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Original Article

The Pattern of Claimed Medicolegal Issues and Challenges Encountered in Handling Cases in the Addis Ababa City Administration (2015 - 2023)

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Abstract

Background: *Medico-legal claims are rising globally often due to malpractice, negligence, and issues surrounding patient safety. In Addis Ababa, the Health Professionals' Ethics Committee has evaluated over 282 cases in the past seven years, yet the patterns of accusations and challenges in handling these cases remain unclear.*

Objective: *To assess the pattern of claimed medico legal issues and challenges encountered in handling cases in the Addis Ababa City Administration from 2015 to 2023.*

Methods: *A sequential explanatory mixed-methods approach was used, consisting of a descriptive cross-sectional quantitative study and a phenomenological qualitative study. The quantitative phase involved analysis of 210 medico-legal case records using SPSS version 28, with descriptive statistics and Chi-square tests ($P < 0.05$) to assess associations. The qualitative phase explored the perspectives of 16 current and former ethics committee members through in-depth interviews, analyzed using Colaizzi's seven-step method with Atlas.ti version 9.*

Results: *A total of 210 files were reviewed, with 95% (N=195) originating from residents of Addis Ababa. Among the patients, 121 (58.6%) were admitted with life-threatening emergencies. Of these cases, 66 (31.4%) were related to obstetrics and gynecology, 41 (20%) to general surgery, 32 (15%) to orthopedics and trauma, The committee found that 31.9% (67) of cases involved ethical breaches or malpractice. A chi-square test showed a significant association ($p < 0.005$) between healthcare ethics violations and factors like patient death, resource shortages, referrals, treatment delays, and communication issues. The qualitative study highlighted five main themes: evidence availability, knowledge gaps, documentation, space availability, and cooperation.*

Conclusion: *The study reveals that most medico-legal cases involved women and urban residents between the ages of 18 and 45. Major contributing factors included inadequate infrastructure, unethical practices, and substandard procedures frequently observed in private clinics. Obstetrics and gynecology were the most commonly implicated specialties, highlighting the critical role of effective communication. Disciplinary actions primarily involve OB-GYN specialists, clinical nurses, and general surgeons, indicating the need for focused training. The majority of disputes arose from delays in diagnosis, treatment, and clinical decision-making. To address these issues, the study recommends proactive risk management, improved communication, ethical guidance, efficient care coordination, continuous professional development, and a stronger commitment to institutional accountability.*

Keywords: *Pattern, Claimed Medicolegal Issues, Challenges, Handling Cases*

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Healthcare professionals are responsible for saving lives, but they face increasing assaults and litigations (1). They have a legal duty to adhere to a reasonable standard of care, both ethically and legally (2). Medico-legal issues arise from clinical cases, potentially leading to lawsuits due to omission, failure, carelessness, negligence, and inability to fulfil professional obligations. These issues also involve applying medico knowledge for legal purposes (1). Medico-legal files are opened when patients or families suspect ethical breaches during treatment.

Medicolegal cases in healthcare settings are often associated with potential medical errors or malpractices. Studies have highlighted a strong correlation between these cases and specific areas of clinical practice. In Saudi Arabia (3), most medicolegal cases stem from malpractice in surgery and emergency care, with obstetrics and surgery being the most frequently involved specialties. Similar findings have been reported from Pakistan, India, Egypt, and Ethiopia, where emergency care and trauma (4,5), surgical procedures (6), and obstetrics/gynecology (6,7) are common causes.

Demographics also play a role. Young adults and males appear to be more frequently involved in medicolegal cases (5 ,4). Additionally, traffic accidents and malpractice claims are more common in urban areas than in rural areas (4 ,6). The private healthcare sector may also see more claims (6). A study in Ethiopia revealed death in 57.6% of medicolegal cases, with surgical errors being the most common complaint (7)

A surge in medico-legal claims arises from a confluence of multifaceted influences. One study underscored the impact of healthcare quality, errors, resource constraints, and evolving legal environments (8). Similarly, other authors' perspectives introduce a financial dimension, proposing that rising award amounts, extended life expectancies, and private care cost assessments act as potential motivators (9). However, motivations transcend mere financial gain, as emphasized by Birks *et al* (10). Patients might seek recompense for harm, prevent future occurrences, obtain explanations, ensure accountability and clear communication from the service provider, or address emotional distress.

Clear communication in healthcare is vital. Informed patients recover faster and require fewer readmissions (10-14). Conversely, poor communication is costly, leading to medication errors, revisits, and dissatisfaction (14,15). Transparency protects patients and builds trust (11,16); while miscommunication and even complaints can highlight areas for improvement, as healthcare is a constant learning process for clinicians (7).

Handling medico-legal cases presents a complex landscape. Studies reveal both internal and external factors contributing to these challenges. For instance, a phenomenological study on the challenges of hospital ethics committees conducted in Iran highlights external issues such as unclear guidelines, weak oversight, and organizational culture (17). Similarly, the Indian study on challenges faced in handling medico-legal cases in a selected teaching hospital emphasized internal hurdles such as knowledge gaps, patient involvement, logistical difficulties, and internal pressures (18). These findings underscore the need for a comprehensive approach to address these multifaceted challenges.

In 2012, the Addis Ababa City Government established the Food and Drug Authority (FDA), and in 2014, the Health Professionals' Ethics Committee was formed to investigate unprofessional conduct and medico-legal claims against health professionals (19). The committee includes a diverse group of members such as healthcare professionals, community representatives, legal experts, and officials from relevant authorities. Since its formation, over 282 applications have been filed as lawsuits, with most cases being investigated and the findings returned to the claimants and plaintiffs. However, despite investigating more than 282 cases from 2015 to 2023, the specific patterns of issues and challenges faced by the Health Professionals' Ethics Committee in Addis Ababa have not yet been fully understood. This study, therefore, aims to identify and assess the types of medico-legal issues and the challenges encountered by the committee in handling these cases from 2015 to 2023.

Methods and materials

Study setting and period

The study was carried out from May 1 to July 31, 2023, at the Addis Ababa City Government AAFDA in Ethiopia's capital city. The population is 5,006,000 (28), and there are 14 governmental hospitals, 42 private hospitals, and 99 health centers.

