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Medical Litigation in Hospitals in Kampala, Uganda

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Abstract

Seeking legal redress for harm sustained while receiving medical care is common in some developed countries but less common in most developing countries. However, unconfirmed reports suggest that litigation is on the increase even in developing countries like Uganda. Litigation influences the behaviour of both health care workers and hospital managers, with significant consequences for patients and the entire health system. Given the dearth of publications on the extent of medical litigation in developing countries, this exploratory study sought to determine the prevalence, trends, determinants and effects of medical litigation on medical practice in hospitals in Kampala. Using a mixed methods approach, ten Kampala hospitals belonging to the government, private not-for-profit (PNFP) and for-profit (PFP) organisations that had been in operation for at least 5 years were purposively studied. Participants included medical directors, officials from courts of judicature, health professional bodies, and officials from health care consumer organisations. The study revealed that medical litigation in Kampala was still minimal but increasing steadily. Surgeons and Obstetricians / Gynecologists were the specialties most at risk of medical litigation. Significant factors responsible for the increase in medical litigation trends were: heavy workload; increased exposure to medical information; and increased awareness on patient rights. Medical litigation has led to improvement in quality of health care, huge financial burden to the health care providers, and suspension or outright withdrawal of health workers from medical practice. Efforts to reduce litigation include continuous professional development, better staff recruitment practices and strict enforcement of standard operating procedures. There is need for dialogue between the patient safety stakeholders, staff training on patient-centred care and training of managers on the implications and processes of medical litigation.

Keywords

Medical Litigation (ML), Health Workers, Uganda, Kampala, Bolitho Test, Bolam Test, Duty of Care

1. Introduction

Medical errors are a frequent occurrence in health care and a significant cause of disability, loss of life, and heavy health care costs. A US Institute of Medicine (IOM) report which revealed that 44,000 to 98,000 deaths occur in the American health system annually due to avoidable medical injuries [3] raised international awareness of medical errors and their consequences. Subsequent US reports have revealed death tolls and other negative effects to be even much higher [6-11]. In Latin America, 1 in 7 Medicare patients in the hospitals experience a medical error, 44 percent of which are preventable [32]. In Britain, about 800 medical mistakes are committed daily and doctors misdiagnose fatal illnesses 20 percent of the time [2]. Increasingly, patients take their doctors and/or their hospitals to courts of law for failure to meet the expected standards of care. Though costly, lawsuits are opportunities to learn about patient safety improvement [18]. The possibility of lawsuits has encouraged better communication with patients, more patient involvement in decision making and encouraged accountability for actions during healthcare delivery. Medical litigation dates back several centuries to the formative stages of the common law [5].

In fault-based prosecution systems, the success of medical litigation is based upon the plaintiff proving duty of care; injury; causation; and breach of duty/negligence [30]. The plaintiff has to establish that the practitioner owed him/her a

duty of care. The plaintiff should have suffered injury. It should be established that the care offered fell below the expected standard of care, given the provider's training and experience. It should further be established that the reported failure to uphold standards was due to negligence. Finally, it should be established that the reported negligence of the duty of care caused or contributed to the injury suffered. For long, medical peers were given the right to determine fellow practitioners' alleged negligence basing on professional standards, the so-called *Bolam* test [1]. However, this right was challenged in the *Bolitho* case on grounds of conflict of interest, thus giving this right to the courts [1].

To prove breach of the duty of care, evidence should be adduced to the effect that the defendant(s) exhibited attitudes, policies, systems or practices which could have possibly precipitated the failure to comply with health and safety regulations during care [29]. Causation is proven if the particular acts or omissions of the defendant during healthcare delivery were the definite cause of the error or injury incurred by the claimant/plaintiff [30].

Several countries have, however, shifted from the prosecution approach to the Administrative Compensation / "No-Fault" system [30], in which the injured party may not take legal action. Assessment by a professional body is adequate to determine negligence and the right to compensation. This has significantly reduced the costs of medical litigation. While such developments are reported in developed countries, there is still a dearth of literature on medical errors and medical litigation in developing countries, where adverse events are probably higher, especially in lower level health care facilities with shortages of qualified health workers. However, seeking legal redress is a poor culture in many developing countries due to barriers like low levels of education, lack of money to initiate lawsuits, scarcity of physicians, immature health care systems, regulatory deficits, and weak civil society [4].

Although medical litigation has helped to reduce the incidence of medical malpractice, thus improving the quality of health care by making providers more careful, this has been achieved at excessive financial cost, which may not be affordable to most developing country health systems and patients. High costs reduce equity in access to health care and health workers are overly cautious in taking on patients and order excessive and unnecessary investigations and treatment (defensive medicine) [16-18]. Significant medical litigation reduces patient-centered care. As health providers become more concerned about their own safety and the money they can make to prepare for any possible lawsuit, patients are seen as potential litigants rather than people in need of care. Medical litigation may have scared away a prospective young generation from joining the medical professions, or pushed them to prioritize the low-risk specialties, caused damage to practitioners' reputation, or fostered early retirement. It also diverts the scarce health resources.

