

Health care practice and the minimisation of patient medical litigation

STEPHANIE MOYLE

Stephanie Moyle is the Principal of Moyle Solicitors, a firm specialising in health law.

Abstract

This article explores why patients sue their health care providers. Following an extensive literature review, it identifies 'sue' motivators and then examines the legal basis of medical litigation by reviewing contemporary case law. Armed with the 'sue' motivators and having considered the types of claims brought against health care providers, the article focuses upon what health care providers may do to minimise litigation. It recommends specific provocative measures, which are based upon satisfying a myriad of patient needs through consenting practices, and early recognition and resolution of patient issues by providers.

Introduction

The risk of medical negligence litigation is real and unavoidable. Most health care providers and their insurers would gladly avoid claims for compensation arising from alleged negligent treatment by health care providers and the legal costs associated with those claims. The cost of practising defensive medicine¹ in an attempt to avoid the risk of litigation is also borne by providers and others.

There are further, somewhat intangible, costs associated with complaints and litigation that are borne by health care providers but are less easily measured, such as damage to professional reputation, and the large emotional cost associated with litigation and complaints by clients.

To consider what strategies may be developed to minimise litigation against health care providers, it is first necessary to examine:

- why clients commence litigation against health care providers, and
- the basis of medico-legal actions.

Why clients litigate

There seems to be surprisingly little relationship between the quality of care actually provided and the institution of legal proceedings. Poor-quality care does not appear to be the cause of the many medical negligence claims being brought against providers. According to Weiler et al. (1993), a 'very small proportion of those persons who suffer disabling medical injury actually institute proceedings against the provider of medical treatment'.

One of the conclusions of the Tito Report (Commonwealth Department of Human Services and Health 1995, p 24) was that 'the reasons that court actions are taken are complex, and knowledge that a mistake, even a clearly negligent one, has occurred is usually not enough to give rise to litigation ... It is clear that few people suffering even a highly preventable adverse event with significant resultant disability ever sue their healthcare professional.'

What is clear is that 'patients do not sue practitioners they like' (Batchelor et al. 1997, p 25). To some extent a public sector health care provider, a largely faceless institution, is 'more easy to criticise and therefore may be more easily sued' (Batchelor et al. 1997, p 25).

A review of the relevant literature has revealed that clients sue health care providers for a variety of reasons, including the following.

- An attempt to seek information about treatment or because information about treatment was not provided or explanations were not given, or were not timely, or they were not given by a senior person, or they were given unsympathetically or as a result of poor communication after the original incident.
- An attempt to prevent a recurrence to some other person, or a concern that nothing is being done to prevent a recurrence of the adverse event, or to improve the standard of care or to ensure accountability. Patients want accountability, discipline, reaction, explanation.
- An attempt to obtain compensation for injury.
- An attempt to correct poor communication as a result of the client's perception of the way the doctors talk to them, or for being treated with insensitivity; as patients perceived that providers do not respect patients or do not listen; as patients felt ignored and neglected; and as patients believed the providers did not spend enough time with them.
- An attempt to seek an admission of negligence.

(Hickson et al. 1994; Vincent et al. 1994; Commonwealth Department of Human Services and Health 1995; *Journal of American Medical Association* 1997).

In addition, the Tito Report (Commonwealth Department of Human Services and Health 1995, p 24) suggested that increased litigation against health care providers might be prompted by unrealistically optimistic expectations of health care as a result of:

- (a) well-publicised successes associated with the latest medical technology
- (b) the lack of data available on adverse patient outcomes to health interventions, and
- (c) health care professionals who may be reluctant to discuss all the possible risks associated with the various treatments.

Hall & Dornan (1998) found that patient satisfaction with health care was related to such issues as access, cost, overall quality, humanity, confidence, availability of information, bureaucratic procedures, physical facilities and the handling of psycho-social problems, the continuity of care and the outcome of care.

Clearly, patient *perceptions* of the way they have been treated provide the primary motivation for litigation, regardless of the reality of the service provided. Poor communication between patients and health care providers is a recurrent theme in litigation.

The legal basis of medical litigation

Generally, medical negligence actions are based upon:

- an alleged failure of the health care provider to obtain the ‘informed consent’ of the patient prior to a health intervention, and/or
- negligent medical treatment (including failure to treat or diagnose).

What can be done to minimise medical litigation

Medical litigation actions often contain an allegation that there has been a failure by the health care provider to obtain informed consent. The process of obtaining informed consent is not one of completing a form, but rather one of communication. This process, by definition, requires information to pass from the medical practitioner to the patient and vice versa. Any intervention to prevent litigation means a focus on the communication between clients and health care providers. Two specific aspects of provider–client communication, complaint handling and obtaining consent, are considered below.

