

MEDICAL PROTECTION SOCIETY  
PROFESSIONAL SUPPORT AND EXPERT ADVICE

MPS



Putting members **first**

# Common Problems Managing the Risks in General Practice in South Africa

[www.mps-group.org](http://www.mps-group.org)

# Contents

Chapter 1	<b>Laws, ethics and professional regulation</b>	PAGE 1
	<b>Introduction</b>	PAGE 1
	<b>Patients' constitutional rights</b>	PAGE 2
	<b>Case law</b>	PAGE 4
	<b>The role and powers of the Council</b>	PAGE 6
	<b>Ethical considerations</b>	PAGE 9
Chapter 2	<b>Working environment</b>	PAGE 20
	<b>Policies, protocols and guidelines</b>	PAGE 20
	<b>Incident reporting system</b>	PAGE 25
	<b>Health and safety</b>	PAGE 25
Chapter 3	<b>Clinical management of patients</b>	PAGE 27
	<b>Diagnosis</b>	PAGE 27
	<b>Keeping comprehensive and contemporaneous records</b>	PAGE 34
	<b>Follow-up arrangements</b>	PAGE 37
	<b>Safe prescribing</b>	PAGE 38
	<b>Acting within your competency</b>	PAGE 39
Chapter 4	<b>Non-clinical attributes</b>	PAGE 40
	<b>Communication skills</b>	PAGE 40
	<b>Ability to reflect and learn</b>	PAGE 44
	<b>Keeping mistakes in perspective</b>	PAGE 45
Chapter 5	<b>Appendices and References</b>	PAGE 46

Important – please note: Due to the dynamic nature of medical law we suggest that you access our website at [www.mps-group.org](http://www.mps-group.org) for the most up-to-date information.

© Medical Protection Society 2012. Review date August 2013.

The right of Sandy Anthony to be identified as the author of the text of this work has been asserted by her in accordance with Copyright, Designs and Patents Act 1988.

This booklet was produced as a resource for MPS members in South Africa. It is intended as general guidance only. For more specific practical advice and support with medicolegal issues that may arise, please contact MPS.

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

We are a mutual, not-for-profit organisation offering more than 270,000 members help with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Fairness is at the heart of how we conduct our business. We actively protect and promote the interests of members and the wider profession. Equally, we believe that patients who have suffered harm from negligent treatment should receive fair compensation. We promote safer practice by running risk management and education programmes to reduce avoidable harm.

MPS is not an insurance company. The benefits of membership are discretionary – this allows us the flexibility to provide help and support even in unusual circumstances.

# Laws, ethics and professional regulation

## Introduction

Because the practice of medicine is so intimately concerned with people's bodies, personal vulnerabilities and wellbeing, it is subject to legal and ethical restrictions, all of which have evolved or been designed to protect patients' interests. They constrain healthcare practitioners to behave competently and ethically, and to conduct themselves with probity. Although in many respects intertwined, there are three distinct sources of legal and ethical principles that inform medical practice:

- the Constitution, and all the statutes and regulations stemming from it that embody its principles
- case law
- the Health Professions Council of South Africa, which is mandated to set and maintain standards.



## Patients' constitutional rights

The Constitution is the supreme law of the Republic. Therefore all statutes and conduct must support and reflect its principles and aims. Under the Constitution, all citizens enjoy certain rights, and – as a doctor – you have a responsibility to ensure that those rights are respected; patients also have responsibilities, which are set out in the Patient's Charter. The Patient's Charter is an explicit statement of the rights and responsibilities implied by the Constitution. These are:

### A patient's rights

- A healthy and safe environment
- Participation in decision-making
- Access to healthcare services, which include:
  - Receiving timely emergency care
  - Treatment and rehabilitation
  - Provision for special needs
  - Counselling
  - Palliative care
  - A positive disposition
  - Health information
- Knowledge of one's own health insurance/medical aid scheme
- Choice of health services
- Be treated by a named healthcare provider
- Confidentiality and privacy
- Informed consent
- Refusal of treatment
- Be referred for a second opinion
- Continuity of care
- Complain about health services.