Although local media reports suggest that medical litigation is on the rise in Uganda, scientific studies on the extent of alleged or true patient harm and subsequent medical litigation and their effects are scarce. Media reports have, nevertheless, prompted government action to address maternal health issues. This study attempted, therefore, to contribute to filling this knowledge gap by analyzing the trends of medical litigation, the factors that influence medical litigation, effects of medical litigation on the patients, health workers, and the hospitals.

2. Methodology

This exploratory descriptive cross-sectional study was conducted in Kampala city, expected to have higher rates of medical litigation than other parts of the predominantly rural country. Qualitative data were collected through interviews with the managers of ten urban hospitals (1 government, 3 private not-for-profit, 6 private for-profit) and judicial officers. Medical litigation was presumed to be a rare event in Uganda and, therefore, only hospitals that had been in operation for at least 5 years (2007 to 2012) were included.

The manager of each hospital was requested to indicate the reasons for medico-legal action against the hospital. The files of medico-legal cases were reviewed and the fate of the patients, health workers and effects of litigation on the hospital were assessed.

Ethical approval for the study was provided by the institutional review board of each hospital.

3. Results

3.1. Trends of Medical Litigation

Despite providing ethical approval and assurances of anonymity and confidentiality, the managers of most hospitals did not provide direct access to medical litigation files because they considered them to be too sensitive. However, verbal information indicated that medical litigation was on a gradual rise. At the time of the study, 2/10 hospital managers had received notification of intention to sue, 3/10 had had cases in court, 5/10 were handling cases with the professional councils (especially the Uganda Medical and Dental Practitioners Council) and only 1/10 had no disciplinary or medico-legal experience. From court records, medico-legal cases were still a very small fraction of cases handled:

> *"In places like Kampala, being an urban area and a capital city, one would expect so many cases. However, in every 500 court cases, only one is on medical litigation … some patients… do not think they have a right but rather feel favored to be attended to by the health workers"* (Judiciary official).

3.2. Factors That Influenced Medical Litigation

Patient-related factors that led to medical litigation included increased public awareness about medical treatment and patients' rights. Participants related this to the work of

non-government organizations, increased exposure of medical information through various media including internet, and increased reading culture. It was reported that more people nowadays read about treatment for different ailments on the internet, how doctors practice in the different countries, what happens when malpractice occurs, and other related subjects. The social connections of the patients were also found to contribute significantly to the likelihood of medical litigation. Patients closely linked with influential people like politicians, lawyers, army officers, police and high-ranking civil servants were encouraged and supported financially by their relatives to sue in case of perceived harm. New patients were more likely to sue than those who had ever sought treatment from the same hospital.

Generally, patients were disinclined to sue health workers or hospitals. Only sudden and unexpected deaths prompted litigation:

> *"As long as the doctor appears ... patients think the doctor has tried their best. ....litigation ...largely occurs following the unexpected death of a patient or permanent injury to the patient"* (Manager, PNFP Hospital).

Other patient-related factors mentioned included; high education level, higher socio-economic status (since they can afford the services of a lawyer), opportunism and non-disclosure of other prior health conditions (which some patients' alleged later as a misdiagnosis by the health workers).

Health worker factors that influenced the likelihood of litigation were low morale due to poor pay, dual practice leading to absenteeism, heavy workload, and poor training leading to poor health worker-patient relationship and declining professionalism. Surgeons, obstetricians/ gynecologists and the young/middle aged (due to inexperience or declining professionalism) were more likely to be sued for negligence:

> *"Money is the driving force of many health workers, and they are doing many things they cannot manage…Medicine used to be noble. Now it is business, pure business".* (Manager, Government Hospital)

The most significant hospital factor creating grounds for medical litigation was inadequate supplies. Health workers with inadequate supplies tended to improvise or avoid certain essential procedures, thus providing care of poor quality. Private hospitals faced more cases of litigation than the government hospital studied. Most participants thought this to be due to the popular belief that it was easier to get legal costs from private hospitals than government, rather than poorer quality of care. They also believed that settling disputes immediately after they happened would save hospitals from litigation than if they delayed:

> *"In most cases, people just want an apology. If someone comes out to say 'I am sorry', the claimant drops the case"* (Manager, PNFP Hospital)

One hospital factor that reduced the prevalence of litigation was the practice of not giving patient files and medical notes to patients. Plaintiffs did not have written evidence to present to courts as evidence, unless court demanded them.