Study design

The study employed an explanatory sequential mixed -methods design. It began with a dominant descriptive cross-sectional quantitative component using a structured questionnaire to review closed medico-legal case files, followed by a qualitative phenome-

nological component involving in-depth interviews with current and former ethics committee members. This integration was intended to enhance the overall validity and depth of the findings.

Source population
This study investigated medico-legal cases submitted to the AAFDA legal office for ethics committee review between 2015 and 2023. The analysis included both case files and interviews with current and former committee members.

Inclusion and exclusion criteria
Inclusion Criteria:

Cases: Medicolegal cases that have been investigated and reviewed by the Health Professionals Ethics Committee (HPEC) on two or more occasions.

Participants (for in-depth interviews): Members of the HPEC with at least six months of experience.

Exclusion Criteria:

Cases that were transferred to the Federal Ministry of Health (FMOH) ethics committee and had not undergone at least two reviews by the local HPEC.

Sample Size Determination and Sampling Strategy
The study employed a two-step approach to determine the sample size and select participants for both the quantitative and qualitative components. For the quantitative part, all 210 medico-legal case files that were fully investigated and received final decisions by the Health Professionals Ethics Committee were included, using a census sampling strategy. This ensured comprehensive coverage of all eligible cases, enabling accurate analysis of case trends, decisions, and outcomes.

For the qualitative component, purposive sampling was used to select 16 members of the Health Professionals Ethics Committee for key informant in-depth interviews. Participants were selected based on their relevant experience, active membership status, and involvement in recent case reviews. This sampling strategy ensured the inclusion of information-rich informants capable of providing deep insights into the committee's core functions, decision-making processes, and ethical challenges. The sample size of 16 was determined based on the principle of data saturation, where interviews were conducted until no new themes or information emerged, ensuring a comprehensive understanding of administrative, policy-related, and ethical issues, as well as the personal and professional impact of serving on the committee.

Data Collection and Instruments
For the quantitative data collection, a structured questionnaire developed through a review of relevant literature (3,5,6 and manuals on medico-legal cases (1.2.11.12) was used. The questionnaire, was divided into three sections focusing on the following:

1. Sociodemographic characteristics of patients
2. The types of medico-legal issues (surgical, medical, obstetrics/gynecology, etc.
3. .Motivations behind claims and challenges faced in handling them within Addis Ababa.

Data for the qualitative study was gathered through in-depth interviews with members of the Health Professionals Ethics Committee. The interviews focused on understanding the committee's core functions and the challenges faced by members, such as administrative, policy-related, resource constraints, and difficulties in organizing cases. Members were asked to share suggestions for improving the committee's operations and to describe how they ensure fair and impartial decision-making while managing potential undue influence. The interviews also explored the significant issues that might prompt patients or their families to file cases, as well as the impact of serving on the committee on members' personal and professional ethics. Furthermore, committee members were asked to reflect on the process of delivering decisions to both parties involved and their perceptions of the reactions from both complainants and the accused health professionals. These interviews provided valuable insights into the committee's functioning, decision-making processes, and the challenges it faces.

Data collection technique
Data collection for this study, conducted between May 1 to July 31, 2023, involved reviewing all medico-legal case documents within the Addis Ababa City Government Food, Medicine, and Health Care Administration and Control Authority. Seven senior health professionals with different specialty and sub specialties, trained by the lead researcher, collected the data. The questionnaire underwent a pretesting phase to ensure its validity and reliability. This involved a review by health professionals and a test run on 5% of the documents outside the main data collection period. The pretest results informed participants of any necessary adjustments to the wording or sequence of the questionnaire.

Data Quality Assurance
The data were collected via a pretested questionnaire administered by trained healthcare professionals. The principal investigator maintained close supervision throughout, ensuring completeness, clarity, and consistency of the collected data. Before analysis, the data underwent a thorough cleaning process.

Data analysis procedure
Data analysis involved cleaning and coding the data using SPSS version 28. Descriptive statistics, including the means, medians, and frequencies,

were used to summarize the characteristics of the medico-legal issues and challenges faced. The qualitative data analysis process began with one of the authors who transcribed the Amharic interviews and translated them into English. Another author verified the translation's accuracy. The transcripts were then analyzed using descriptive phenomenology and the seven steps of the Colaizzi method (20). The data analysis process included reading and rereading the data, identifying significant statements, formulating meanings, organizing meanings into themes, identifying relationships, synthesizing themes into a comprehensive description, and validating the description with participants. Through this process, 92 distinct codes emerged from the transcribed interviews. Both deductive and inductive coding approaches were utilized, ultimately leading to the identification of five overarching themes. Additionally, ATLAS.ti version 9 (Atlas 23) software was used for coding and analysis of the qualitative data.

Ethical consideration

Ethical approval was obtained from the Addis Ababa University College of Health Sciences prior to the commencement of the study, with reference number 037/23/Anesthesia. A support letter from AAFDA was also acquired, and written informed consent was obtained before collecting secondary data.

Results

I Quantitative Results

1.The pattern of claimed Medicolegal Issues

1.1. Demographic data

A total of 210 closed individuals (investigated by the committee) were analyzed, and 92.2% (n=195) of the clients whose medicolegal cases were from Addis Ababa, while 3.3% (n=7) were from other locations. The majority, 38.6% (81) of the patients for whom Initiating a legal case were between 18 and 45 years of age (Figure 1).

The gender distribution was 51.4% (108) female and 48.6% (102) male. The qualitative component of the study involved in-depth interviews with eighteen members of the Health Professions Ethics Committee (HPEC). Of these, ten were male. Their overall professional experience varied: one had 1–10 years, eight had 10–20 years, and nine had more than 20 years of service. In terms of age, the majority were between 41 and 50 years old (10 individuals), followed by 51 to 60 years (5 individuals), 31 to 40 years (2 individuals), and 20 to 30 years (1 individual).