### A patient's responsibilities

- To take care of his or her health
- To care for and protect the environment
- To respect the rights of other patients and health providers

- To utilise the healthcare system properly and not abuse it
- To know his or her local health service and what they offer
- To provide healthcare providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes
- To advise the healthcare providers of his or her wishes with regard to his or her death
- To comply with the prescribed treatment or rehabilitation procedures
- To enquire about the related costs of the treatment and/or rehabilitation and arrange for payment
- To take care of health records in his or her possession.

Many of the principles and ideals expressed in the Constitution have been encoded in legislation, some of which has a direct bearing on the work and business of general practice. The Promotion of Access to Information Act of 2000, for example, gives everyone a right of access to their records (including health records) if they need them to exercise or protect their rights, even if the holder of the information is a private business.

Other statutes and regulations that may affect general practice (see Box 1) include the Children's Act, which clarifies children's rights and parental responsibilities; the Communicable Diseases Regulations, which set out medical practitioners' responsibilities regarding notifiable diseases; and various regulations under the Health Professions Act governing the licensing of practices, among other things.

### **Box 1: Examples of statutes and regulations relevant to general practice**

- Children's Act Regulations 2010
- Choice on Termination of Pregnancy Act 1996
- Communicable Diseases Regulations 2008
- Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007
- Domestic Violence Act 1998
- Health Professions Act 1974
- Mental Health Care Act 2002
- National Health Act 2003
- Older Persons Act 2006
- Promotion of Access to Information Act 2000
- Sexual Offences Act 2007

## Case law

Case law – or common law – is the body of written opinions made by judges when they make their rulings. The case law with most relevance for medical practitioners is that derived from civil claims alleging medical negligence, and the most relevant of these are those that define or clarify a breach of duty of care or causation.

An allegation of negligence will only succeed if the plaintiff can satisfy the court, on a balance of probabilities, that all three of the following conditions apply:

1. the plaintiff was owed a duty of care by the defendant
2. the duty of care was breached
3. harm resulted from the breach (causation).

Assuming that the first criterion is established (which is usually the case), the plaintiff must then present convincing evidence that the healthcare professional concerned could reasonably have foreseen the consequences of his or her action and did not guard against such an eventuality; moreover, it must be demonstrated that the practitioner's actions fell short of the standards the law considers reasonable. The test of reasonable conduct was set out in the judgment of a 1924 case<sup>1</sup> as follows:

“[In] deciding what is reasonable the court will have regard to the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs.”

This means that, if a doctor's management of a patient is considered reasonable by a responsible body of his or her peers, a court would be unlikely to find him or her guilty of negligence.

It does not always follow that a breach of the duty of care results in harm to a patient. In fact, there are many instances in which the outcome would have been the same for the patient whether the breach of duty had occurred or not. For example, a delay in diagnosing an already untreatable tumour is unlikely to affect the outcome for the patient. This is where the testimony of expert witnesses can be crucial for arguing the causation element of a claim. What it often comes down to is if the judge prefers one expert's opinion over another's.

The plaintiff's case will only succeed if the judge finds that a breach of duty did result in harm to the patient.

The number and value of clinical negligence claims brought in South Africa has been rising rapidly in recent years. In MPS's experience alone, the estimated value of reported claims rose by 132% between 2008 and 2010. The good news for general practitioners is that most of these increases have been seen in the riskier specialties such as obstetrics, spinal surgery, neurosurgery and neonatology. However, family doctors who carry out invasive procedures should be aware

that they are more at risk of litigation and take care to ensure that, except in an emergency, they only undertake procedures that are clinically indicated, act within their competence and take proper informed consent.

Delayed diagnosis is the number one reason for claims against general practitioners. This category includes failure to diagnose, failure to revise an incorrect diagnosis in light of new evidence and failure to examine or investigate. What also probably underlies many of these claims is an overall failure of communication, either with the patient or with colleagues, or both.

In addition to facing a civil claim in negligence, doctors whose practice falls short of acceptable standards may face disciplinary action by the Health Professions Council.





## The role and powers of the Council

The Health Professions Council of South Africa (the Council) is mandated, under the Health Professions Act 56 of 1974, to regulate registered healthcare practitioners. The Medical and Dental Board regulates medical and dental practitioners. It does this by:

- setting and maintaining standards of training and practice for healthcare professionals, and disciplining those who fall short of those standards, if necessary
- setting and monitoring mandatory requirements for the continuing professional development of all registered practitioners and ensuring that training institutions adhere to the Council's standards
- setting professional and ethical standards and publishing guidelines for practitioners to follow.

