The threat of litigation: Private obstetric care – *quo vadis*?

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Because of changes in litigation frequency and estimated claims value, indemnity costs for South African obstetricians have increased sharply and may soon become virtually unaffordable. There is the real possibility of very serious public health consequences and it is important that the matter is addressed as a matter of urgency. Resolution is by no means limited to obstetric care, but it is important that obstetricians become actively involved in the debate. While the alternatives suggested may be considered unpalatable they are raised to open and stimulate debate – they are by no means prescriptive. Clearly the debate has to extend beyond the obstetric or indeed the medical community and urgent and serious consideration will have to be given to tort reform.

> *'The first thing we do, let's kill all the lawyers'*
>
> (William Shakespeare, Henry VI, Part II, Act IV, scene ii, lines 83-84)

Recently the Medical Protection Society (MPS) has experienced a 30% increase in the frequency of medical negligence claims in South Africa.[1] Over the same period there has been a concomitant 132% increase in the estimation of the value of South African claims.[1]

Not-for-profit mutual organisations' indemnity subscription rates, or alternatively insurers' premiums, are set to cover anticipated future costs; a major distinction being that insurers have to factor in a margin for shareholder profits. There are two income streams for the financial reserve: investments and subscriptions. Nothing is to be gained by artificially keeping rates low; funding to cover future claims and administrative costs has to be maintained – there is no other obvious alternative. Unsurprisingly then, given the increase in anticipated future financial liability, there has been a rapid increase in the cost of indemnity cover.

The increase in litigation and consequent increase in subscription rates has lead to understandable concern. The question has recently been asked, 'Is South Africa on the verge of a medical malpractice litigation storm?' reflecting the increasing awareness and concern about the subject.[2] The area where the increase in claims value is the most pronounced is in cases where there is catastrophic injury and the specialties most affected are obstetrics, neonatology and spinal surgery.[1] The costs in obstetric and neonatal cases are exacerbated by the fact that the injuries are to the young, with long life expectancies.

Given the rapid increase in indemnity costs for obstetric care, a recent article entitled, 'The spectre of litigation – a dark cloud on the obstetric horizon' may have been somewhat prescient.[3] The subject was again raised in, 'Obstetric litigation – time to reflect?'[4] All three articles make for interesting and thought-provoking reading and there is much that can and must be done.

What may be driving the increasing litigation and the value of claims?

Firstly, addressing the increasing claims frequency, changes to the Road Accident Fund have made working in the field less attractive to lawyers.[5,6] It is tempting to consider that lawyers previously working in that field are attracted to medical negligence work where their training, knowledge and expertise are an asset.[7] More and more lawyers now also appear to be taking cases on a contingency basis ('no win, no fee'). While contingency arrangements do increase access to the law to all, in reality the actual benefits are probably mainly felt by those where the chance of success, being a lucrative settlement, is relatively high.[8] A strong argument can however be made that access to redress is facilitated and this is inherently good.

What is driving up the estimated value of claims? Care for catastrophic injuries is expensive. Inevitably in obstetric high claims, the injury has occurred to a child and, as a result of improvements in medical care, these children thankfully now survive and often have a long lifespan. Their medical and other care is sophisticated and expensive and, when factoring these costs over a lifetime, inflation plays an additional important role. MPS' experience is that claimant lawyers are also specialising in these cases and their claims are becoming more sophisticated with increasing experience and confidence.

Contingency fees may also play a role in increasing the value of the claim. According to the Contingency Fees Act of 1997, should lawyers take a case on a 'no win, no fee' basis then, if successful, they can double their fee up to a maximum of 25% of the award for damages.[9] There is some speculation that in some cases lawyers take up to 25% of the award even if it exceeds a doubling of their normal fee – one way of alleviating the speculation would be to make the contingency fee contract open to the defendant. Additionally, contingency fee arrangements where the lawyers have a vested interest in elevating the value of a claim introduce an uneasy tension into the equation.[10] Twenty-five per cent of a R20 million award is a substantial fee, and you do not have to win many cases of that magnitude for your business not only to be viable but lucrative.