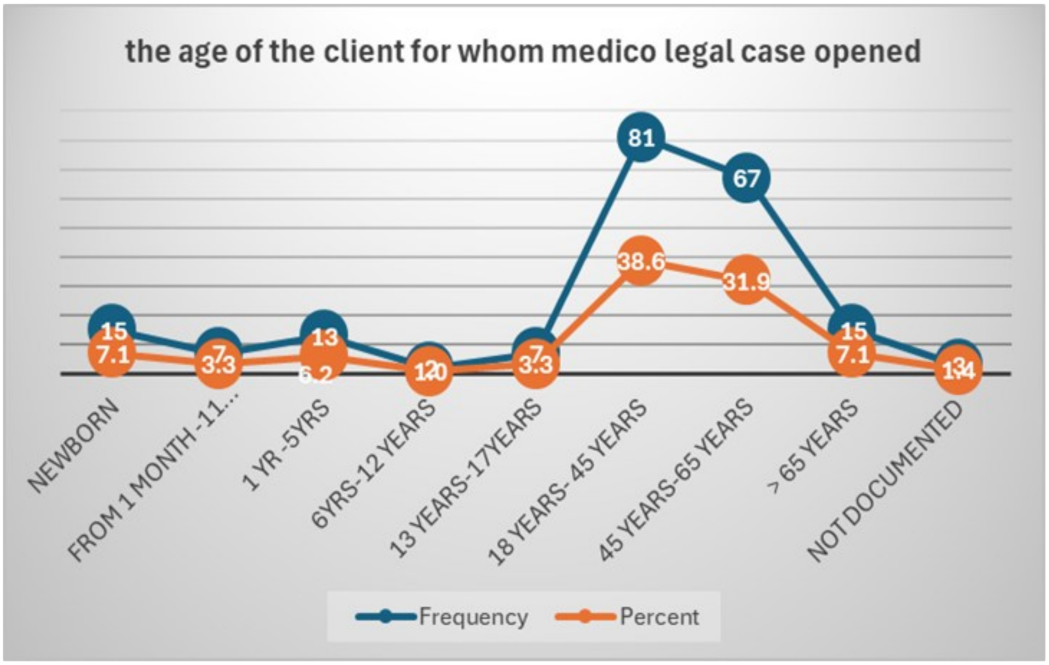

Figure 1: The age of clients who underwent surgery via the AAFMHACA for whom medicolegal cases.

Regarding their tenure within the HPEC, three had served less than one year, two had 1–2 years, six had 2–3 years, three had 3–4 years, and four had over 4 years of service. This distribution reflects a diverse range of professional and committee experience among the members.

1.2 Ownership of the health facility and Initiating Medico-Legal Cases

The study also examined the ownership of health care facilities involved in medico-legal cases. Private facilities were the source of 55% (n=115) of the cases investigated. Public (government) facilities accounted for 40% (n=84), while 5% (n=10) were from NGO health facilities. Table 1 shows the entities responsible for initiating medico-legal cases at the AAFDA Health Professionals Committee.

Table 1: Entities Responsible for Initiating Medico-Legal Case Health Professionals Committee.

Who brought The ML case?	f(n)	(%)
The Client/Patient	73	34.8
Relatives/Families	71	33.8
Police Office	47	22.4
Court/Justice Office	5	2.4
Not Mentioned	1	0.5
The Health Institution/Hospital H.C	10	4.8
The Health Professionals	2	1.0
Mass Media	1	0.5

1.3 Patient conditions at admission and clinical management at the emergency department

An analysis of patient conditions at admission within the medico-legal case files revealed that over half (58.6%, n=121) of the patients experienced life-threatening emergencies. Figure 2 details the specific breakdown of patient conditions upon admission.

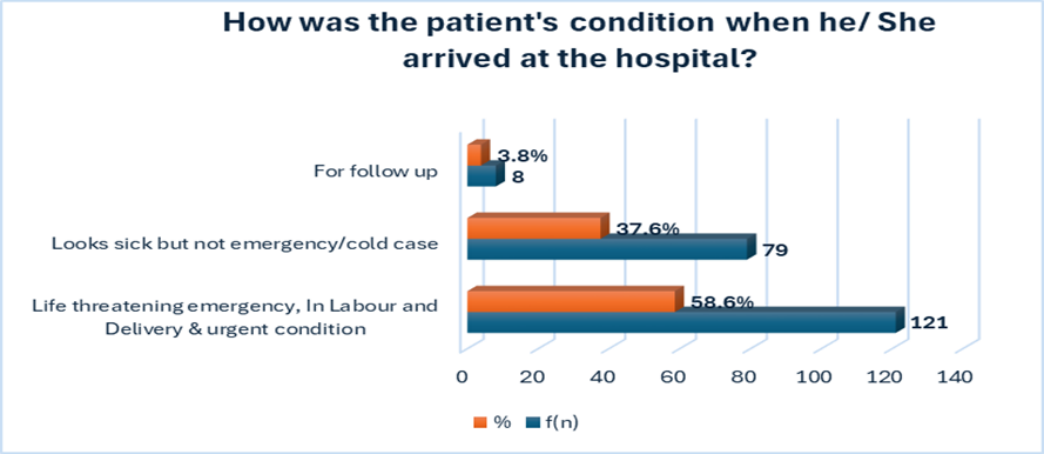

Figure 2: Patient condition at admission

This study also evaluated emergency medical care in a department and revealed that 27% of patients received CPR, 29% were given necessary emergency medication, 10% underwent the required procedure at the emergency department, and 13% underwent emergency surgery directly.

Upon arrival at the healthcare facility, most patients 64.3% (135) met frontline healthcare professionals who were on duty, and only 10% of patients met with a second consultant (the senior health professional on duty).

1.4 Medico-Legal claims Landscape by Specialty

This study investigated the distribution of medico-legal cases across healthcare specialties. Obstetrics &gynecology, and antenatal care (ANC) comprised the highest proportion of cases, at 31.4% (66). General surgery, orthopedic surgery, and anesthesia followed at rates of 20% (41), 15% (32), and 9% (19), respectively. Figure 3 shows a detailed breakdown of medical legal claims by specialty.