Judiciary system factors that reduced litigation included the long waiting time for a case to be prosecuted successfully, being an average of 3 - 5 years:

> *"It takes a very long time to close a medico-legal case - an average of 3-5 years. You do not go to court or professional council and think you will get justice in a month"* (Manager, Government hospital)

3.3. Effects of Medical Litigation

Most managers in this study believed that malpractice suits have contributed to improving clinical practice, as the health workers became more attentive to the quality of care they offered. However, they also believed that the lawsuits brought emotional stress and demotivation to managers and health workers:

> *"...people feel they gave their best, yet somebody is suing them. ...they start seeing patients differently"* (Manager, PHP Hospital).

Other effects of medical litigation reportedly suffered by health workers were: loss of time due to the lengthy court process; revoking of the operating license; withdrawal from practice either as a result of the urge to retire voluntarily or by law; suspension from practice; dented image or career; and failure to get employment elsewhere, largely as a result of dented image. Managers also mentioned that health workers who lost cases suffered financial effects due to the fines and huge compensation paid out which, at times, compelled the victims to sell property to raise the money.

In the hospitals, litigation has often led to improved health care services and tightened systems to prevent acts that could lead to lawsuits. However, some not-for-profit hospitals have lost donor funding for fear that such funds would be used to pay legal compensation for medical malpractice. Medico-legal compensation was said to be more burdensome in hospitals that had no insurance for medical indemnity. For-profit hospitals had constant fears of a dented image, and losing key workers and clientele, especially when the cases were published in the media. All private hospitals feared revocation of their operating licenses and suspension of their health workers from practice by the professional councils, defensive medicine and closure by law or due to bankruptcy in cases of heavy compensation.

3.4. Measures to Prevent or Mitigate Medical Litigation

Medical litigation has prompted reforms in most of the hospitals studied. Most reported reforms were in human resource management policies. These included: indemnity insurance, especially for surgeons and gynecologists; putting

more focus on staff welfare; opening up a public relations office; employing a medical doctor as the director of the hospital; closer scrutiny of the practice records of staff at recruitment; recruitment of only licensed staff; annual renewal of practicing licenses; and recruitment of mature professionals who are able to uphold professional ethics; using highly qualified staff, e.g. consultants, on a full-time basis; and instituting continuous professional development in medical and management skills.

4. Discussion

Though still minimal, medical litigation is on a steady increase in Uganda. There is also potential for many more and heavier malpractice claims. Current low rates of litigation are attributable to low levels of awareness of patients' rights, lack of knowledge of the litigation procedure, high costs of engaging legal support, long bureaucratic procedures, fear of suing government and the limited chances of a plaintiff winning a medical malpractice case. Some previous studies have also found that although plaintiffs win a majority of other cases, the chances of winning medical malpractice suits are lower [16,17,19]. Litigation may have benefits to the health system as it serves as a check to laxity and substandard care.

This study highlights the role of public media and the internet as the means through which the public is informed about patients' rights. Such channels could also be used by stakeholders to promote good medical practice and minimize gaps in quality care. A finding similar to previous studies was the observation that most of the reported suits were against surgical practitioners (gynecologists and surgeons), similar to observations in other studies [24, 28]. Such suits may push practitioners away from specializing in those fields. This could also lead to defensive medicine. It is not clear whether, indeed, the two specialisations are more prone to errors than others or due to the high charges for surgery that tempt litigants in the quest for money.

Poor morale, dualism, work overload, poor facilitation, inadequate materials and poor regulation of health workers were also highlighted in this study. Such system shortcomings contribute to failure to meet quality standards and patients' expectations, thus increasing the risk of malpractice litigation [32]. Fear of malpractice litigation has led to policies for the improvement of the quality of healthcare. However, such measures are only at the level of individual institutions and mainly dependent on past experience of litigation. On the supply side of health care, there are few national health system-wide efforts to prevent the risk of medical litigation, such as the introduction of Client Charters [31]. On the demand side, however, health consumer organisations are increasing their efforts to educate the public. This will increase the risk of litigation in the near future and the health system needs to be appropriately prepared for this trend.

5. Conclusion and Recommendations

Litigation for medical malpractice is still little in Kampala, but gaining ground. Managers need to prepare hospital systems to prevent instances of medical malpractice and to manage instances of litigation appropriately. This calls for more focus on patient-centered care, better equipment, and better staffing with the right people who have the right attitudes. This will also need training, supervision and evaluation of practice and patient safety systems. There is also need for systems for proper safety data capture and medical error reporting, a culture of settlement of incidents before recourse to litigation, and a general patient safety culture. In addition, there is need for a forum for dialogue between health consumer organisations and the providers, in order for the correct information to be passed to the public, especially about cases eligible for litigation. There is also need for more patient safety research.

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