Article

Possible sequelae of rising indemnity costs

The speed at which indemnity costs for obstetricians are rising is cause for concern. The lament that obstetric indemnity may soon be unaffordable is not scare-mongering. As indemnity costs rise, the issue of affordability is individual to the practitioner. It is likely that those who did less obstetrics will already have decided not to do deliveries any more and those whose practices rely on obstetrics and who do many deliveries will be able to afford higher indemnity costs. It is however not inconceivable that more and more doctors will feel that obstetric indemnity is unaffordable, leaving less choice for patients.

Eventually obstetric indemnity may become unaffordable for the vast majority of obstetricians. This could raise a public health issue; women who can afford to utilise the private sector will still become pregnant and require delivery.[11] If they are unindemnified, private obstetricians may be unwilling to care for or deliver these private patients. The only place they will be able to deliver, with access to nursing or medical care, will be state facilities.

This will increase the workload of state facilities and be to the disadvantage of the people whose care is their primary task. Additionally the state will now be burdened with a group of patients who are inclined to sue if and when things go wrong. This will lead to an increased burden of litigation on the state. Since the state does not independently budget for litigation losses, every Rand lost by the state to litigation is a Rand lost to public care. The vicious cycle is easy to see. Already hard-pressed state facilities have a heavy workload and can ill afford the increased burden of demanding patients. Overburdened facilities will be unable to cope and intrapartum care will deteriorate, resulting in problems and litigation that will take money that could have been used to improve the system.

An additional public health issue is that younger doctors considering specialisation will realise that the future viability of the higher-risk specialties is limited in private practice and decide against these specialties.[12,13] In the shorter term these highly motivated and hard-working individuals will not be available in the state facilities as registrars and later not as specialists. It is not inconceivable that we could soon see a decline in the numbers entering obstetrics and gynaecology or showing an interest in neonatal care or spinal surgery.

What to do?

Given the potential sequelae – extending right up to serious public health issues – resolution clearly extends far beyond what the obstetric community can address. However, it is important to consider what is potentially resolvable by the obstetric community, or more crudely, how can we put our house in order?

Before considering what to do it is important to reflect on what not to do. What ideas are superficially or emotionally appealing but worth rejecting following deliberation? While the issue may impact on future obstetric care, and those who deliver it may be drawn emotionally into the debate, resolution will not be achieved through emotional arguments.

Despite this article's opening Shakespeare quote, vilifying claimant lawyers, although possibly psychologically gratifying, is of no value. Blaming them for the situation is analogous to blaming criminal defence lawyers for defending criminals, thus being responsible for rising crime.[9] Claimant lawyers will justify their actions by saying, quite rightly, that in the absence of negligence there would be no problem. They are merely assisting patients who have been injured by negligent care and we must get our house in order – a difficult argument to refute.[3]

Another suggestion offered as a solution is that, given that in the majority of successfully litigated cerebral palsy cases the problem occurred during labour, elective caesarean sections should be performed on all patients. However, considering the small number of cerebral palsy cases that would be prevented and the number of caesarean sections that would have to be performed, results in a disproportionately high number-needed-to-treat to prevent one cerebral palsy case, and this argument is not sustainable either ethically or economically.

Being unindemnified does save on subscription or premium fees; however, the costs of litigation, particularly when sued successfully, are unsustainable for an individual. The claimant would be inadequately compensated and the doctor would be financially ruined. It is for this reason that the government, quite correctly, is considering introducing mandatory indemnity or insurance to cover potential losses, and it would be unlawful to practise without appropriate indemnity arrangements.

On the positive side, what can be done by the profession? Firstly and most easily, inform important role players of the problem and possible sequelae. Given the potential public health ramifications, the South African Society of Obstetricians and Gynaecologists (SASOG) and MPS have made representations to the relevant authorities.[14-16]

Claimant lawyers will argue that obstetricians are largely responsible for the predicament in which they find themselves. There is either a problem with care offered by individual obstetricians or there is a problem with the system rendering obstetric care. Individually obstetricians may need to look at improving their patient care; alternatively, if the system is found wanting, it requires improvement or change.