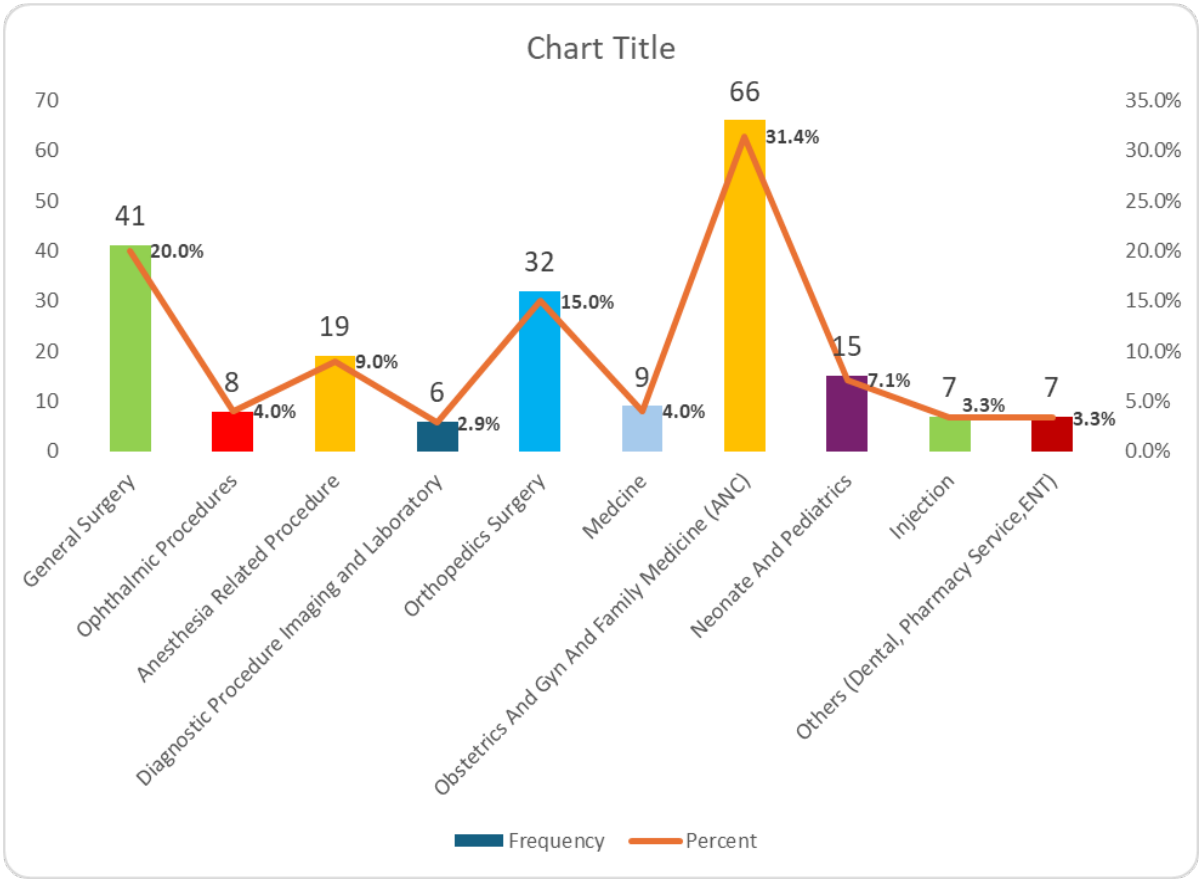

Figure 3: Medico-Legal claims Landscape by Specialty

1.5 Client's Status During Claiming to Ethics Committee and Confirmed Causes of Death and Complications

The Ethics Committee reviewed the status of patients involved in medico-legal cases. They found that 44.3% (93) had passed away. Of the remaining patients, 39.5% (83) had complications. The Committee also investigated the cause of death for deceased patients, with the leading causes being cardiopulmonary arrest at 25% (27) and hemorrhage at 24% (26) as seen in Table 2. The majority (25.3%) of complications identified in the HPEC investigation were due to delayed diagnosis, referral, and treatment, along with poor follow-up and monitoring. The details are shown in Table 3.

Table 2: Confirmed Causes of Death in Medico-Legal Cases at HPEC (N =93)

Confirmed cause of Death	F(n)	(%)
Hemorrhage	24	26%
Hypoxia	17	18%
Cardiopulmonary arrest	25	27%
Multiple Organ Failure	11	12%
Difficult to detect	2	2%
Sepsis (Infection)	2	2%
Others (allergy…	12	13%
Total	93	100%

Table 3: Suggested reasons for complications (n= 83)

Suggested reason for complications	f (n)	(%)
Delayed diagnosis, referral, and treatment	21	25.3%
Physical Injury, Deformity,	5	6.0%
unable to provide BLS and resuscitation	4	4.8%
Retained foreign object (Gauze, Forceps.)	4	4.8%
Unable to manage bleeding, allergy reaction	9	10.8%
No, the next consultant	11	13.3%
Wrong procedure/wrong site surgery	8	9.6%
Poor follow up, poor monitoring	21	25.3%
Total	83	100%

1.6 Resource limitation in the health facilities.
The HPEC investigated resource limitations in health facilities while clients went to them. Their analysis revealed that 48.6% (79) of facilities had limitations. These limitations included basic medical equipment, drugs, oxygen, lack of blood and blood products (26.2%; 55), and service setup issues (11.4%; 24), such as a lack of ICU and NICU units.

1.7 The pattern of ethical breach or malpractice and the committee's decision
The analysis of the pattern of ethical breaches or malpractice revealed that the HPEC identified 31.9% (67) of cases as ethical breaches or malpractice. Of these, 34.3% (23) had ethical breaches, and 65.7% (44) had malpractice, including negligence and treatment errors.

1.7.1 Patterns of Ethical Breaches or Malpractice Identified by the HPEC by Professional Category
The HPEC identified patterns of ethical breaches or malpractice by professional category. Their analysis revealed that out of 103 health professionals who were found to have committed ethical breaches or

malpractice, 14.6% (15) were gynecologists and obstetricians, followed by nurses (12.6%) (13). The distribution of these ethical breaches and malpractice cases is shown in Figure 4

1.7.2 Disciplinary Measures Taken by HPEC-based Professional Category

The HPEC, which is authorized to take significant disciplinary action against health professionals for ethical breaches or malpractice in healthcare services, levied disciplinary actions against 103 health professionals involved in 69 medico-legal cases. The specific actions taken are detailed in Figure 5.

