaving her wheelchair-bound and jobless. In her court action against both doctors (claiming negligence), expert testimony established that she had suffered an unusual stroke, difficult to accurately diagnose. Neither doctor could thus be held liable. Both doctors provided clear clinical notes, especially Dr SC, who had known she worked for a medical negligence lawyer. The case was heard nine years after the event, emphasising the value of the clear written notes.

Confidentiality

- During a round of golf, Dr K disclosed his patient's HIV positive status to two colleagues. All those involved, including the patient's male partner, moved in the same social circles. Dr K's defence of truth and the public interest were rejected, his having claimed that sharing his patient's status with a GP and dentist, whom the patient also consulted, was justified due to "retrospective or future exposure". The court said there was no reason to assume the other doctors had to fear prospective exposure, nor was HIV or AIDS a reportable condition under the National Health Act. Disclosure is strictly prescribed only under certain conditions, including endangering a third party's health or life, child abuse/neglect (or that of the elderly), sexual crimes against children or mentally disabled persons, and notifiable diseases.

Informed consent

- Mrs McD suffered severe toothache and consulted her dentist who diagnosed impacted wisdom teeth. He recommended extraction under general anaesthesia and she consented to him operating. After the operation, she experienced pins and needles on the left side of her face. Permanent damage of her inferior alveolar nerve was diagnosed, the damage having occurred during the operation. The court found the dentist negligent, saying that had the operation been done by a skilled maxillo-facial surgeon, permanent nerve damage would have been less likely. The dentist failed to inform Mrs McD of the material risks associated with the operation. She had neither the knowledge, appreciation, or understanding of the nature and extent of the harm or risk involved.