1. INTRODUCTION

1.1. The practice of Medicine is a noble profession. Medical practitioners are bound by oath and ethics to act in the interests of those under their care.

1.2. The author acknowledges and respects the high standards of medical practice in South African hospitals and teaching institutions.

1.3. In this light it is appalling that so many claims, for so much money, have been brought against the MECs for Health on the basis of medical malpractice/negligence. It is even more appalling that practitioners of a noble profession have caused so much harm to so many members of the public.

1.4. There is an urgent need for South African doctors, nurses and hospitals to curb the suffering and wasteful expenditure that result from medical malpractice/negligence.

1.5. This document comments on fundamental medical- and legal realities in relation to malpractice/negligence, and puts forward a number of practical proposals to curb the harm.

2. WHAT IS MEDICAL MALPRACTICE/NEGLIGENCE?

2.1. Medical treatment is judged to be malpractice or negligent when it falls **below the standard** of a **reasonable practitioner** in **that discipline** under the **prevailing circumstances**. All 4 highlighted criteria are taken into account.

2.2. Malpractice generally refers to the a **wrongful commission** of an act that should not have occurred, while negligence generally refers to the **wrongful omission** of a necessary act.

2.3. For medical malpractice/negligence to result in an award for monetary compensation it is necessary for the claimant to prove each of the following : -

2.3.1. The occurrence of malpractice and/or negligence.

2.3.2. That such malpractice/negligence was the direct cause of identifiable harm, that would not have occurred but for the malpractice/negligence.

2.3.3. That such harm is permanent.

2.4. For a claim for compensation to succeed there needs to be a finding that such incorrect acts and/or omissions were not merely “a slip of the knife”, “an error of judgement”, “an unavoidable mistake”, “failure to choose the best treatment option”, “failure to meet the standard of optimal treatment” or “inability to afford the best quality equipment”.

2.5. The “standard of a reasonable practitioner” can be understood by reference to various actual standards of medical practice : -

2.5.1. **Best standard**. Many practitioners believe or claim that they practice at this high level. Some achieve it.

2.5.2. **Good standard**. All practitioners should aim for and attempt to maintain this standard. Fortunately many do.

2.5.3. **Average standard**. Only the most humble practitioners believe or claim that they practice at this level. It is fortunate for the majority who, despite their beliefs and proclamations, in fact practice at this level, that they are quite safe from claims for malpractice or negligence.

2.5.4. **Below average but reasonable standard**. Nobody would admit to practicing at this disappointing level. In reality there are many who do. Many patients who suffer permanent harm due to complications associated with this level of practice believe that they have suffered an injustice when the law refuses to grant compensation on the basis that although wrong, the level of treatment is not judged to be below the reasonable standard. Practitioners and hospitals are fortunate that the law protects them in this way.

2.5.5. **Below the reasonable standard – malpractice / negligence**. It is only after a wrongful commission or wrongful omission has been proven to be at this level, that the claimant has a basis in law to claim monetary compensation. Every properly trained practitioner who has a conscience should be able to avoid descending to this level. Those without a conscience should be barred from medical practice.

3. ACCOUNTABILITY

3.1. Medical practitioners, nurses and hospital administrators should experience a deep sense of shame at the tip of the iceberg of harm that emerges publicly in the form of massive financial claims for damages related to level 5, while damages related to mistakes at

levels 4 and above go unnoticed.

3.2. Medical practitioners, nurses and hospital administrators should collectively take responsibility for interventions to curb human suffering, damages and wasteful expenditure.

3.3. There is a commonly held view that claims against doctors and/or hospitals for medical malpractice/negligence represent an unfair imposition upon them by unscrupulous claimants, lawyers, experts and courts.

3.4. Doctors typically complain that they have to pay huge sums for insurance against making mistakes, that everybody makes mistakes, but that only doctors have to pay for them.

3.5. These incorrect views are born out of misunderstanding of the process of medical malpractice/negligence litigation.

3.6. Attorneys and medicolegal experts in practice in this field are faced with tragic cases of human suffering and major damages that clearly result from complications of treatment that are not compensable because the incorrect acts and omissions cannot be proven to be below the standard of reasonable practitioners under the circumstances.