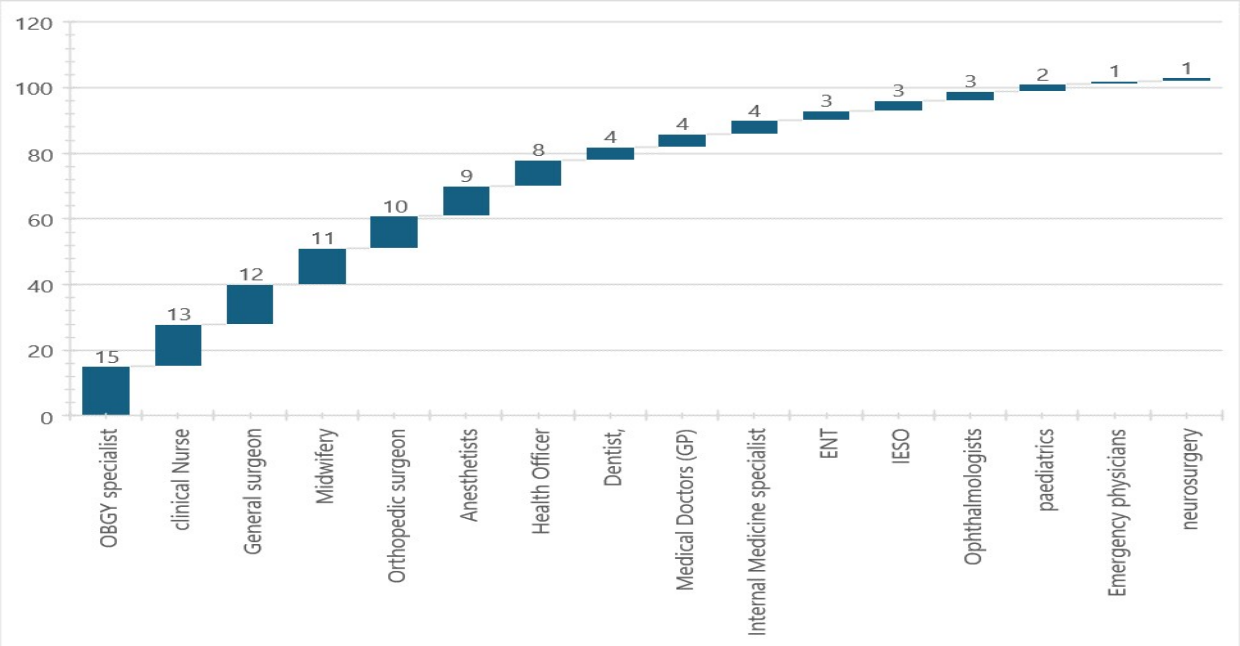

Figure 4: Patterns of Ethical Breaches or Malpractice Identified by HPEC by Professional Category (N=103).

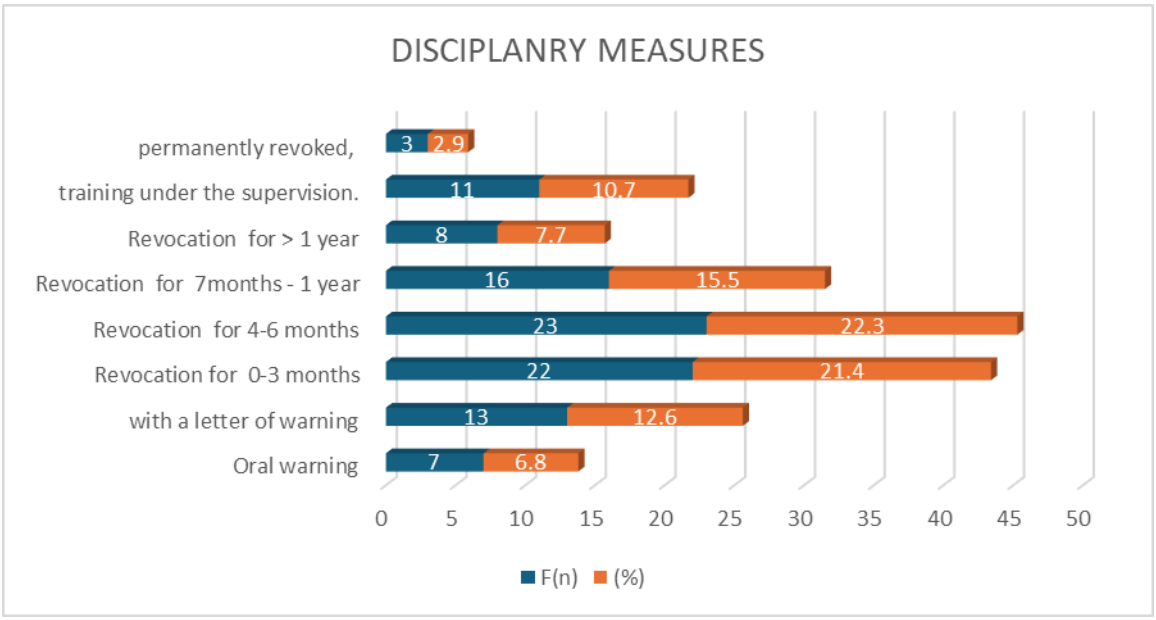

Figure 5: Disciplinary measures taken by HPEC-based professional category (N=103).

2. Claimants' Motivations for Filing Complaints with HPEC

The HPEC investigated the motivations behind medico-legal cases filed at AAFDA. Their investigation revealed that communication gaps between healthcare professionals and patients/families were a significant factor, with evidence found in 71.4% (150) of cases. Additionally, the committee analyzed the primary reasons for complaints filed by plaintiffs or family representatives. The analysis revealed that 49% (103) of patients experienced a perceived medical error during healthcare services. Another 14% (29) of the patients were motivated by a desire for reimbursement and compensation for other reasons. Figure 6 provides more detail.

