

Status of medical liability claims in Saudi Arabia

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BACKGROUND: With the evolution of healthcare services in Saudi Arabia, there has been an increase in the number of medical practice litigations. The author analyzed the medical malpractice litigation that was referred to the National Medico-Legal Committee (MLC) in order to evaluate the magnitude and underlying factors of the problem in Saudi Arabia.

METHODS: A retrospective analysis of the official records of Medico-Legal malpractice claims over the period 1420H-1424H (1999-2003) was performed. The incidence among different medical specialties, location, and final resolution of each claim were identified.

RESULTS: Data analysis revealed an increasing trend in the total number of claims over the study period, with a sharp increase in the transition between 1422H and 1423H (2001-2002). The distribution of claims over different medical specialties showed that obstetrical practice took the lead with 27%, followed by general surgery and subspecialties, represented by 17% each, internal medicine 13%, while pediatrics contributed 10% of claims; the fewest claims were in dentistry with 2.5%. The majority of claims were referred to Ministry of Health and private sectors medical facilities. Most claims were from the Riyadh region over the period between 1420H to 1422H (1999-2001), while thereafter, during 1423 and 1424H (2002 and 2003), the Holy Capital had the highest number of claims referred to the MLC.

CONCLUSION: Adherence to standards of medical practice is by far the best approach to avoid or reduce the incidence of litigation.

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Healthcare services in Saudi Arabia have evolved greatly over the past two decades in both the governmental and private sectors. These developments have resulted from the upgrading of technology at facilities as well as the improved training and experience of medical practitioners.¹ However, the increasing population, together with an increased awareness of health matters, has resulted in a trend toward increasing medical practice litigations.¹ This is reflected by the number of complaints and claims against health care providers (whether generally as a facility or individually against physicians). To handle the impact of increased litigation, it has been necessary to formulate and set standards and regulations that determine the responsibilities of health care providers towards patients. The Regulations of Medical Practice, developed by the Ministry of Health (MOH), are aimed at improving the quality of health care. The Medico-Legal Committee (MLC) carries the responsibility of receiving claims and investigating the professional malpractice that results in morbidity or mortality. Investigations involve reviewing all patient medical files and records as well as interviewing the presumed accused medical staff members, in order to reach a verdict.

Of the clinical specialties implicated in litigations, obstetrical practice is the leading specialty followed by different surgical specialties and finally by anaesthesia, dentistry and laboratories, specifically blood banks.

As an active member of the MLC in the Riyadh region, under the authority of the MOH in Saudi Arabia, I found an analysis of malpractice claims from various aspects to be imperative. This analysis, which includes the different medical specialties, may hopefully play a role in updating the regulations of the MLC as well as providing useful information from both from the professional and the legal aspects to my colleagues.

Methods

The raw data for analysis was provided from the official documents of the MLC in Riyadh under the authority of the MOH in Saudi Arabia. The data, gathered from all the Medico-Legal subcommittees (6 subcommittees over 1420H to 1422H, and upgraded to eight subcommittees thereafter during 1423H, 1424H) covering the various health care regions in the Kingdom of Saudi Arabia, included all claims against all medical specialties. As a member of the MLC in the Riyadh region, I analyzed the data provided in official documents. The number of cases included in this study does not represent the total number of litigations against different specialties because there were other cases that were investigated at a lower level and were not included.

Data included the number of claims over the period between 1420 H to 1424 H). The data was provided in tables and identified the following:

- The number of MLC monthly sessions in each region held over the year.
- The number of claims investigated by each subcommittee over the year.
- The justified final decisions of conviction or clearance from the claim.
- The number, medical specialty and qualifications of physicians involved.
- The number of physicians, nurses or technicians convicted or cleared after interrogations.
- The rank of the medical facility involved in the claim.

Retrospective data analysis was performed on all medical malpractice claims. Further, the rank of the medical facility and the geographical location involved in the claim were examined to provide an

overview of the quality of health care provided by different sectors in the Kingdom of Saudi Arabia.

Results

Data analysis revealed an increasing trend in the total number of claims in different medical specialties over the study period (Figure 1). A 21% increase in medical malpractice litigations was noted between 1422H and 1423H (from 569 to 718 claims). The distribution of claims over different medical specialties showed that obstetrical practice took the lead with 27%, followed by general surgery and subspecialties being represented by 17% each, internal medicine 13%, while pediatrics contributed 10% of the claims (Figure 2). Dentistry had the fewest claims, with 2.5%. The distribution of claims for different medical centers is shown in Table 1. The greatest number of conviction of claims against physicians were in the Riyadh region during 1420H to 1422H, while the Holy Capital took the lead afterward in 1423H and 1424H (Table 2).

Discussion

Our analysis revealed some data that was hidden because it was initially out of our scope of interest. As an active member of the MLC in the Riyadh region and one involved in investigations and analysis of different lawsuits and claims in medical care, I have the privilege of offering some insight about the magnitude of the problem from different aspects.

