Papers
Alternatives

Countering medical negligence

Medical negligence: Between the escalation of the problem, media exploitation of officials, and lack of a clear implementation mechanism

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The deterioration of medical services and the misadministration of the medical sector in Egypt have always been linked to the absence of monitoring and accountability. The problem has also been lately escalating with the rise in the number of patients who died as a result of medical negligence and made the phenomenon impossible to overlook. According to a statement by the Administrative Prosecution, the cases of medical negligence in public hospitals alone reached 594 in 2014. Constant demands for countering the problem of medical negligence only resulted in surprise visits to hospitals by officials, governors, or representatives from the Administrative Control Authority, all of whom expressed their astonishment at the deterioration of medical services in the units they visited. They mostly commented on lack of commitment on the part of the staff, delay in offering medical services, unnecessary medical intervention, violation of basic medical principles, and lack of post-surgery care. Among the most striking aspects of this negligence was frequent refusal to accept emergency cases in violation of the Prime Minister's decree that obliges hospitals to accommodate emergencies for 48 hours and in violation of Article 118 of the Egyptian constitution, based on a report issued by the Administrative Control Authority. Such visits are usually concluded by referring the hospital manager or the doctor on-duty to a disciplinary committee without taking any additional steps towards devising a mechanism for identifying the reasons leading to this problem and coming up with solutions.

A survey of organizational entities that regulate doctors' work in Egypt reveals that the Doctors' Syndicate, known to be the most powerful professional union in the healthcare sector, is in charge of taking disciplinary actions on the professional level against negligent doctors. The criminal aspect is, on the other hand, the responsibility of the General Prosecution Authority yet the process has to be attended by a representative from the syndicate.

According to the law, the Prosecutor General has to notify the Doctors' Syndicate of any case involving the professional performance of doctors. The syndicate includes three divisions in charge of investigating professional violations by doctors:

1- **Investigations/ complaints committee:** The committee is comprised of two members from the syndicate board and one member of the General Prosecution Authority. The committee examines and investigates complaints through bringing the file of the case subject of the complaint from the hospital and sending it to an expert for scientific opinion after crossing out the names. The claimant and the offender are then

summoned for testimony. In case of complaints unrelated to professional offences, the two parties and witnesses are summoned for testimony and if the committee finds the offender(s) guilty, the case is referred to the Professional Ethics Committee.

2- **Professional Ethics Committee:** This committee is also known as the Disciplinary Court. It is comprised of seven members: three members of the syndicate board, two from the State Council, a judge from the Administrative Prosecution Authority, and the syndicate's lawyer. The committee is in charge of issuing verdicts that range from a maximum fine of LE 1,000 to suspension from three months to one year—all lenient penalties that do not offer the necessary deterrence for mistakes that might cost patients their lives.
3- **Appeals Committee:** The committee is comprised of three members: two from the syndicate board and one from the Court of Appeals. It is through this committee that verdicts issued by the Professional Ethics Committee are appealed.

Three regulations govern the syndicate's work and the verdicts issued by the syndicate's committees: the Syndicate Law, the Syndicate Regulation, and the Professional Ethics Regulation—all unfortunately lacking a system of penalties that correspond to the types of offences. For example, in 2010 the syndicate received 779 professional offences complaints, 543 of which were shelved following reports by reviewing doctors who confirm or deny that a given doctor is guilty based on the patient's file, the doctor's file, and the doctor's testimony. Then 226 files were rejected citing irrelevance to the syndicate's specialization. The overall result was referring only 10 doctors to the Disciplinary Court, a very limited number when compared to that of the received complaints.

The purpose of this paper is analyzing the efficiency of the system based on which negligent doctors are penalized and the role it plays in curbing medical negligence with special emphasis on accountability and monitoring. A survey of a number of international experiences in combating medical negligence would be helpful in this regard.

Medical negligence: International experiences

The accountability system for medical negligence is different in the United from its counterparts in Scandinavia, yet one common factor is that all of them distinguish between types of errors in negligence cases and acknowledge that not every error is the doctor's fault and not every error is a result of negligence. For example, system errors are human errors that

happen accidentally while adverse effects are the result of negligence during the medical care process due to failure to comply with the required standard(s).