The core document that all medical practitioners should be aware of is the *Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act, 1974*. It contains rules (not just guidelines) that medical practitioners are expected to adhere to (see Box 2). If they don't, they may be subject to discipline by the Council.

### Box 2: Main responsibilities of health practitioners

A practitioner shall at all times

- a. act in the best interests of his or her patients;
- b. respect patient confidentiality, privacy, choices and dignity;
- c. maintain the highest standards of personal conduct and integrity;
- d. provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others;
- e. keep his or her professional knowledge and skills up to date;
- f. maintain proper and effective communication with his or her patients and other professionals;
- g. except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment himself or herself, from his or her next of kin; and
- h. keep accurate patient records.

HPCSA, *Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974* (as amended by Government Notice No. R 68 of 2 February 2009), para 27a





© iStockphoto.com/Lise Gagne

The *Ethical Rules* cover almost every aspect of practice, from advertising and financial probity to patient confidentiality and relationships with professional colleagues. These somewhat tersely stated principles have been further expanded into a series of 16 guidance booklets (see the list in Appendix 1), which practitioners can use to inform their practice and thus ensure that they are operating within the bounds of the Rules. If nothing else, all medical practitioners should read *Guidelines for Good Practice*, which sets out the 13 core values that should govern all medical professionals' practice, and against which their conduct will be measured in the event of a complaint to the Council.

The Medical and Dental Board of the Council may discipline a doctor for infringing any of the ethical rules, and lists the following examples on its web page:

- Unauthorised advertising
- Overservicing of patients
- Criminal convictions
- Improper relationships with patients
- Improper conduct of practitioners
- Operational procedure without patient's permission or consent
- Disclosure of information in regard to patient without his/her permission
- Incompetence in regard to treatment of patients

- Excessive fees charged/overcharging
- Insufficient care towards patients
- Racial discrimination
- Rude behaviour towards patients
- Prescriptions to already addicted patients
- Perverse incentives and kickbacks.

The Board has the power to impose a wide array of penalties on doctors whose professional conduct is found wanting. The most severe penalty is to be completely struck off the register, but other sanctions include suspension from practice and fines (see Box 3 for examples of transgressions and the penalties they incurred).

### **Box 3: Examples of cases of unprofessional conduct decided in 2011**

- A doctor was suspended from practice for 12 months for failing to provide follow-up care following an invasive procedure and for failing to arrange for a postmortem examination following an unnatural death.
- A doctor who provided substandard care to a critically ill patient was fined R10,000.
- A fine of R10,000 was imposed on a doctor for disclosing confidential information without the patient's consent.
- Another doctor's practice was suspended for 12 months (with a further 4-year suspension suspended provided he is not found guilty of a similar offence during that period) for entering into a sexual relationship with one of his patients.
- A doctor who employed a locum who was not registered with the HPCSA and also fraudulently claimed for professional services not actually rendered had his practice suspended for three years.
- The practice of a doctor who worked as a locum in private practice while his registration limited him to work in the public sector under supervision was suspended for 12 months.
- A doctor found guilty of indecently assaulting and sexually harassing a patient was removed from the register.

HPCSA, Finalised Matters January to December 2011 [www.hpcsa.co.za/conduct\\_guilty\\_verdicts.php](http://www.hpcsa.co.za/conduct_guilty_verdicts.php)

## Ethical considerations

The medical profession subscribes to a strict code of ethical conduct; breaching any of them may attract disciplinary penalties from the Council, but we focus here on three main areas:

- respect for patient autonomy (informed consent, shared decision-making)
- respect for patient confidentiality
- probity.

### Respect for patient autonomy

This section contains only a brief overview of consent issues, which can be complex. You will find more detailed advice in the MPS booklet, *Consent to Medical Treatment in South Africa – An MPS Guide*. This is available either in hard copy (free for MPS members) or on the MPS website.

### Managing expectations

Quite apart from the legal and ethical requirement to do so, there is a very good practical reason for seeking informed consent – it may prevent claims and complaints about you if the outcome of treatment is less than optimal. Many claims and complaints are brought, not because a doctor has been negligent, but because the patient's expectations have been disappointed. If you discuss openly with your patients what is and is not possible, they will have more realistic expectations and are therefore less likely to feel disappointed when an otherwise successful treatment leaves them with residual problems, or when it doesn't work at all.

