

Counting the public healthcare litigation bill

In addition to the cost in grief and trauma to families and the shattered confidence of under-resourced, under-supervised and over-worked doctors, South Africa (SA)'s nine provincial health departments face a ZAR24 billion patient litigation bill (2010 - 2014, with ZAR500 million paid).

This startling financial indicator of patient risk in our under-resourced public hospitals came from Dr Terence Carter, deputy director-general of hospitals in the National Department of Health (NDoH), in a presentation to the Rural Doctors Association of South Africa (RuDASA) in Grahamstown on 6 August this year. He said the claims figure had risen to ZAR37 billion by last year. Citing province-by-province litigation statistics, he told of an unnamed Limpopo hospital where clinical negligence and resource constraints had combined to result in the birth of a headless baby in May last year. Illustrating why protocol adherence, supervision and clinical governance were so vital in reducing patient death and injury, Carter did, however, emphasise that resource constraints 'could be a cop-out' for those who failed to adhere to existing available clinical guidelines.

Horrific case study

Carter said that after a lawyer's phone call to health minister Dr Aaron Motsoaledi a full year after the headless baby incident, it emerged that the relevant hospital chief, his district manager and the district clinical specialist had no knowledge of it. A woman, 38 weeks pregnant and suffering from severe hypertension, was referred to the local district hospital from a clinic, where she was correctly given magnesium sulphate. The most senior hospital clinical manager on call was given the file, noted that her blood pressure had dropped, and prescribed appropriate additional drugs before she was taken back to her ward and 'simply left'. Having had a previous caesarean section, she should have delivered her baby within 24 hours, Carter said. Instead, she went into labour at 2 am, several days after admission. The nurses tried in vain to deliver what was a footling breech infant, realising after several attempts that it had died. The doctor arrived at 7 am and his attempts (allegedly) 'decapitated the baby', with the mother being sent on to theatre to deliver the head. During the ensuing

C-section, it was found that the woman's uterus had ruptured. She was referred to a tertiary hospital for a hysterectomy, where the attending gynaecologist found that her ovaries were damaged beyond repair.

Too many nurses and doctors thought clinical protocols were 'optional', treating them 'like multiple-choice questions'. Medical litigation history in South Africa illustrated that there was little defence if a healthcare worker did not follow protocols. Resource constraints, however, were a viable defence, 'because you can't expect the impossible'.

Carter said that when he confronted the relevant head of department at the tertiary hospital, he professed ignorance, nor had he tried to find out what had gone wrong and why. 'There is no way maternal mortality in that province is going to be brought down. Nothing was done, all the way down [the management line], so the question of clinical governance is crucial when it comes to litigation,' he said. Too many nurses and doctors thought clinical protocols were 'optional', treating them 'like multiple-choice questions'. Medical litigation history in SA illustrated that there was little or no defence if a healthcare worker did not follow protocols. Resource constraints, however, could be a viable defence, 'because you can't expect the impossible'. He said doctors made life-and-death decisions on a daily basis, based on available resources, but were being 'hung out to dry'.

'They have to decide who gets to ICU and theatre and who doesn't. It's true that doctors are usually on their own when these tough decisions are made, based on human resource constraints. [However,] when you make them, make sure they're in good faith and you're adhering to available protocols,' he advised his audience. Turning to the climate of hierarchal fear among junior clinicians, reported recently in the lay media, he said he found it 'astounding' that some doctors did not know there was a law protecting whistle-blowers. 'Even the SABC

case demonstrated this recently,' Carter observed, referring to the July court order reinstating four journalists fired by maverick CEO Hlaudi Motsoaneng for questioning his censoring of violent service delivery protests.

Whistle-blowers 'vital' – Carter

Healthcare workers thought of officials as more powerful than the law and the courts, often because there was a general state of fear and victimisation. 'Even if other people know (or share a complaint), they won't come forward to support you.' In an interview with *Izindaba* later, Carter said he had in mind the much-publicised case of Addington Hospital intern Yumna Moosa, told by her consultant seniors to destroy an orthopaedic block logbook feedback entry in which she had noted that their 'racist and sexist' remarks were unwelcome. Her head of department refused to sign off her internship, bringing charges of clinical incompetence that the Health Professions Council of South Africa (HPCSA) overturned after she easily passed an observed test at another hospital. Her secret taping of her seniors' comments went viral among junior doctors, with her father-in-law, RuDASA veteran and head of family medicine at the University of Cape Town, Prof. Steve Reid, making an unsuccessful bid to mediate with the hospital CEO. At the time of writing, Moosa's CCMA hearing remained set down for 5 October. Reid told *Izindaba* at the RuDASA conference that 'this vindictive intimidation is completely out of place – they've dug a big hole for themselves'. Carter said the matter had been referred to the KwaZulu-Natal premier, who had assured him that there would be an independent probe. He said he hoped it would 'encourage whistle-blowers to know their rights'.