Complaint handling

Clearly, when adverse events occur, clients want:

- an explanation for what has occurred or has resulted in the adverse event or unfortunate outcome
- an apology (rather than an admission of liability)
- information about what steps are being taken so that there is an expectation that similar events will not recur.

Health care providers can offer a complaint-handling system aimed at resolving any client issues as soon as possible after the events which have given rise to the complaint. The delayed resolution of client issues or complaints causes clients to litigate. A retrospective study of former patients by Vincent et al. (1994) found that, of those clients who commenced litigation against their former health care providers following an incident, nearly half would not have undertaken litigation (perhaps with the benefit of hindsight) had they received an explanation and an apology. Many others in that group indicated that they would not have instituted proceedings had the provider made an admission of negligence, had an investigation been carried out by the hospital, or had they been listened to and felt that they had been dealt with honestly.

The reasons behind client litigation set out above indicate that any complaint-handling system should encompass methods of treating patients with compassion, sensitivity and courtesy, and dispelling patient anger and resentment.

As part of the design and implementation of a complaint-handling system, it would be useful to ascertain the number of complainants who have become litigants – that is, whether the current litigants against a provider have previously made complaints to the provider. Any provider analysis of current litigation is likely to reveal that many of the present litigants never made a complaint to the provider. In these circumstances, the provider has obviously not had the opportunity to resolve the clients' complaint in a more cost-effective manner than through litigation. Early intervention of the kind referred to by Vincent et al. (1994) can occur only if the provider is aware of the complaint. The challenge, then, is to ensure that clients complain to the provider immediately after the event that gives rise to the complaint.

The results of a survey conducted by the Scottish National Health Service (NHS) 'indicated that three per cent of NHS users felt the need to make a complaint' and only 'one-third of those who felt the need to complain, actually did so' (Seelos & Adamson 1994, p 28). There are apparently many reasons why dissatisfied clients do not automatically complain. In the Scottish NHS survey, three-quarters of all NHS users did not know to whom they should complain. Even more frequently, dissatisfied users said they either did not think their complaining would make a difference or they did not want to cause trouble. Seelos and Adamson (1994) concluded that gratitude mixed with fear or awe of the medical profession, plain fear of retribution, or other reasons for non-contact were all reasons that clients did not complain.

Therefore, it is clear that health care providers should implement and thereafter promote to their clients an effective client complaint-handling system which will encourage clients to comment or to complain at or about the time of service delivery, rather than by serving a writ.

Attempts to have providers positively encourage complaints by clients at the time and place of service delivery are likely to be met with some resistance. The experience in the United Kingdom may be considered relevant. Seelos and Adamson (1994, p 31) considered that:

Traditionally complaints within the NHS have been equated with serious allegations against individuals. This has promoted complaints being regarded as threatening and something of which every medical professional lives in fear.

They add:

As far as the overall culture change is concerned, they are fighting against a blame-orientated culture that has existed for years. Having to convince highly qualified professionals that their real fears should not stop them from becoming more positive towards complaint handling as a whole, but that they should actually encourage patient comments and complaints, presents a challenge in its own right.

On the other hand, the Victorian Health Services Commissioner (1998) maintains that medical practitioners can acknowledge a person's grief or pain and express regret without admitting legal liability. While this strategy has met with a positive response from medical insurers, medical practitioners have been less convinced and remain cautious.

Understandably, there is a perception that any resources devoted to patient liaison services or complaint-handling systems could mean a diversion of resources from the provision of health care itself. What must be appreciated, however, is the cost of resolving complaints externally. Seelos and Adamson (1994, p 30) state that:

The resource concern is that argument can be developed that opening the system and actively encouraging users to contact the NHS with their comments and criticisms would utilise further resources in a system where the cause of many complaints is in fact fundamental lack of resources.

They go on to argue that:

The counter argument to this reasoning is that an easy mistake to make is to believe that managing complaints means to create complaints. The fact is, there are significant resources already being expended on defence and denial. Instead there needs to be a balancing of resource allocation to allow for prevention for more than just medical negligence cases.

Indeed, they add, a review:

must establish whether existing resources can be used more efficiently both in terms of outcome effectiveness for individual complaints, informal as well as formal, and in terms of data collection and usage at the different levels. It is necessary to cost the current system and establish whether it is providing value for money.

Clearly, what is sought is the minimisation of litigation, not an escalation in formal complaints without an appreciable decrease in the number of litigation matters against providers. Such escalation 'could be avoided if consumers' concerns and needs for explanations and information were recognised and responded to at an earlier stage in the process' (Seelos & Adamson 1994, p 29). Having their legitimate concerns listened to and validated would diffuse patient anger upon the occurrence of a sub-optimal outcome.