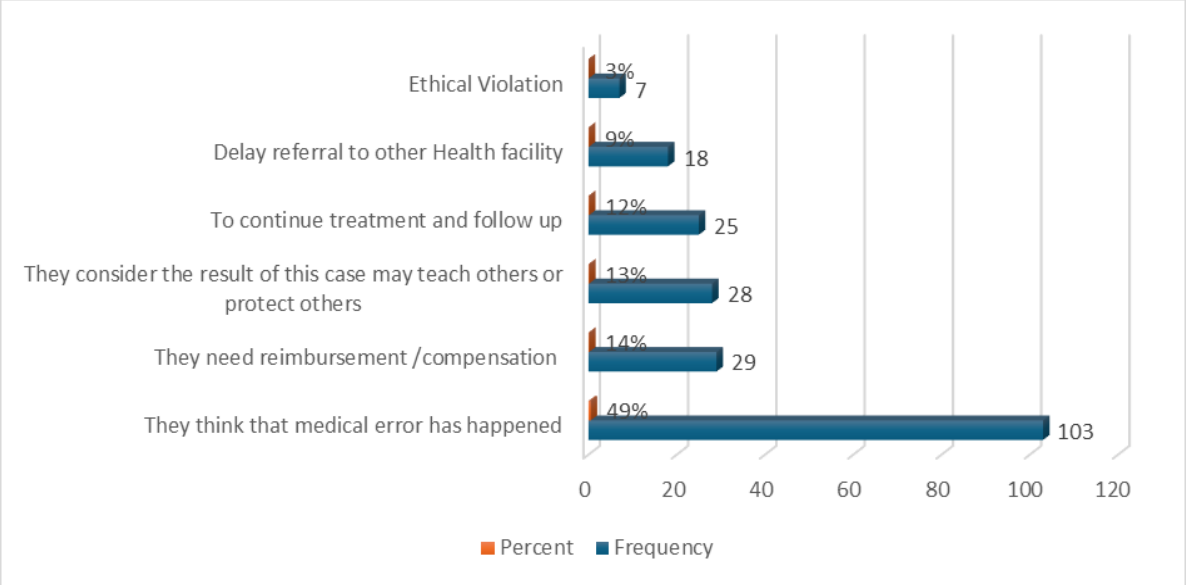

Figure 6: Claimants' Motivations for Filing Complaints with HPEC

3. Challenges Encountered by HPEC During Medic-Legal Case Management

3.1. Investigative Delays and Rationale for Extended Timelines in Medico-Legal Cases

The HPEC's investigation process identified decision delays as a major challenge. Their findings revealed that 71% (n=149) of patients experienced delays in the investigation and final decision-making process. The duration of these delays varied, ranging from 1 to 5 years, as illustrated in Figure 8. The chart shows that the highest number of cases 61 individuals occurred within one year or less. This was followed by 45 individuals with 2–3 years of delay, and 42 individuals with 3–4 years. A total of 30 individuals experienced delays of 1–2 years. The number of cases decreased significantly among those with longer delays, with 17 individuals waiting for 4–5 years and only 15 cases taking more than 5 years. This trend suggests that a large proportion of medico-legal cases involved delays during the early years of the investigation process.

The investigation process also revealed factors contributing to delays in making a final decision. In 29% (43) of the cases, delays stemmed from the time-consuming process of gathering all relevant healthcare professionals from the involved facilities. Additionally, the HPEC encountered difficulties in obtaining necessary supporting evidence from both healthcare facilities and claimants. Specifically, delays were caused by the lack of supportive evidence from patients, families, prosecutors, or police in 28% (41) of cases, irregular HPEC meetings due to the COVID-19 pandemic or facilitation barriers in 26% (38) of cases, and the inability to obtain supportive evidence from health facilities in 18% (27) of cases.

4. Associations Between the Final Committee Decision and Various Factors

A chi-square test was conducted to assess the relationship between various factors and the final committee decision to identify an ethical breach/ malpractice by the Healthcare Professionals Ethics Committee (HPEC). The results revealed statistically significant associations ($p < 0.005$) between the following factors and the identified ethical violations: client status at the start of the claim, referral due to lack of resources, delay in treatment/diagnosis, and communication gaps. Deceased clients had a higher proportion of identified breaches than alive clients. Similarly, claims with delays in treatment/diagnosis and those with communication gaps also had a significantly higher proportion of identified breaches. Table 4 shows the details.

Table 4: Association between the final decision of the committee and several factors(N=210)

Factors		Ethical breach/ Mal-practice Identified: Yes (N=67) (%)	Ethical breach/ Mal-practice Identified: No (N=143) (%)	P-Value
Ownership of the institution	Public	28(40.6)	57(40.4)	0.705
	Private	37(55.2)	78(54.8)	
	NGO	2(2.9)	8(5.7)	
Client's status during the claimant's opening medicolegal file	Passed away	38(56.7)	55(38.5)	0.020*
	Alive with complications	21(31.3)	41(28.7)	
	Alive with No complication	6(9.0)	27(18.9)	
	Unknown	2(3.0)	19(13.3)	
The duty HP was on duty	Yes	56(83.6)	79(55.2)	<0.001*
	No	11(16.4)	64(44.8)	
Referral due to Lack of Resources (drugs, equipment, ICU, NICU)	Yes	17(25.4)	17(11.9)	0.013*
	No	50(74.6)	126(88.1)	
communication gap	Yes	54(80.6)	96(67.1)	0.044*
	No	13(19.4)	47(32.9)	
Delay in treatment and diagnosis	Yes	54(80.6)	2(1.4)	<0.001*
	No	13(19.4)	141(98.6)	

II The qualitative results

1. Challenges in the Case Investigation Process

This study utilized descriptive phenomenology, identified 92 distinct codes from interviews using deductive and inductive coding, and identified 5 themes from 23 categories (Table 5).

The qualitative analysis revealed challenges faced by HPEC in investigating medico-legal cases. These included difficulties in collecting evidence from both health facilities and claimants. Specifically, obtaining documents from health facilities in a timely manner proved problematic. Furthermore, knowledge gaps on medico-legal issues were identified among all parties involved, along with communication issues. Additionally, concerns were raised regarding poor quality and incomplete medical records, coordination, and resource constraints, particularly limited space availability. Participant quotes provided during the study period offer further insights into these challenges.