Those who have researched the subject seem to agree that you should aim for shared decision-making when one or more of the following apply:

- the patient prefers to be involved in decision-making
- there is a degree of uncertainty about the outcome of treatment options
- two or more options with similar potential outcomes are available
- the risks and benefits of the proposed treatments are high
- the patient has a chronic illness.

If you discuss treatment options with a patient and duly note the substance of the discussion in the patient's notes, it will be much easier to defend your position if an allegation of negligence is later made against you.

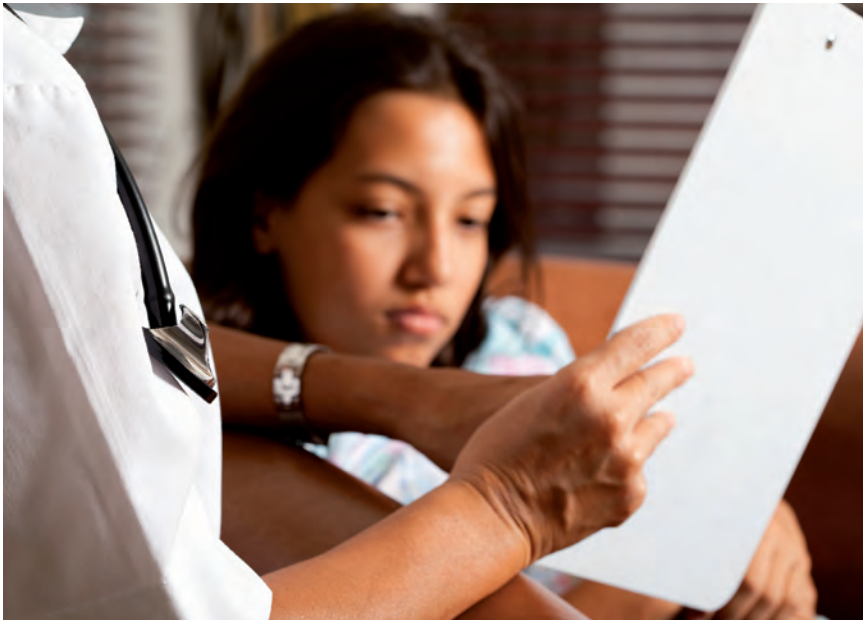
## Consent to treatment

As stated earlier, a patient's right to autonomy is enshrined in the Constitution and is therefore an ideal that carries the force of law. In particular, the Health Act of 2003 (Chapter 2, sections 1 and 2) explicitly obliges healthcare providers to inform a health service user of:

- a. “the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
- b. the range of diagnostic procedures and treatment options generally available to the user;
- c. the benefits, risks, costs and consequences generally associated with each option; and
- d. the user's right to refuse health services and explain the implications, risks and obligations of such refusal.

“The healthcare provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy.”

Be aware that consent is not something that only applies to invasive surgical procedures. Technically, any bodily contact with a patient is an assault if the patient did not consent to it. Clearly, it would be ludicrous to obtain formal consent before



performing every little act, such as measuring blood pressure or feeling a pulse, so the law allows healthcare practitioners to carry out much of their work on the basis of implied consent. If patients co-operate with your actions (for example, rolling a sleeve up for the sphygmomanometer cuff), you may assume their consent. Even so, a short explanation of what you intend to do, and why, is still advisable – especially if it entails examining genitals or breasts. Even an examination of the fundus of the eye with an ophthalmoscope or palpating the glands in the neck can feel threatening to patients if they don't know what to expect.

Consent is also needed for non-interventional treatments such as drug therapy, and for investigations and tests. Although it might seem that you have implied consent if the patient co-operates by taking the medication prescribed or by allowing you to take a blood sample, if the patient is unaware of the possible side-effects of the drug, or doesn't know what blood tests you're going to request, the consent is invalid because the patient did not make an informed decision.