The process of medical litigations starts once a patient or one of his/her relatives complains of a medical malpractice that from their point of view ends with a morbidity or mortality. The complaint is directed either to the MOH or the city government according to the medical facility involved in the complaint. The process of investigation and interrogation proceeds with the medical staff either sharing the responsibility or attending the event. The MLC is then assigned to follow through with a thorough review of all documents and medical files together with an interview with individuals from both sides of the claim—the plaintiff and defendant(s), in order to reach a final decision on the accusation or clearance from the claim according to the “Regulations of Medical Practice, which is based on professional aspects and governed by Islamic Shariaah law”.¹

Professional liability as an entity covers three different aspects: civil, punitive and disciplinary liability. Civil liability is the responsibility of a physician towards the patient when harm has been inflicted as a result of direct action in violation of medical rules

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or proven negligence. Punitive liability deals with physicians who violate the rules and regulations of medical practice even though no subsequent harm resulted to the patient. Disciplinary liability occurs when a physician has failed to meet professional standards, requirements and ethics.¹ Finally, the claim may end up with a warning, financial compensation according to Shariaah law, or prohibiting medical practice and withdrawal of medical license or imprisonment in some cases.¹

There was an increasing trend in the total number of litigations over the study period. This could have been related to the increased population as well as the increased number of medical facilities. However, increased litigation could also stem from people becoming more aware of standard medical care and demanding it as well. In addition, a sharp increase was noted in the transition between 1423H and 1424H, which could be explained by the institution of two new committees in the Holy Capital and Ehsaa.

Anesthesia has been classed as a high-risk specialty.² This classification is based on the fact that the state of hypnosis may result in airway obstruction, pulmonary aspiration or trauma.² Most anesthetic drugs have undesirable adverse effects on both cardiovascular and respiratory systems. Further, an anesthetized patient is totally dependent on the anesthetist and equipment for maintenance of his vital functions.² Thus, my specialty as an anesthetist gave me the urge to further analyze and concentrate on the scope of anesthesia-related malpractice claims and its relationship to the total number of claims, to which it contributed about 3% to 4% of claims. Nevertheless, if one looks at the relationship to the number of finally accused claims and specifically against physicians, there was a higher percentage of anesthesia-related malpractice, between 6.1% to 9.1% of the total accused claims. Different studies and meta-analyses worldwide have navigated the scope of anesthesia-related malpractice and conclude that cardio-respiratory arrest and cerebral damage resulting from hypoxemia are the leading causes of mortality or severe morbidity.^{2,3,4,5} Oxygen supply to the patient is of the highest concern rather than any defect in alveolar gas exchange or oxygen delivery to the tissues, meaning equipment failure or matters dealing with a compromised upper airway with the inability to adequately ventilate a hypnotized, sedated and/or paralyzed patient.² Neuroaxial deficits resulting after regional anesthesia was the second common cause, but with a wide range of consequences, as simple as transient neurapraxia up

Table 1. The yearly number of final decisions in claims classified by sector of the medical health care service.

	1420	1421	1422	1423	1424
Ministry of Health Medical Services	111	100	123	188	188
Private Sector Medical Services	124	123	123	169	144
Military Medical Services	16	13	14	17	12
University Medical Services	5	1	6	6	3
Other Medical Services	9	18	5	13	6

Table 2. Distribution of convicted decisions over Saudi Arabia in different regions as represented by the official Medico-Legal Committees.

	1420	1421	1422	1423	1424
Riyadh	88	67	47	48	54
Makka Province	11	31	39	65	37
Eastern Province	29	25	44	31	34
Madina Al- Monawara	33	27	11	42	13
Aseer	30	14	23	24	36
Qassim	12	22	12	12	21
Holy Capital	---	---	---	53	61
Ehsaa	---	---	---	10	14

to permanent loss of function resulting from peripheral nerve damage or spinal cord injury.² In the West, lawsuits against intraoperative awareness are not uncommon, with its psychological effect on patients in the postoperative period.^{6,7,8} The aim of examining such details in some cases is to widen the scope for anesthetists for matters that may be treated as out of their responsibility and to make clear that their main role is only intraoperative management. At the same time, we hope that this will not lead to what is called an attitude of "defensive medicine", but rather will lead to a safer practice of medicine, which is of course our ultimate interest.⁹

Nonetheless, it is worth mentioning that the ranking and equipment and staffing of the medical facility plays an important role in the increased incidence of litigations. Data analysis revealed that the MOH and private sectors contribute more than 90% of the total number of claims that are referred to the MLC. MOH hospitals and small clinics cover most of the small cities and most of these facilities are un-

