

## Malpractice in the intensive care unit

Error in the intensive care unit (ICU) is a well-documented and common problem.<sup>1</sup> This is understandable when one looks at the complexity of critical illness combined with the range of invasive and potentially dangerous interventions that are routinely used there. Until recently medical malpractice claims arising from alleged mismanagement in the ICU were rare, but there has been an increase in such claims in South Africa, with several High Court cases currently pending. The old assumption that intensive care saves lives and any injury or mishap that occurs in the process is therefore 'par for the course' no longer holds sway.

Whether the increase in litigation is due to an actual increase in adverse events or to a change in public awareness is difficult to assess. Certainly, active canvassing by legal firms specialising in personal injury claims offering to initiate claims on a contingency fee basis has become more prevalent, perhaps because Road Traffic Accident Fund cases are drying up. The Medical Protection Society is experiencing an increasing number of claims generally, and the value of damages awarded is skyrocketing.<sup>2</sup>

In this issue, De Beer and colleagues describe the current state of intensive care nursing in South Africa as well as the challenges faced. These include the limited number of ICU beds in the public sector and the extreme shortage of suitably qualified nurses in both the public and the private sectors. More concerning are the barriers nurses experience in obtaining a qualification in critical care and the low number of critical care nurses graduating.<sup>3</sup> Coupled with a high attrition rate due to burn-out and better job opportunities offered in other sectors and abroad, this leads to a situation where even private ICUs struggle to staff their units and maintain standards. The combination of high levels of bed occupancy, critically ill patients and inexperienced nurses provides a perfect milieu for mistakes and accidents that can lead to a claim for damages.

On the medical side the situation is not much better. The standard of care is that critically ill patients should be managed in 'closed' ICUs by a team of health care professionals led by a specialist in critical care medicine or a pulmonologist with an interest in critical care.<sup>4,5</sup> However, only 1% of ICUs in the private sector and 7% in the public sector are 'ideal closed units'. Most of these are in the major academic hospitals.<sup>6</sup> Although critically ill patients in the private sector are often treated by various and appropriate specialists, these doctors tend to visit the patient at different times of the day, may issue conflicting orders, and make their own private notes. There is no team. Critical care specialists have difficulty establishing themselves in private hospitals as they are either treated as the 'intern' while the referring doctor retains control of the case, or they are only referred end-stage patients where their input is neither clinically nor financially rewarding.

Even under the best of circumstances, management in the ICU frequently – one could argue *inevitably* – results in 'iatrogenic' disorders. John Marshall presents the interesting viewpoint that critical illness is inherently iatrogenic because it only occurs in patients who have survived a medical intervention for a life-threatening disorder.<sup>7</sup> Furthermore, the whole construct of critical illness is based on the consequences of the initial resuscitative

efforts or results from the interventions that are routinely practised in the ICU.<sup>7</sup> So, for example, the intravenous fluid used to resuscitate a patient with septic shock will aggravate the hypoxia, which leads to intubation and ventilation followed by ventilator-induced lung injury and ventilator-associated pneumonia. With this complexity it is difficult to establish the boundaries between cause and effect and between acceptable complications and preventable negligence.

Patients who survive a prolonged stay in the ICU are not infrequently left with lifelong problems as a consequence. Prolonged muscle weakness, cognitive disorders, and post-traumatic stress disorder affecting both patient and family members are all well described.<sup>8,9</sup> Who can blame the patient for being angry?

Patients are also often admitted to intensive care as a consequence of an iatrogenic event. One study found that 19.5% of admissions had a prior iatrogenic event, the most common being adverse drug disorders, postoperative infections and complications of medical procedures.<sup>10</sup> Personal injury lawyers spread the net widely and the ICU staff can be caught up, especially if long-term disability is not directly related to the original injury.

How can we protect ourselves from legal action, which can be both emotionally and professionally devastating, not to mention financially disastrous if one is not insured? Guidelines and protocols are not necessarily the answer. Hospital administrators love guidelines because they shift the blame to either the guideline writer or the individual who failed to comply. Guidelines have a place, but are of no use if they are out of date, so impractical they cannot be complied with, or not accepted by the staff. There can never be a guideline for every situation, and intensive care cannot be conducted by recipe. By all means have guidelines for the basics, but they must be practical, flexible, accepted and regularly updated.

Most important is to maintain high professional standards. This means ensuring that both the medical practitioners and the nurses managing critically ill patients are specialists in critical care. In addition, they need to keep up to date with the rapidly changing world of critical care medicine. A multidisciplinary in-house academic programme is a good start.

Secondly, intensive care management should be team based. The ICU team includes the nurses, doctors, dietitians, physiotherapists and others contributing to patient care on a daily basis. The team needs a leader, preferably an intensivist who encourages a 'flat hierarchy' and an open and effective communication system.<sup>11</sup> This requires a joint ward round where the various professionals can provide their input and remind, challenge and support each other. Even a very good but dominant individual cannot beat a team when it comes to decision making.<sup>12</sup> A harmonious team also means that the patient and family do not pick up conflicting messages about the patient's progress and expected outcome.

Keeping good notes is essential, not only as the most important defence weapon in the (no longer unlikely) event of a legal issue, but also as part of the communication around patient management. Notes should not only record clinical findings and events but the

reason *why* decisions were made. It is advisable to keep a copy of one's own notes as well as sharing them with colleagues in the patient's hospital folder.

Finally, maintaining a supportive relationship with the patient's family is extremely important, not only to assist them through an emotionally difficult time but also because they are the patient's surrogate decision makers. Families need information, but one should avoid the mistake of flooding them with medical minutiae. Giving them time to ask questions is more important. It is not usually possible to establish a relationship with the patient while they are critically ill, but a follow-up visit after they have left the ICU is an important way of linking with them at a personal level and at the same time giving them an explanation of what happened and what the likely consequences are.

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