Patient complaints, particularly following adverse events, are also a valuable opportunity to learn what is wrong with a system and to identify those areas that may be a problem, for example, treatment, equipment, systems and/or communication. Accordingly, implementing a complaint-handling system that encourages client feedback should have a dual effect in reducing the amount of litigation against health care providers. The system should bring more dissatisfied clients to the attention of the provider, allowing resolution before litigation when appropriate. Furthermore, an efficient and effective means of dealing with the concerns of clients will avoid litigation caused by a poorly implemented complaint-handling system.

Obtaining consent

The Tito Report (Commonwealth Department of Human Services and Health 1995) concluded that further research is needed to study the process of informed consent in clinical trials, and to obtain a better insight into the myth and reality of informed consent in daily practice. It is clear that improving the consenting/communication process affords an opportunity to create in the minds of clients more realistic expectations about the anticipated outcomes of health care interventions and therefore should reduce the rate of litigation by clients against providers.

The report goes on to say that, where a client is better informed about risks and benefits, has a realistic appreciation of probable outcomes of treatment, is able to reach informed decisions about their health care and is actively involved in decision-making about their health care, it is more likely that they will be less likely to complain or litigate if an adverse event occurs. The adverse event will be accepted as a risk that they were prepared to take when it was weighed against the possible benefits.

Improving the communication process that forms the basis of the client's consent to treatment should have a dual effect on the number of claims instituted against health care providers. The number of actions should be reduced overall as communication between the provider and the client is improved generally and, specifically, the proportion of actions based on an alleged failure by the provider to obtain the informed consent of the patient before treatment should also fall.

Of course, the health care provider in either the public or the private sector has limited time to spend with each client. This factor alone is arguably the greatest handicap to obtaining 'informed consent' from clients. The communication process necessary to obtain the client's informed consent to treatment consumes much of the limited time that the provider has to spend with each client. The practical reality may be that the health care provider will see the patient only once before the beginning of the recommended treatment. Any attempt to improve communication between health care provider and client should be designed with this factor in mind.

One way of overcoming the difficulty of informing clients about procedures, outcomes and choices would be to develop standardised consenting systems which contain, or guide the provider on the information that is required to be provided to the patient.

This is not to say that consent forms used in the past that contained blanket authorisation for any procedure, including those required by 'necessity', are appropriate. Clearly, 'generic' type consent forms are largely worthless and of no legal effect (*Rogers v Lumbermens Mutual Casualty Co* 119 So 2d 649 (1960)). If standardised provider and client information packages suitable for certain procedures were developed, the provider could devote time to addressing specific questions from the client.

Before implementing standardised information packages, it is vital to consider what information should be given to clients as required by law, ethics and the colleges. Furthermore:

It must be recognised that most of the professional mystique in relation to medical advice and treatment has been reduced by rising standards of patient education and a desire by patients to be fully informed about and discuss the implications of any contemplated medical procedure or treatment (The Board of Management of Royal Perth Hospital & Anor v Frost, Supreme Court of Western Australia (Full Court), 26 February 1997, 130/95, p 5).

But, of course, before anyone was clever enough to use the phrase 'informed consent', a surgeon, indeed any doctor, owed to their patient a duty which included the giving of careful and thorough advice and information (*Daniels v Burfield*, SA Supreme Court No. 3072, 17.10.91, p 13).

Clearly, the law requires patients to be informed by their health care providers of 'material risks' inherent in the proposed treatment – except in circumstances where there is a particular danger that the provision of relevant information will harm the unusually nervous, disturbed or volatile patient (*Rogers v Whitaker* (1992) 175 CLR 479, p 490).

A risk is said to be material if a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that this patient, if warned of the risk, would be likely to attach significance to it. Risks must be stated in percentage terms if possible. It is generally inappropriate for health care providers to describe risks as 'small' or 'slight' (*Karparti v Spira & Ors*, NSW Supreme Court No. 15853/92, 6.6.95).