Asked to cite the most dramatic examples of hospitals failing to deliver an acceptable service owing to shortages of healthcare workers and expertise, Carter named Rob Ferriera Hospital in Nelspruit, Mpumalanga, and Universitas Hospital in Bloemfontein, Free State. He said that Rob Ferriera was once a 'premier' tertiary hospital but had haemorrhaged competent and experienced medical officers and specialists because of 'significant instability' at senior management and leadership level (last November), narrowly escaping losing its HPCSA intern training accreditation. A new head of depart-

ment had recently been appointed, however, and things had begun to improve. 'Once you've had a drop in standards it's really difficult to recover,' he added.

Taking small bites of the elephant

Interventions aimed at addressing the overall healthcare delivery crisis were nevertheless 'well advanced', with ex-UCT dean of medicine Prof. Marion Jacobs's Academy of Leadership and Management underpinning Motsaedi's earlier hospital CEO competence and skills audit. The audit overhauled the national hospital leadership cadre, retrenching or redeploying dozens of CEOs, moving away from qualifications towards competence and individual and system performances, 'or basically just the simple ability to do their work'. The Office for Healthcare Standards (OHCS), a pre-National Health Insurance (NHI) quality assurance inspectorate and support body, recently found that less than 10% of public hospitals were compliant with their minimum required standards. Carter said the target was 80% or greater compliance, with the bar set at different levels for 'extreme, vital, essential and developmental' interventions.

The OHCS also took into account the sustainable development goals, especially when it came to maternal, neonatal and infant mortality. 'Every manager must make a contribution to achieve these targets. It's not about whether you passed your

MBA, cum laude. It's about your hospital performing.' A recent health infrastructure audit also showed there was 'some serious work that needs doing'. The NDoH was moving away from prioritising new facilities to stopping older facilities from becoming run down. Linked to that was 'fit-for-purpose' technology that complied with international standards, and securing maintenance and service contracts with reputable companies. The hospital supply chain also needed improvement, and his department was working with National Treasury to introduce transversal contracts instead of the piecemeal procurement system currently in place.

On human resources, Carter said the annual output of doctors, nurses and clinical associates was slowly improving, with the interim mass training of SA doctors in Cuba proving the catalyst for broadening current medical campuses to accommodate more students locally. He said the envisaged massive pre-NHI reorganisation of the healthcare system was premised on a primary healthcare model based on the promotion of health and the prevention of diseases instead of the current hospicentric 'rescue' model. Rehabilitation and palliative care would also be increasingly emphasised.

'We want to introduce the concept of health-promoting hospitals, not just curative. It's totally wrong for an orthopaedic surgeon to only know how to replace a hip and knee. What about overweight patients? The orthoped should ensure preventive and

rehabilitative care. It's also not enough to just do a gastroscopy when the patient is also smoking – or treat diabetes when you're not focused on lifestyle,' he said. Healthcare services were fragmented and curative, with 'rampant, uncontrolled commercialism'.

Citing province-by-province litigation statistics, he told of an unnamed Limpopo hospital where clinical negligence and resource constraints combined to result in the birth of a headless baby in May last year.

Topping the accumulated litigation claims charts from 2010 to 2014 was Johannesburg, Gauteng Province (ZAR14 019 billion). It was followed by Durban, KwaZulu-Natal (ZAR5 477 billion) and Mthatha, East London and Port Elizabeth in the Eastern Cape (total ZAR3.53 billion). Bloemfontein in the Free State was ranked fourth at ZAR780 million, while Cape Town in the Western Cape lay fifth at ZAR562 million. The province with the lowest litigation costs was the Northern Cape (Kimberley), at a 'mere' ZAR47.83 million.

Chris Bateman
chrisb@hmpg.co.za

S Afr Med J 2016;106(11):1063-1064.
DOI:10.7196/SAMJ.2016.v106i11.12059