Medico-legal litigation: Balancing spiralling costs with fair compensation

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A Medico Legal Summit was convened by the National Minister of Health, Dr Aaron Motsoaledi, on 9 and 10 March this year. In his keynote address (published in full on page 4), Dr Motsoaledi stated that the summit was long overdue. He expressed concerns, and rightfully so, that medico-legal litigation had reached a crisis of epic proportions in the country. It became clear as the summit unfolded over the two days that the triggers to litigation in the healthcare context are primarily two-fold: medical malpractice and/or professional negligence and patient safety reasons. While the private sector grapples largely with the former, the state sector healthcare facilities deal with a combination of both causes. This editorial discusses some of the causes and impact of increasing medical litigation, and considers possible interventions in this regard.

Intentional unlawful or negligent conduct by practitioners resulting in injury or damage to their patients or property leads to medical malpractice claims, e.g. intentional breach of a patient's confidentiality.[1] Professional negligence stems from healthcare practitioners negligently failing to exercise the degree of skill and care of a reasonably skilled practitioner in his or her field of practice.[2] It follows therefore that a specialist would be expected to effect a higher degree of skill as compared to a family practitioner and the more complicated the procedure undertaken, the greater the degree of skill and care necessary.[3] Hence competent management of patients is essential if valid claims of professional negligence are to be avoided.

Patient safety, on the other hand, can be defined very simply as '… the prevention of errors and adverse effects to patients associated with health care'.[4] Hence, there should be the absence of preventable harm at healthcare facilities when managing patients there. Patient safety is a component of good quality healthcare services and understandably, this would contribute to improved health outcomes. Currently, globally, 10% of patients in healthcare facilities are harmed as a result of preventable errors or adverse events, 14% of patients suffer from hospital-acquired infections and between 20 and 40% of health spending is wasted because of poor quality of care and safety failures.[5] There are obviously additional costs associated with safety failures. Costs to patients include those to cover disability where this occurs, lost productivity and future medical expenses. Costs to the healthcare facility include those of treating infections, further hospitalisations and, of course, litigation.

The presentation from the office of the Chief Litigation Officer, Department of Justice and Constitutional Development at the summit, highlighted that the increasing litigation faced by the Department of Health was due to medico-legal claims, motor vehicle accidents, access to information, labour-related and human resource matters and non-compliance or poor compliance with court orders. It went on to describe the challenges faced by state attorneys in the management of litigation of medical negligence claims. These include lack of capacity at the office, shortage of skilled support staff, poor accountability, shortage of medico-legal specialists to advise the Department, inadequate and untimely instructions including those instructions to settle, late submission of medical records, difficulties with consulting with expert witnesses, budget constraints by state hospitals and opportunistic litigation. The total claim in terms of contingency liability at the level of this office is in the region of R25 billion (Presentation at the Medico Legal Summit from the Office of the Chief Litigation Officer, Department of Justice and Constitutional Development) While there is compelling argument to be made that contingency liability is a potent factor towards the spiralling costs of medical litigation, the reality is that it does respond to the principle of compensatory justice for poor and disenfranchised patients who have been harmed as a result of neglect or safety failures and cannot afford access to litigation.

With regard to professional negligence in the private sector, the spiralling inflation is due to, in the main, a substantial increase in the magnitude of the claims while the claims frequency has increased only moderately. The highest settled claims in South Africa by the Medical Protection Society (MPS), a key medical insurer in the country were R6 million in 2006, R14 million in 2008 and R33 million in 2013. The MPS's highest current claim (from 2013) is R80 million. In obstetrics, the highest settled claim was R24 million in 2014. With obstetrics, neurosurgery and spinal surgery being the 'high risk' categories (Presentation by Dr Graham Howarth, MPS at the Medico Legal Summit) it is not surprising that reports have started surfacing of practitioners shying away from managing patients in these disciplines. The reality is that practitioners will not specialise in certain disciplines, resulting in skills shortages in these fields. Clearly this could result in deterioration of care for patients at large.

The increase in medico-legal litigation stems from a number of causes and no one single factor can be blamed for this. Addressing the problem requires a multidisciplinary approach and includes tackling the systems failures, ensuring competent, compassionate management of patients and striving towards ensuring the delivery of good quality healthcare services. The actual dilemma though, is that of balancing fair compensation for harms with the public good. The law will not help in this regard because currently there

is no specific legislation that addresses medical litigation and these claims are dealt with by the common law, and more specifically the law of delict where negligence is determined by the criteria of reasonableness and foreseeability[1] and little regard is given to the impact of the magnitude of quantum of claims on society at large. Law reform has been resorted to in several jurisdictions around the world with legal remedies ranging from no fault to capped regimes. It is advisable that 'capping', if considered in South Africa, is approached with caution as it could result in constitutional challenge.

Without doubt, urgent interventions are necessary to improve our current situation. However, these must be implemented responsibly and in line with justice in order to ensure that compensation, where indicated, is fair. Prevention is key and the responsibility of both health administrators and practitioners. Risks need to be contained and only claims which are defensible should be defended. In the state sector, it is important to remember that public money used for the settlement of claims is much needed financial resources that will otherwise be lost to the hospital services. Prevention applies to practitioners too and they would do well in recognising and avoiding the risks that have potential for malpractice and professional negligence claims. Perhaps the time has arrived for the establishment of a statutory national litigation authority or council where litigation claims could be considered and settled by mediation.

References

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