

Compensation for injury from medical treatment is a social justice obligation

The problem of injury or death resulting from negligent medical advice or treatment has not received attention from South African researchers. Consequently, the extent of serious harm to patients from medical intervention remains anyone's guess. But if the epidemiology of adverse events in clinical practice elsewhere in the world is anything to go by, it is safe to assume that medically caused injury, disability and death are not uncommon occurrences in our country.

Medical malpractice or negligence is described as the failure of a practitioner to act in accordance with the accepted norms and standards of care, or to foresee and therefore prevent adverse consequences that a professional person with the necessary skills and training should foresee. The definition must also include the practitioner who exposes a patient to risk by knowingly providing treatment or performing a procedure beyond his or her scope of professional competence. The hallmark of a negligent adverse event is that the event is independent of the pathology under treatment.

Importantly, though, negligence is not the one and only cause for medically related injury or death. Writing in the *BMJ*, Calinas-Correira,¹ a crusader for action to reduce iatrogenic harm, cites large studies to support her assertion that 'major USA and UK hospitals kill one for every 200 hospitalised patients', but cautions that 'large numbers of patients are killed and injured by perfectly sound and proper medical interventions' owing to such mishaps as unanticipated drug reactions, instrument malfunctions and systems failures. It is her view that the latter causes receive far too little attention in the discourse on medical injury.

Major studies into iatrogenic harm conducted in a number of countries point to incidence rates of between 3% and 16%, depending on the methodological criteria. The pioneering 1991 Harvard study² by Brennan *et al.* found that 3.7% of patients admitted to New York acute care hospitals sustained medical management-related injury that prolonged hospital stay and/or caused permanent disability. Extrapolating from existing literature, Weingart *et al.*³ reach the staggering conclusion that 'In the United States, medical error results in 44 000 - 98 000 unnecessary deaths each year, and one million excess injuries.'

An Australian investigation⁴ modelled on the Harvard study found that an adverse event occurred in 16.6% of admissions, resulting in permanent disability in 13.7%, and death in 4.9%. A recent New Zealand study⁵ found that the elderly, people of colour, and patients in particular clinical disciplines were at higher risk of injury due to preventable causes. These rates are an underestimate, as many mishaps remain unrecorded by doctors and unreported by patients. Preventable medical injury is not limited to in-hospital care, but little is known about the prevalence of medical error in private doctors' practices and outpatient clinic settings.

The injured patient's recourse is to sue for damages and, according to the Medical Protection Society, the medical malpractice indemnity provider for most doctors in the country, South Africa has experienced a surge in both the number of suits and the quantum of compensatory awards in recent years. Medical practice is a human endeavour, and the potential for medical error

is inherent in the hands of even the most competent and conscientious practitioner. Patients are aware of this, and will generally accept the risk of inadvertent injury where there is a relationship of trust, honesty and mutual respect with the doctor. More often than not, therefore, malpractice litigation reflects the ultimate breakdown in an already unsound and implicitly distrustful doctor-patient relationship.

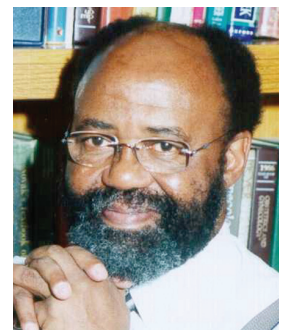
Not infrequently, South African doctors set themselves up for trouble by undertaking technical procedures for which they are ill qualified, employing new technology with which they have little or no experience, promising outcomes about which there is dubious certainty, or administering new and dangerous drugs with lackadaisical attention to possible adverse effects. Some doctors have even set up unregistered operating theatres in their private practices to inflict on their patients cosmetic and other surgery for which they are not registered with the HPCSA.

Whatever the case may be, it is only right that patients who sustain preventable medical injury are entitled to appropriate compensation, both as a matter of social justice and as an incentive for prudent and conscientious care on the part of the practitioner.

However, the 'tort' legal route to compensation, whereby the patient must sue in the courts to prove liability for negligent care, is cumbersome, expensive and counter-productive for both parties, with the lawyers being the only winners. The system is hugely expensive, and it can take years before the litigant sees any money, if he or she ever does. As in the US, malpractice insurance premiums are skyrocketing in South Africa, particularly for obstetrics, plastic surgery and neurosurgery. The provision of malpractice indemnity has become a huge dilemma for provincial health authorities and doctors in the public service.

Progressive countries such as New Zealand, Denmark, Sweden and Finland have adopted the so-called 'no-fault' compensation system (the merits of which are examined in a recent article in *Annals of Medicine*⁶), which dispenses with the adversarial tort format and the need to prove negligence, and lets an expert panel rather than a court of law adjudicate claims for medical injury, however and by whomever caused. The system is simpler, quicker, cheaper, and benefits more victims than the tort system – something South Africa should look at.

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Editor



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