To be considered valid, consent to a medical intervention must meet three criteria:

1. **Information** – The patient must be informed about the material risks and benefits of the proposed intervention.
2. **Capacity** – He or she must be capable of taking in the information, weighing it in the balance and arriving at a decision.
3. **Non-coercion** – The patient must be free of undue pressure or coercion in making his or her decision.

## Information

The information that should be given to patients so that they may make an informed decision is listed in Box 4 on page 12. Just presenting patients with information sheets or briskly rattling off a list of possible side-effects of a drug is not sufficient, however. The information must be tailored to the needs of the individual – it must therefore be presented in a form the patient can understand and in the context of his or her particular preferences and circumstances. The Council offers this guidance regarding the context in which the information should be presented:

*“When providing information, health care practitioners must do their best to find out about patients’ individual needs and priorities. For example, patients’ beliefs, culture, occupation or other factors may have a bearing on the information they need in order to reach a decision. Health care practitioners should not make assumptions about patients’ views, but discuss these matters with them and ask them whether they have any concerns about the treatment or the risks it may involve.”<sup>2</sup>*

These are important considerations as each patient will take a different view on the implications of the risks and benefits, depending on his or her personal priorities. A patient who earns his living as a professional driver, for example, is likely to be reluctant to take medication that causes drowsiness.

## Capacity

Even if you do explain your intentions to the patient, you will also need to check that he or she understands what you've been saying, otherwise you will fall at the second fence (the patient's capacity to understand and weigh choices in the balance). (See Appendix 2 for a guide to assessing decisional capacity.)

### **Box 4: Information the patient should be given in the consent process**

- “Details of the diagnosis, and prognosis, and the likely prognosis if the condition is left untreated.
- Uncertainties about the diagnosis, including options for further investigation prior to treatment.
- Options for treatment or management of the condition, including the option not to treat.
- The purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure, including common and serious side effects.
- For each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes which may be caused or necessitated by the treatment.
- Advice about whether a proposed treatment is experimental.
- How and when the patient's condition and any side effects will be monitored or re-assessed.
- The name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team.
- Whether students will be involved, and the extent to which students may be involved in an investigation or treatment.
- A reminder that patients can change their minds about a decision at any time.
- A reminder that patients have a right to seek a second opinion.
- Where applicable, details of costs or charges which the patient may have to meet.”

HPCSA, *Seeking Patients' Informed Consent: The Ethical Considerations* (2007), para 3.1.3.

## Non-coercion

Lastly, you should not put patients under pressure to agree to a particular intervention (and you must be particularly scrupulous in this regard if you have a financial interest in a facility you wish to refer the patient to). As a doctor, you have a duty to give your patients the benefit of your expert opinion, so there is nothing wrong with advising them and letting them know what your preferred course of action would be if you were in their shoes, but be careful not to let your advice cross over into pressure or coercion. See the case report below for an example of how easy it is to be in position where you're guilty of coercion.



### Case report: A rushed decision

Mr H is a plasterer in his late 40s. He has been experiencing pain in his left knee, on and off, for several years, but this has been adequately managed with a combination of physiotherapy and NSAIDs. One day, he comes to see his GP, Dr J, complaining of intense pain and limited movement in his knee. Dr J, noting Mr H's history and finding, on examination, that the knee is slightly swollen, recommends an intra-articular injection of Kenalog. As he is aware that Mr H is self-employed and needs to be able to return to work as soon as possible, he suggests that he administer the injection there and then.

Mr H is doubtful about having an injection straight into the joint, but Dr J brushes aside his doubts, saying that it will get him "up and running in no time". He points out that it is unlikely he will get another appointment at the practice until the following week, which will only delay his recovery.

Mr H reluctantly acquiesces, and allows Dr J to administer the injection. Unfortunately, he subsequently develops septic arthritis in the joint. Although this is successfully treated with antibiotics, he loses several more weeks of work and decides to sue Dr J for compensation. His claim alleges invalid consent, not only because he had not been warned about the small risk of infection, but because he had felt coerced into making a hasty decision.



## Other considerations

So far, we have only covered consent as it applies to adults with decisional capacity. For patients who lack decisional capacity (children who are too young to understand, and adults with a mental impairment that prevents them from understanding), a proxy may consent on their behalf.