Considering the system, the model for private obstetric care is similar throughout South Africa and to a large extent will be familiar to all. Obstetricians tend to work on their own or in small group practices. Patients tend to see the same practitioner throughout their pregnancy and anticipate that their obstetrician will deliver them. The majority of patients probably have their obstetrician in attendance for the delivery unless it occurs after hours, where either a partner or a colleague who shares after-hours work may perform the delivery.

Patients who present in early uncomplicated labour tend to be managed during the first stage of labour by labour ward nursing staff employed by the hospital, the obstetrician being called late during the first stage of labour in anticipation of performing the delivery. Most private obstetricians have their consulting rooms in or near the hospital where they perform the majority of their deliveries. This means that during working hours they may be available at fairly short notice or can easily

pop in to see patients in labour. This does however mean that for over 75% of the week, the obstetrician is not as easily accessible. Given that none of the private hospitals have an on-site obstetrician available, the primary responsibility for intrapartum care falls to labour ward personnel, with the obstetrician or a colleague being remotely available.

The model is not without its problems. The patient contracts with the doctor to take responsibility for the delivery process while in reality primary responsibility usually only occurs for the delivery itself. Primary responsibility for management of the first stage falls to labour ward personnel. It may be argued that,as the model has not been criticised, patients accept it, and in reality by choosing where they deliver are making a choice about who manages them in labour and accept the remote model used.

The model may be sustainable when the labour ward is always staffed by enough experienced midwives whom the obstetrician trusts, but suggestions have been made that not all labour wards are always staffed by midwives,[17] let alone experienced midwives. If this is the case, the model becomes problematic and raises interesting issues regarding counselling and consent in anticipation of a vaginal delivery.

Even when the labour ward is staffed by experienced and trusted midwives, the current model may raise tensions. Primary management is currently being shared between employed midwives, whose employer – the hospital – is vicariously liable for their acts or omissions, and the obstetrician. Shared care raises potential medicolegal conflicts; if the obstetrician is primarily responsible for the management, but not caring for the woman primarily in the first stage of labour, who takes legal responsibility if a problem is missed or not reported to the obstetrician?

What alternative models are there? An option would be larger practices where it is feasible to always have one obstetrician in the labour ward. Another option is for hospital groups to employ obstetricians so there is always an obstetrician in the labour ward. Both these models rely on the assumption that an obstetrician in the labour ward, as opposed to remote obstetric care, would improve the situation. Other models (Table I), which have been shown to decrease litigation claims have been described but contrast sharply with the model currently used in South Africa.[18-20]

Table I shows the proposed principles in a comprehensive redesign of a patient safety process that resulted in fewer caesarean deliveries and reduced litigation.

Individual or small group practices have additional problems that extend beyond the delivery suite. Inevitably there will, at best, be minor differences in clinical care and the way that individual practitioners prefer to approach an issue. Consequently nursing staff will be confronted with differing protocols, and this is contrary to the sentiment of uniform process and procedures. Peer review is also difficult for practitioners who work in isolation, particularly if peers in their area also compete for the same patients. Risk assessment and risk management are also difficult as some events are rare, and may therefore not be easily identified in an individual practice.

Table I. Principles of redesign of procedure[19]

1. Uniform processes and procedure.
2. Every member of the obstetric team should not only be empowered but also required to intervene and halt any process that is deemed to be dangerous.
3. Caesarean delivery is best viewed as a process alternative, not an outcome or quality endpoint.
4. Malpractice loss is best avoided by a reduction in adverse outcomes and the development of unambiguous practice guidelines, rather than by attempting to make unusual care more ‘defensible’ through the use of ambiguous guidelines.
5. Effective peer review is essential to quality medical practice.

Summary

Rising indemnity costs are clearly unsustainable and may lead to a coerced major change in practice with a shift of patients and risk across to the state sector. A more palatable solution for practitioners and acceptable solution to patients may be to change the way in which private obstetric care is delivered; however, these changes will have to occur sooner rather than later. Clearly, although major, these changes will not be enough in isolation and policy makers’ thoughts will have to turn to tort reform as a matter of urgency.[21]

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