Other recommendations about the information (including risks of treatment) to be provided to clients by health care providers include:

- encouraging clients to ask questions
- detailing known risks when an adverse outcome is common (Royal Australian College of Physicians 1998) even though the detriment is slight or, when the adverse outcome is severe, even though its occurrence is rare (Health Care Committee of the NHMRC 1994)
- giving information on relevant treatment options, including no treatment at all, and the benefits, risks and financial costs of those options (Health Care Committee of the NHMRC 1994; Commonwealth Department of Human Services and Health 1995)

- explaining the skills and experience of any health care professional from whom they seek assistance (*Chappel v Hart* (1998) HCA 55, 2 Sept 1998)
- revealing the health care professional's practice, preferences and relevant financial interests, for example, in services or facilities to which the patient can be referred, when these could affect the advice being provided
- explaining whether the health care professional whom they consult or the health care facility or service they use has adequate indemnity or insurance cover, whether direct or vicarious liability, for any negligent action or omission which results in damage to them
- explaining what to do if something goes wrong with their health care
- detailing services and assistance that can help them if they have an adverse event
- telling them how to access confidential information about their condition and treatment in their health care records (Commonwealth Department of Human Services and Health 1995).

Good communication means that each party will have a clear understanding of the information being offered. Consequently, medical jargon and terminology are to be avoided in the consenting process. The information imparted by either party must necessarily be expressed in language the other party understands, can assimilate and can consider and reflect upon. There is said to be no special skill in communicating the necessary information. The skill lies in communicating the relevant information to the patient in terms which are reasonably adequate for the purpose, having regard to the patient's capacity to understand the information (*Rogers v Whitaker* (1992) 175 CLR 479, p 490).

To achieve the most desirable outcome in the process of communication, it is inappropriate that the consenting process should take place over a short time. If a standardised system of obtaining consent is developed, it should allow the client time to consider the information provided (in a less stressful scenario than, say, the surgeon's rooms); to reflect upon the information; to consider what issues the patient wishes to raise with the doctor as specific areas of concern; and to be given a reasonable opportunity to reverse the decision they may have made about any proposed treatment (*Hribar v Wells*, Full Supreme Court of South Australia, 94/1497, 8.6.95, p 5).

The communication process that allows the health care provider to obtain a patient's informed consent to treatment should be reduced to writing and contain sufficient detail to substantiate the obtaining of informed consent. This is not to say that oral consent is not equally as valid as written consent (*Hribar v Wells*, Full Supreme Court of South Australia, 94/1497, 8.6.95, p 5). However, recollections by clients and health care providers fade over time, and are bound to conflict by the time the parties are giving evidence in court.

Using standardised patient and information systems such as information brochures and patient and clinical pathways offers an opportunity to provide the patient with

information in document form. The client can take the information away, consider the information, and attend their next practitioner appointment having prepared issues of concern that can be discussed. This 'take away' format also allows the patient to bring the relevant documentation to each attendance, and to use the documents and patient-input areas to build upon the required knowledge and understanding necessary to give consent. Further, the health care provider can ensure immediately before treatment that the consent has not been revoked. The question of when or if a consent form may expire can then be avoided.

It is important, however, that if standardised information is to be provided to clients in document form, the health care provider should ensure that the document contains all relevant information and, if further information is provided, a record is kept. Further, the document should be clearly dated. The provider should also be able to ascertain from the client record exactly when and what documentary and other information was provided to the patient. Such detailed record-keeping should enable the health care provider to know exactly what has been provided to the client at each stage of consultation and treatment.

A client who has suffered damage may succeed against a provider and be awarded damages only when the provider has failed to warn of a risk that eventuates, and the client is able to convince the court that if the provider had warned of the risk they would not have undergone the treatment (*Rogers v Whitaker* (1992) 175 CLR 479, p 490; *Hribar v Wells*, Full Supreme Court of South Australia, 94/1497, 8.6.95, p 17). A written or other record of the exact information provided to the client is vital to any defence of the provider because it will enable the court to consider the conduct of the provider against the relevant standard of care required of them by law.

It has been established that:

The factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or the provision of information or advice; the different cases raise varying difficulties which require consideration of different factors (Ainsworth v Levi 1995, p 13 citing Rogers v Whitaker 1992, p 489). This standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant professional trade. Even in the sphere of the diagnosis and treatment, the heartland of the skilled medical practitioner, the Bolam principle² has not always been applied. Further, and more important, particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded and, instead, the courts have adopted the principle that while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to the 'paramount consideration that a person is entitled to make his own decisions about his life' (Ainsworth v Levi, Supreme Court of New South Wales, Court of Appeal, 440/84, 30/8/95, p 5).

Furthermore, it has been established that:

whilst evidence of the practice usually adopted by persons in the position of the defendant will generally be of great assistance, and often decisive, the way must be left open to a plaintiff to persuade the court that the practice does not ensure an adequate standard of care (Re: E and Australian Red Cross Society; Australian Red Cross Society New South Wales and Central Sydney Area Health Service 99 ALR 601, p 647).