Table 5 -The identified themes and subthemes (categories)

Them	Category
Evidence Availability	Lack of evidence availability from family
	Lack of evidence availability from health facility
	Collecting documents as Professional witness
	Data quality and integrity
	Relevance of evidence:
	Timeliness of evidence
Knowledge and communication gap	Content-based gaps
	Process-based gaps
	Conceptual gaps
	Communication gap
Documentation	Record Types
	Documentation Practices
	Legal Implications
	Technological Advancements
	Special Considerations
Resource/space availability	Adequacy
	Accessibility
	Utilization
	Impact
Coordination/Cooperation/	Teamwork and collaboration
	Clear roles and responsibilities
	Knowledge sharing and training
	Collaboration with regulatory bodies

1.1 Evidence Availability

The findings of this study revealed that the HPEC faced challenges in collecting evidence due to missing family and health facility records, difficulties obtaining documents from professionals, and concerns about data quality, completeness, and timeliness; this finding is supported by the responses given by participants.

"A key decision delay, says a 4-year veteran in the HPEC," is lack of evidence for/against claims: missing family & facility records, difficulty getting professional documents, and data quality/ completeness/timeliness concerns."

Securing necessary evidence from stakeholders is a major challenge, slowing down medico-legal investigations.

A senior committee physician said, "Timely decisions suffer without full evidence. Strikingly, claimants, healthcare providers, facilities, and sometimes police are delayed by withholding evidence. Even patient records mysteriously vanish."

1.2 Knowledge and communication gaps

The HPEC plays a crucial role in medico-legal case investigations, but a significant knowledge gap exists among health professionals, health Facilities, and claimants regarding its autonomy, responsibilities, and power, posing challenges for both parties involved.

Study participant (senior female) highlights

"*There is limited understanding of HPEC among health professionals, facilities, patients & families. This lack of knowledge, particularly regarding medico-legal investigations, could put health care professionals at risk in lawsuits."*

Similarly, the second senior specialist stated that *"in order to overcome the recurrent claims on health care and raise the consciousness of health professionals, preventative ethics must be considered at all levels of the health care system".*

In healthcare, strong communication between professionals and patients is vital. Poor communication can lead to medico-legal claims, emphasizing the need for clear explanations and patient involvement in care.
One of the senior specialists working as a member of the HPEC said that

"Our investigations reveal that poor communication during care, consent, and procedures is a frequent trigger for medico-legal claims. Health facilities and professionals must prioritize improving communication through training and individual effort."

Similarly, a female legal officer working as a member of the HPEC stated that

"A recurring theme in medico-legal investigations is the lack of understanding between patients and healthcare providers. This often stems from inadequate communication regarding a patient's condition and treatment plan. In essence, poor communication is a major gap we consistently encounter."

Documentation

The interviewees unanimously identified deficient documentation as a major healthcare professional limitation, encompassing record types, practices, legal implications, technology use, and special considerations."
One of the senior female specialists at HPEC said:

"*Records in investigations lack crucial details, often incomplete and illegible. While health professionals claim proper care, undocumented actions leave them exposed in lawsuits. Remember, proper medical records are their sole defense."*

Resource/space availability

The HPEC requires meeting halls, staff, expertise, and facilities for swift investigations, which helps minimize delays and improve case processing.

Regarding this, the participants complained as

One senior specialist said, "Despite authority support (meetings, patient claims, evidence collection), limitations hinder performance. No dedicated meeting hall forces committee members to wait in corridors, impacting efficiency. AAFMHAC leadership vacating their own office to accommodate meetings highlights resource constraints."

Coordination/Cooperation

Professional ethics committees promote teamwork, collaboration, clear roles, knowledge sharing, external collaboration with regulatory bodies, professional organizations, and public outreach, ensuring efficient processes and shared goals.

One of the senior specialist interviewees said that

"Coordination appears positive but driven by individual dedication. Systemic support from leadership is crucial. Additionally, exemplary cooperation and teamwork among committee members is highly commendable."

Discussion

This sequential explanatory mixed methods study investigated the patterns and challenges associated with medico-legal cases, combining quantitative findings with qualitative insights to enhance understanding of systemic and contextual factors affecting patient safety and provider accountability.

Quantitative results highlighted that the most affected demographic groups were urban residents aged 18 –45 years, with women being the most frequently involved. This trend may be attributed to better healthcare access, heightened awareness, and the high incidence of obstetric cases in urban areas. The

leading causes of medico-legal incidents were improper procedures, unethical conduct, and inadequately equipped facilities. These findings underscore the urgent need to enhance healthcare quality, particularly in the field of obstetrics and gynecology.
Interestingly, these findings differ from a 2015 study in an Indian hospital, which reported that the majority of medico-legal cases involved males due to the high frequency of road traffic accidents (5,21). However, they align with studies from Egypt and Saudi Arabia, where urban areas and private healthcare institutions experienced a higher rate of medico-legal claims than rural areas and the public sector. In both countries, obstetrics and gynecology were also the most common specialties implicated in these cases (3,6).

Further analysis in this study revealed that private healthcare facilities were more prone to medico-legal claims, consistent with the Egyptian study (6). This raises questions about the role of financial interests, the potential for inappropriate interventions, and differing standards of care in private versus public settings highlighting the need for further inquiry and targeted oversight.

Another notable quantitative finding was that nearly 60% of patients involved in medico-legal cases were critically ill upon admission. This aligns with findings from Bangladesh and Nigeria, where a relationship was observed between severity of illness and medico-legal involvement. However, studies conducted in the United States and Australia reported no significant difference in illness severity among patients in medico-legal cases (22, 23,24,25), suggesting that contextual healthcare factors may mediate this association.

Obstetrics and gynecology represented the most frequently implicated specialty, followed by general surgery mirroring results from studies conducted in the United States, which identified high malpractice claim rates in these fields (25,26). This may reflect the complex nature of care, increased risk of adverse outcomes, and frequent patient-provider interactions in these specialties. The implication is clear: communication, patient safety systems, and clinical decision-making processes in high-risk areas must be strengthened.

A central theme identified in this study was communication failure. Quantitative data showed that 71.4% of medico-legal cases involved some form of communication breakdown. This is consistent with the U.S.-based findings where communication failures were a leading cause of malpractice claims (26) and with the Australian study showing communication issues in 40% of medical board complaints (24). Qualitative data in the current study explained these failures further, identifying contributing factors such as the complexity of medical information, limited consultation time, cultural sensitivity gaps, and the emotional burden associated with obstetric care.