3.7. If doctors, nurses and hospital management want to keep lawyers and claimants out of their hair, they need only to ensure that patients are treated at levels 1, 2, 3 or 4 above, and that level 5 does not occur. Lawyers and claimants who sue for complications associated with levels 1, 2, 3 or 4 will lose money. Experienced lawyers are not so foolish.

3.8. In concept it is really quite simple. Doctors and other service providers simply need to stop being negligent and to stop committing acts of malpractice. If doctors believe that they function at a reasonable level, all they need to do is to maintain the level they set for themselves.

3.9. When a doctor or other service provider has failed himself or herself, as well as his or her patient, colleagues and employer, he or she should take accountability for the damages, should engage in meaningful discussion with his or her peers so that he or she, together with his or her peers, can learn from the adverse experience.

3.10. It is through the honest and distressing experience of taking ownership of the outcome, together with discussion of what could and should have been done instead, that the involved practitioner, as well as all peers involved in the discussion, will all learn and be motivated to avoid repetition of the wrongful act and/or omission.

3.11. In essence medical malpractice/negligence claims succeed because of bad behaviour by doctors and other service providers. What is required to plug the hole and stop the harm is to stop the bad behaviour.

4. BEHAVIOUR MODIFICATION

4.1. If hospital management and clinical heads are serious about addressing the problems of medical malpractice/negligence, they need to take effective steps to improve the behaviour of doctors and other service providers.

4.2. Improving the behaviour of doctors and other service providers requires 2 distinctly different kinds of intervention : -

4.2.1. Educational interventions.

4.2.2. Motivational interventions.

4.3. The SAMLS (South African Medicolegal Society) is willing to assist in educational interventions aimed at curbing medical malpractice/negligence.

4.4. Unfortunately educational interventions, in the absence of motivational interventions, are unlikely to result in any significant improvement. It is assumed that all practitioners are properly qualified and trained to do the jobs to which they are appointed. If this is true, the huge ongoing costs of medical malpractice and negligence litigation must be attributed to a lack of motivation to behave properly.

4.5. It is submitted that the most effective method of motivating doctors and other service providers to behave properly is to expose them to the review of their peers whenever their bad behaviour has fallen below the standard of a reasonable practitioner and has resulted in human suffering and wasteful expenditure.

5. PRACTICAL PROPOSALS

5.1. Peer Review Meetings

5.1.1. The single most important proposal is obligatory peer review of the responsible doctor or other service provider.

5.1.1.1. Following each and every malpractice claim the Head of Department should convene a peer review meeting of all doctors and other relevant staff in the hospital.

5.1.1.2. At the meeting a designated medical practitioner and/or lawyer should inform the meeting of the facts of the case.

5.1.1.3. The responsible doctor or other service provider should explain to his or her peers what happened, what went wrong, why it went wrong and what he or she now has to say about it.

5.1.1.4. The peers should then participate in a discussion, in which it is expected that all should be touched by the suffering of the patient as well as the suffering of the doctor.

5.1.1.5. Through this distressing experience everybody present at the meeting should learn important lessons and should be motivated to avoid such errors in future.

5.1.1.6. The proceedings should be recorded in minutes, which document what went wrong and why and which focus on constructive recommendations.

5.1.1.7. These minutes should be legally protected as privileged documents.

5.1.1.8. Copies of these minutes should be kept and safeguarded by the Head of Department, Hospital CEO,

MEC for Health and DG of the DoH.

5.2. M&M Meetings

5.2.1. All Heads of Department should be required to hold regular morbidity and mortality meetings.

5.2.1.1. At these meetings cases should be presented in which complications or unfavourable outcomes have occurred, whether or not such complications or unfavourable outcomes are considered to have been due to negligence, non-negligent mistakes, bad luck, overwhelming pathology or any other reasons.

5.2.1.2. The reasons for such complications or unfavourable outcomes should be examined objectively. The discussion should be used as a learning opportunity in avoidance of complications and unfavourable outcomes.

5.2.1.3. Each such meeting will provide a fruitful opportunity for a senior practitioner to talk about pitfalls that can result in negligent damages and encourage a culture of quality medical practice aimed at patient safety.