Diligent record-keeping will also enable the provider to avoid the unenviable ‘it was my invariable practice to warn/tell clients of XYZ’ defence if the client institutes litigation. The ‘invariable practice’ defence is one which finds little favour with the courts faced with a plaintiff claiming specifically that the provider did not provide the relevant information.

Conclusion

Any strategy to minimise medical litigation must be founded upon a coordinated plan to improve provider–client communication. For some providers such a plan may require a change in the manner or method of dealing with clients. In those circumstances, providers can be persuaded to make the required changes if they understand the known reasons why clients sue their health care providers, what information the law requires to be provided to clients, and the nature of evidence likely to be required to successfully defend a medical negligence action.

In practical terms, any strategy which aims to minimise medical litigation may be achieved through adopting a plan which includes the standardisation of consenting systems, the standardisation of the method of recording the ‘informed consent’ process, and a well-publicised early intervention plan/complaint-handling system to resolve complaints at the point of service delivery.

It is clear that clients require their health care provider to communicate with them about their health needs, rather than to decide their medical fate for them. Those health care providers who focus upon satisfying the entire range of client needs, revealed by the factors which motivate client litigation, have assured themselves of the best possible defence against medical litigation.

Endnotes

1. In 1997 a medico-legal survey was undertaken and subsequently published in the journal of the Medical Defence Union (January 1998). This showed that some 81% of practitioners were aware of the *Rogers v Whitaker* case and 84% said that they had changed the nature of their practice in response to their concerns about litigation over the last five-year period.
2. Bolam Principle – *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582

See where McNair J said at page 587:

[A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.

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References

Ainsworth v Levi, Supreme Court of New South Wales, Court of Appeal, 440/84, 30/8/95.

Australian Standard, 'Complaints Handling', AS 4269-1995.

Batchelor C, Owens DJ, Read M & Bloor M 1997, 'Patient satisfaction studies: Methodology, management and consumer evaluation', *International Journal of Health Care Quality Assurance*, vol 7, no 7, pp 22–30.

Chappel v Hart (1998) HCA 55, 2 Sept 1998.

Commonwealth Department of Human Services and Health 1995, *Review of Professional Indemnity Arrangements for Healthcare Professionals – Compensation and Professional Indemnity in Healthcare* (Tito Report) Final Report, November.

Daniels v Burfield, SA Supreme Court No 3072, 17.10.91.

Journal of American Medical Association 1997, Editorial, February.

Hall JA & Dornan MC 1998, 'What patients like about their medical care and how often they are asked: A manner analysis of the satisfaction literature', *Social Science & Medicine*, vol 27, no 9, pp 235–9.

Harvard Risk Management Foundation, *Prevention and Control of Malpractice Claims*, Harvard Risk Management Foundation, Cambridge, Massachusetts.

Health Care Committee of the NHMRC 1994, *General Guidelines for Medical Practitioners on Providing Information to Patients*, prepared by the Health Care Committee of the NHMRC 1994.

Hickson GB et al. 1994, 'Obstetricians' prior malpractice experience and patient satisfaction with care', *Journal of American Medical Association*, 272, pp 1583–7.

Hribar v Wells, Full Court Supreme Court of South Australia, 94/1497 8/6/95.

Karparti v Spira & Ors, NSW Supreme Court No. 15853/92 – 6.6.95, Spender AJ.

Re: E and Australian Red Cross Society; Australian Red Cross Society New South Wales and Central Sydney Area Health Service, 99 ALR 601.

Rogers v Lumbermens Mutual Casualty Co 119 So 2d 649 (1960).

Rogers v Whitaker (1992) 175 CLR 479, p 490.

Royal Australian College of Physicians 1998, *Guidelines for the Medical Profession on Informed Consent*, Fellowship Affairs, October, Royal Australian College of Physicians.

Seelos L & Adamson C 1994, 'Redefining NHS complaint handling – the real challenge', *International Journal of Healthcare Quality Assurance*, vol 7, no 6, pp 26–31.

Shaw v Longly, NSW District Court, Pratt DCJ, 24.11.93.

The Board of Management of Royal Perth Hospital & Anor v Frost, Supreme Court of Western Australia (Full Court), 26 February 1997, 130/95.

Verheggen FW & Van Wijmen FC 1996, 'Informed consent in clinical trials', *Health Policy*, vol 36, no 2, pp 131–53.

Victorian Health Services Commissioner 1998, BLEC Conference, Paper presented at the Medico-Legal Conference, Victoria, March.

Vincent C et al. 1994, 'Why do people sue doctors? A study of patients and relatives taking legal action', *Lancet*, vol 342, June 25, pp 1609–13.

Weiler PC et al. 1993, *A Measure of Malpractice*, Harvard University Press.