These findings call for the implementation of structured communication strategies. This may include standardized communication protocols, professional development programs focused on effective interpersonal skills, sufficient consultation time, and patient-centered care models that promote shared decision-making. Improving communication has the potential to enhance patient trust, reduce dissatisfaction, and limit litigation risks.

Disciplinary measures were most frequently applied to OBGYN specialists, clinical nurses, and general surgeons. This trend is supported by studies in the U.S., which also reported high malpractice claim rates against OBGYNs and surgeons (26,27), and by the Australian data identifying nurses as common subjects of board complaints (24). These trends likely reflect high patient volumes, complex clinical scenarios, and systemic limitations affecting these professions. To address these issues, targeted support, enhanced safety protocols, and continued education are essential.

Quantitative results also demonstrated a significant association ($P < 0.005$) between ethical breaches and the presence of certain factors: the death of a client, healthcare personnel on duty, limited resources, delays in treatment or diagnosis, and communication failures (Table 4). These findings reveal systemic shortcomings contributing to ethical and clinical malpractice. Addressing them will require interventions such as updating clinical protocols, strengthening professional accountability, improving resource allocation, promoting timely care, and reinforcing team-based communication. Regular audits, peer reviews, and fostering a culture of continuous improvement are recommended to reduce legal risk and improve care quality.

An additional major finding from this study is the multifaceted nature of managing medico-legal cases within healthcare systems. Quantitatively, systemic issues including delays in diagnosis, treatment, referral, and poor patient follow-up contributed to 25.3% of complications. These delays were further contextualized through qualitative findings that identified limited clinical evidence, professional knowledge gaps, poor documentation practices, resource scarcity, and fragmented coordination across departments as key barriers. These findings align with international reports which emphasize that poor documentation, inadequate professional training, and uneven resource distribution significantly compromise medico-legal case management (5,12,18). The qualitative phase also showed the need for collaboration between clinicians, legal teams, and ethics committees in overcoming these systemic problems.

The study further explored delays specific to the

medico-legal investigation process. Quantitative findings showed that 29% of delays were due to the time needed to assemble healthcare professionals, 18% were caused by difficulties in obtaining evidence from health facilities, and 28% were related to challenges in collecting evidence from families. These findings were supported by qualitative data describing common obstacles, including missing or incomplete records, administrative delays, and concerns about the accuracy and reliability of the information provided. By triangulating these results, the study identified evidence collection as a major bottleneck in medico-legal processes, significantly contributing to the overall delays in case resolution.

In summary, the integration of quantitative and qualitative results provides a comprehensive understanding of the challenges associated with medico-legal cases. These findings emphasize the need for systemic reforms in communication, documentation, case investigation, and professional accountability. Addressing these areas is essential for improving patient safety, reducing legal exposure, and building a more responsive and resilient healthcare system.

Conclusion and recommendations

Conclusion

In conclusion, the study indicates that women and city dwellers between the ages of 18 and 45 make up the majority of the demographics involved in medico-legal disputes. The primary offenders are those with inadequate facilities, unethical behavior, and defective methods. The observation that these occurrences occur more frequently at private clinics highlights the need for improved medical care. Since obstetrics and gynecology are the most common disciplines, communication skills are more important. The increased use of discipline measures by OBGYN specialists, clinical nurses, and general surgeons highlights the need for specialized care and training. Delays in clinical diagnosis, treatment, and decision-making account for most medicolegal issues.

Recommendations

Based on the research findings, the following are our recommendations:

i High-Risk Patients- Implement protocols for earlyidentification and management of critically ill patients to minimize potential delays in intervention.
ii Communication-Prioritize clear and timely communication with patients regarding decisions, timelines, and potential risks. Invest in training for healthcare professionals on effective communication skills.
iii Preventive Ethics – Clinical ethics committees should be established to promote ethical practice and minimize medico-legal issues.
iv Delays and Collaboration- Streamline procedures for referrals, investigations, and specialist consultations. Foster interdisciplinary collaboration to improve care delivery and case management.
V Protocols Review- The guidelines and protocols utilized by the Health Professionals Ethics Committee should be reviewed and updated to ensure clarity and to establish timely follow-up procedures.
Vi Training and SOPs- Provide continuous training for healthcare professionals on medico-legal issues and best practices. Develop and implement standardized operating procedures (SOPs) for all areas of OBGYN care.
Vii Institutional Responsibility- Healthcare institutions should take responsibility for creating a culture of safety and risk management.

Strength and limitation of the study

Strengths:

i The mixed-methods design provided both bread hand depth of insight.
ii nclusion of all eligible medico-legal case files ensured comprehensive coverage.
iii The study involved experienced ethics committee members, enhancing qualitative credibility.

Limitations:

i Limited to one city, compromising generalizabiity.
ii Retrospective document review may have been affected by incomplete records.
iii Potential for recall bias in qualitative interviews.

Ethics approval and consent to participate

Ethical approval was obtained from the Addis Ababa University Health Science College before the study's commencement with protocol Nº:037/23/Anesthesia.

Informed Consent for Qualitative Interviews

Written informed consent was obtained from all participants after explaining the study's purpose, confidentiality, and their right to withdraw at any time. Only those who gave consent were interviewed.

Consent for publication

A support letter from AAFDA was acquired, and written informed consent was obtained before collecting secondary data

Confidentiality

To ensure confidentiality, all identifiable information was removed from the medico-legal case charts before data extraction. Each case was assigned a unique code, and no names, identification

numbers, or other personal details were recorded or used in the analysis. Access to the original case files was restricted to the principal investigator, and all data were securely stored in password-protected digital files. The findings were reported in aggregate form without referencing any individual or specific case, ensuring that the privacy of patients and involved professionals was fully protected.

Availability of data and materials

The datasets analyzed during the current study are available from the corresponding author upon reasonable request.

Competing interests

The authors declare no competing interests.

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Authors' contributions

The PI was involved in the conception of the research focus area, proposal writing, supervising data collection, data analysis and interpretation, and manuscript writing. All co-authors contributed to data cleaning, coding, and providing valuable comments.

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