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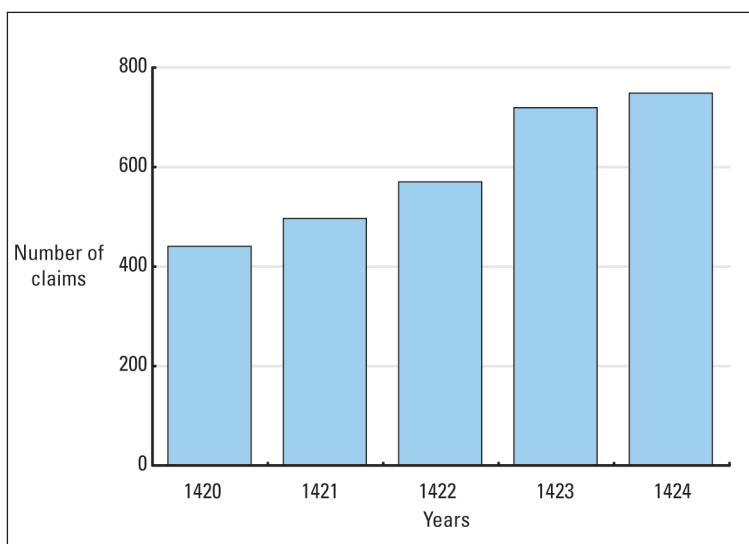


Figure 1. The trend in the total number of claims in different medical specialties.

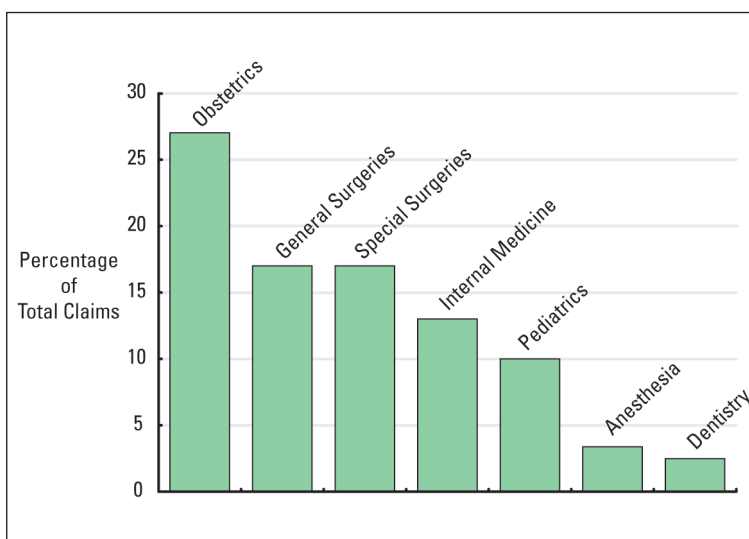


Figure 2. The percentage of claims in different medical specialties.

derstaffed, administered by under-trained physicians, and have inadequate equipment and supplies, a fact which renders such facilities more prone to malpractice and litigations.⁹ In the private sector, which is mostly well equipped and staffed, reduction of costs is the main consideration, which may lead to management under less than ideal conditions. Further, patients who go to the expensive private sector, considering their culture and social class, demand higher quality healthcare services.⁹

Various policies and procedures, rules and regulations and standards of medical practice are all concerned with ensuring a quality medical service

that guarantees patient safety. Following standards could also restrict the magnitude of medical errors, which have been classified by the Agency for Health Research and Quality as diagnostic error, equipment error, misinterpretation of medical orders or data and finally mismanagement, with resultant morbidity as a result of postoperative infections or mismatched blood transfusion, in the case of anesthesiology.¹⁰

Based on experience gained by serving on the MLC and after being exposed to different situations during investigation of claims, I offer my advice based on actual pitfalls observed in investigating cases and the basis of lawsuits:

- Assess your patient thoroughly and ask for consultations from different specialties so as to properly prepare your patient for the stress of any intervention.
- Estimate accurately the patient risk and discuss it in detail with the patient or family members and obtain patient consent before any intervention.
- Document clearly every detail (with date and time); this is the cornerstone that backs you up in case of an incident.
- Follow up your patient closely in the postoperative period, especially in risky patients or in those situations where intraoperative events have been encountered.
- Update your professional knowledge, which is considered the best way to gain confidence and respect among medical staff, and is critical when dealing with well-informed patients or their family members.
- Support continuing medical education, audits, clinical incident reporting, case discussions and morbidity and mortality meetings.
- In case you encounter an incident and are called for interrogation, review the whole case beforehand and write down specific and important events. You should also refresh your memory with the patient records during the interview session. Further, quote relevant literature, which could strengthen your position in practical and professional matters, and lastly it is permissible to provide your testimony in writing.

In conclusion, when you consider that the consequences of an error are disastrous, it is logical to be careful. Prevention is by far the much easier path to reduce the incidence of litigations and it results in a safe and effective method of medical practice. However, this does not mean you should take a de-

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fensive attitude, but to the contrary means a safe and practical attitude is best, based on standards of medical practice. Yet, no one is immune against pitfalls and mishaps, so let us pray to Allah to provide us with his protection and mercy and give us the strength and ability to serve our patients.

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