International studies on medical negligence, especially in the United States, reveal that thousands of medical errors take place every year, very few of which are the result of actual negligence on the doctor's part. In the United States, medial errors are handled by the tort system, which means that it falls under the category of civil wrong. The system punishes service providers whose errors prove to be the result of negligence. The penalty always revolves around a hefty compensation to the patient. This means that the majority of medical errors do not fall under the criminal law jurisdiction.

This system, which obviously emphasized the penalization of the doctor proven guilty of negligence, is criticized for the negative impact it has on the medical system since it pits doctors against patients. Fear of possible errors and legal repercussions might also discourage doctors from carrying out critical surgeries. The criticism this system faced led to the creation of another one known as the Alternative Dispute Resolution, which focuses on offering alternative means of resolving patient-doctor disputes such as reconciliation and arbitration. Any patient subjected to a medical error whether or not as a result of negligence has the right to resort to this alternative system.

According to the alternative system, there are two ways to resolve disputes. The first is that a jury or arbitration committee mediates between the doctor and the patient to reach a reconciliation agreement that is not binding to any of the parties. The second is litigation through the jury. In both cases, both the doctor and the patient benefit more than the regular judicial procedures. There are also discussions on the possible establishment of a medical court that transfers medical errors from tort law to the administrative system.

There is also a tendency to develop the penalty system so that it shifts from penalizing the doctor to penalizing the medical facility. This motivates medical units to ensure the professionalism of the doctors they hire, monitor their performance, and create a work environment that minimizes negligence errors through the cleanliness of the facility, the quality of the equipment, and the availability of medication. Other proposals include a "pay for performance" system where the money paid to the facility corresponds to the quality of the services provided.

In Scandinavia, the system for countering medical negligence is an administrative one based on compensating the patient regardless of who committed the medical error. This is known as the "no fault compensation system" and is applied in Sweden and Denmark as well as New Zealand. According to this system, patients subjected to medical errors have the right to request compensation without needing a lawyer. A consultative team examines the complaint and assesses the value of the compensation. This system guarantees that patients are compensated even when the error is not the result of negligence or an accidental mistake. This is a comprehensive system that analyzes the data provided in the complaints and through them identifies ways of developing the medical system. The system is based on the belief that not all medical errors are the result of negligence on the doctors' part, but are mostly mistakes in the medical system and which could be examined in order to develop the whole system and avoid future recurrences.

Strategies and mechanisms to counter medical negligence in Egypt:

- Establishing an entity called the Egyptian Authority for Comprehensive Quality to monitor the performance at medical facilities. The specializations and working system of this authority, which will have a juridical personality, can be detailed in a presidential decree. The authority will be in charge of setting the main criteria for providing quality medical services, issuing and renewing licenses based on the quality of services, devising cost-effective working methodologies, and promoting professional ethics. In addition, the authority will play the role of arbitrator in disputes arising between patients and doctors/medical facilities.
- Independent units in charge of receiving citizens' complaints and suggestions should be affiliated to this authority. These units are to take feedback seriously and respond promptly while announcing the results of any investigations resulting from this feedback to build trust between patients and doctors/medical facilities and to develop a fair medical system based on the basic right to quality healthcare.
- Setting clear medical service protocols to be known by both service providers and patients in order to create a formula against which the quality of service can be measured and according to which the causes of medical errors and their appropriate penalties can be determined
- The Ministry of Health should identify the different levels of medical errors in coordination with the Doctors' Syndicate and the World Health Organization. Penalties are to be proportionate to the type of error and the damage sustained by the

patient. The medical facility in which the error took place is to be penalized as well to ensure that the disciplinary reaction to a medical error would not be left to the personal inclinations of the hospital manager/owner for example and would therefore be independently and justly made.

- Evaluation and monitoring are to be conducted on three levels: first, the professional medical and nursing level; second, the administrative and financial level; and third, the humanitarian level. This aims at making sure that errors are not only blamed on doctors, but also on the general conditions of the medical facility.
- The Ministry of Health and the Doctors' Syndicate are to regularly review arising medical errors and determine the level(s) to which they belong.
- Applying quality standards on all public and private health providers so that the entire medical system is reformed as is the case in Scandinavia.
- Renewing medical licenses for doctors, nurses, and medical facilities every three years so they can be contingent upon performance and quality and can also be conditioned upon specific types of training or examinations

In addition to relevant players in the healthcare sector, the suggested authority and its affiliated units should also include members of civil society organizations and independent entities related to medical services