Irish Medical Journal
Established 1867

Issue: Ir Med J; Vol 114; No. 5; P345

How Best to Deal with Medical Litigation

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Medicolegal claims are commonly initiated when an adverse clinical outcome is unexpected, unwanted, and harmful. The likelihood is increased when the patient or their family feel that medical facts are being withheld or that the lessons haven't been learned by the institution.

From the doctor's perspective, it is instinctive to be defensive when something happens to a patient. Physicians are very self-critical even when nothing untoward has taken place. This sense of guilt is accentuated when a preventable error has occurred. It is always difficult to rationalise matters when one sets out to do good and ends up with being accused of doing harm.

The defendant doctor has a sense of isolation when a lawsuit is commenced by a patient. The case tends not to be discussed with colleagues. Little help is offered about what is best to do. He or she is faced with the stressful legal process, often for the first time. The wheels turn slowly, and it may a number of years before matters are finally settled.

Litigation makes what is already a challenging and stressful job a lot worse. Furthermore, it is difficult to concentrate on one's day-to-day clinical duties when there is an adversarial high court case looming in the background.

Robert Francis, QC, Chair of Healthwatch, England states that litigation forces doctors and patients into opposite camps[1]. It obstructs the rebuilding of trust, obscures learning, and is enormously expensive. The annual cost of medicolegal cases to the NHS is 8.3 billion sterling.

The Getting it Right First Time (GIRFT) Document sets out the pathways to learning from litigation claims[2]. When a previous error pattern in a specialty is addressed constructively the claims rate falls. Orthopaedic surgery is an encouraging example. It improved from 10% to 5% of negligence claim costs in a 6-year period.

The Document points out that the common medicolegal allegations are failure or delay in diagnosis, and failure to interpret the clinical picture. When investigations are undertaken in a timely fashion, error can be avoided. Mismanagement of cauda equina syndrome is illustrated as an example of a common, costly error. The lack of availability of MRI scanning outside normal working hours is one of the problems. In the UK, a wider access to imaging is being rolled out in order to improve the identification of patients with the condition.

Consent issues are a common cause of malpractice claims. They affect elective treatments and surgery more than emergency procedures. In the former there is more time, and the patient should be provided with all the alternative options. The 'three-legged stool' approach for consent is recommended. The 3 components are; the procedure specific surgeon guided consent form, the patient specific dialogue and written information booklets. Patients should be made aware of the current national guidelines on the management of their condition. The option and consequences of no treatment should also be discussed. The written consent should be obtained 2-4 weeks before the procedure, where possible. This interval gives the patient time to consider their decision before the procedure is undertaken. Specific outpatient, consultant-led consent clinics are another approach.

It is important that patients' expectations of the benefits of the procedure are realistic. They need to be made aware of the level of restriction, discomfort, and pain that will be experienced following an intervention.

Information booklets must be written at a level that the patient can understand. Prior to their introduction they should be 'road tested' by a group of lay people. In one Irish survey it was found that 39% of the individuals have limited health literacy.

NALA (national adult literacy agency) advises on the use of plain English when communicating important information to the public[3]. Some of its key points are to be direct and use 'I, we, and you'. Avoid 'e.g., i.e., etc.' as they are confusing for patients. Do not use medical jargon. Use colour and images appropriately. Sentences should have a maximum of 15 words. The HSE has a large number of patient information leaflets, all of which have been NALA approved. NALA provides both advice and courses on how to write medical information pieces. If the patient remains uncertain about what to do following a consultation about the options, a second opinion should be readily available to them.

When consent is correctly obtained, it reduces subsequent allegations such as 'unnecessary operation', the 'wrong treatment' and 'unsatisfactory outcome to surgery'.

'Never events' such as wrong-site surgery, still feature in negligence claims. The terminology also includes cases where the correct side is operated on but where the location is incorrect. The importance of safety check lists is emphasised. The advice applies to both medical and surgical procedures. I am struck on how very few textbook descriptions of pneumothorax drainage note the importance of confirming the correct side to be aspirated. The commonest cause for wrong site procedures is miscommunication. It is more likely to happen in emergency circumstances such as the ICU and the ED. Another risk is the incorrect listing of the operation[4]. The safer surgery checklist, which was introduced by the WHO in 2009, has been an important advance[5].

Successful medical or surgical treatment depends on everything going to plan. It is understandable that this can't always happen. There will be occasions when the outcome is less than optimal. Every hospital department and general practice should have a pathway in place to deal with this eventuality. The senior clinicians should be engaged with at an early stage. They should be asked to provide comments on the letter of claim and be involved in the drafting of the letter of response. As the process progresses, they should be invited to attend the meetings with the legal counsel and the expert witnesses. This greater involvement of clinicians has been found to increase the efficient and smooth management of a lawsuit.

We need to continue to strive to reduce medical error. When cases arise, we should handle the claims efficiently and use the learning experience to prevent future episodes.

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