5.2.1.4. The proceedings should be recorded in minutes, which document what went wrong and why and which focus on constructive recommendations.

5.2.1.5. These minutes should be legally protected as privileged documents.

5.2.1.6. Copies of these minutes should be kept and

safeguarded by the Head of Department, Hospital CEO, MEC for Health and DG of the DoH.

5.3. Pre-Operative Reading and Discussion

5.3.1. In preparation for surgical procedures and other potentially risky procedures, the responsible practitioner should read up about the procedure, particularly focusing on texts that deal with avoidance of complications.

5.3.2. During preparation or scrubbing up for such procedures, the responsible practitioner should explain to a colleague what he or she is going to do, why he or she is going to do it, what the potential risks are and what he or she is going to do to prevent such risks.

5.4. Checklists and Guidelines

5.4.1. The medical industry can take a very valuable leaf out of the book of the airline industry. It has been proven in the airline industry, and also in medical practice, that the rather simple step of preparing and adhering to a checklist can have a major impact on reducing mistakes and complications.

5.4.2. Clinical heads should determine one or more conditions or procedures in their department that have resulted historically in serious complications.

5.4.3. They should then obtain or develop checklists and guidelines for use by all in their departments to avoid errors and prevent the complications.

5.4.4. WHO checklists and guidelines on patient safety are readily available at www.who.int/patientsafety.

5.5. Workshops/Seminars

5.5.1. Educational workshops or seminars should be held to inform doctors and other service providers about the nature and causes of medical malpractice/negligence, as well as ways to avoid such disastrous errors.

5.5.2. At such educational sessions, in addition to structured presentations, actual case reports of successful negligence claims should be presented and discussed.

5.5.3. The SAMLS, which has considerable medical- and legal expertise among its members, is willing to assist in presenting such educational workshops/seminars.

5.6. Record Keeping

5.6.1. It goes without saying that adequate patient records should be kept. Serious errors in relation to record keeping, that regularly result in detriment to the treating doctor, nurse and/or hospital in legal proceedings, include : -

5.6.1.1. Failure to record relevant facts, diagnoses and/or reasons for interventions.

5.6.1.2. Failure to record properly informed consent for interventions.

5.6.1.3. Fraudulent alteration of records.

5.6.1.4. Missing records.

5.6.2. Clinical notes need not be long, but they should be recorded mindfully, so as to include relevant facts, diagnoses and reasons for interventions.

5.6.3. Notes should also correctly indicate the date and time at which they are recorded.

5.6.4. When something has gone wrong, it is good practice to record more detailed notes at a subsequent point in time, soon enough after the event while relevant facts are still fresh in one's mind, explaining circumstances and reasons.

5.6.5. Such subsequent notes should correctly indicate the date and time at which they are recorded, and should not falsely purport to have been recorded prior to or at the time of the event.

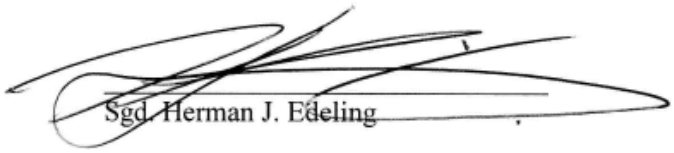
5.6.6. Hospital management should keep records secure. In the event of any claim for damages, full copies of the patient's records should be sent to the MEC and State Attorney to assist them in evaluating the matter and preparing a response.

5.7. Owning up

5.7.1. Because we all have egos and believe that we are good people who work hard and act nobly to help the sick, it is extremely difficult to admit to ourselves, and even more difficult to admit to others, that we have done something wrong.

5.7.2. Accepting our role in errors and complications, followed by honest explanation and apology to the patient, followed in turn by visible and sustained efforts to do whatever possible in the interests of the patient to mitigate the harm, are the most effective means of curbing secondary psychological suffering and reducing the risk that the wronged patient will sue for damages.

5.7.3. We are all humans and humans are not infallible. When we do fail, we need to demonstrate our humanity and why we have been admitted as members of a noble profession.



1 May 2015