When an adult patient lacks the decisional capacity to consent to a proposed intervention, substitutes may be referred to, in the following order of precedence:

1. An advance directive made when the patient had decisional capacity. A valid advance directive that applies to the circumstances must be honoured, unless there is good reason to believe that the patient changed his or her mind.
2. A proxy mandated in writing by the patient to make decisions on his or her behalf.
3. A person authorised by law or a court order.
4. The patient's spouse or partner.
5. Parent.
6. Grandparent.
7. Adult child.
8. Brother or sister.



The only exception to obtaining consent from a valid substitute is in an emergency. If delay would result in serious harm to the patient, you should act in the best interests of the patient.

Where children are concerned, the consent of the parent or legal guardian is required for children who are either under the age of 12 or who lack the decisional capacity to make the decision before them.<sup>†</sup> If the treatment entails a surgical procedure, the child's consent must be supported by a parent's written assent. In practice, it is reasonable to seek the consent of any minor with the capacity to understand the nature and implications of the proposed treatment or procedure, regardless of age. This should not present a problem if the child and parents are in accord about a decision to consent to treatment. If there are two people with parental responsibility, it is usually sufficient for one of them to give consent, but where decisions may have profound, irreversible consequences, both of them should be consulted where practicable. (See *Consent to Medical Treatment in South Africa – An MPS Guide* for more detailed information about consent issues regarding children, and for a guide to parental responsibility.)

## Summary

In summary, when obtaining a patient's consent:

1. Take the patient's particular circumstances into account when discussing options. The issues discussed should include the risks, benefits, cost and expected outcome of each option, including the option of doing nothing.
2. Check the patient's understanding. If the patient lacks decisional capacity, obtain it from someone whom the law recognises as a valid substitute.
3. Be careful not to place the patient under pressure to choose a particular course of treatment. Be transparent about any financial interest you might have in a recommended healthcare facility.

## Respect for patient confidentiality

Confidentiality is usually thought of as an ethical issue. It is, but it is also a legal obligation:

- Employed healthcare workers are usually bound by a confidentiality clause in their contracts.
- There is a common-law duty to preserve professional confidence.
- The Constitution guarantees citizens the right to privacy, including the right to not have the privacy of their communications infringed.<sup>3</sup>
- Rule 13 of the Council's *Ethical Guide* states that practitioners may only divulge confidential information without the patient's consent when specific circumstances apply.

---

<sup>†</sup> This does not apply in the case of a termination of pregnancy. Under the Choice on Termination of Pregnancy Act of 1996 there is no age or maturity test for a girl to consent to a termination.

- The National Health Act makes it an offence to divulge information about health service users without the user's consent. The only permissible exceptions are when the law or a court order requires disclosure, or if non-disclosure would represent a serious threat to public health.<sup>4</sup>

The obligation of confidentiality goes beyond undertaking not to divulge confidential information; it includes a responsibility to make sure that all records containing patient information are kept securely. Confidential records should not be left where other people may have casual access to them and information about patients should be posted or faxed under private and confidential cover, with appropriate measures to ensure that it does not go astray.

Patients should be informed about the kind of information being held about them, how and why it might be shared, and with whom it might be shared. Patient information leaflets are a convenient way of notifying patients about this, but they are not sufficient in themselves. Bear in mind that few patients will bother to read the leaflets, and some may not be able to read them.

It is especially important to inform patients – and to let them know that they have the right to withhold consent – if you intend to use their personal information for purposes other than their immediate care, or to share it with non-medical agents such as welfare workers. In addition, be especially cautious about sharing information governed by specific regulations outlined in Box 5.

### **Box 5: Legislation stipulating confidentiality requirements for certain types of medical information**

*Choice on Termination of Pregnancy Act, 92 of 1996, section 7.*

Records of termination of pregnancy must be made by the practitioner and the person in charge of the facility. The person in charge of the facility must notify the Director-General within one month of the termination, but the information should be de-identified. "The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times unless she herself chooses to disclose that information."

*Children's Act, 28 of 2005, sections 12, 13, 133 and 134*

"Every child has the right to confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interests of the child."

In addition, the Act specifies that information about a child's virginity, HIV status and contraceptive use should not be divulged without the child's consent. In the case of HIV status, the exception is if the child is below the age of 12 and lacks the maturity to understand the implications, in which case the parent or care-giver, a child protection organisation or the person in charge of a hospital may consent to disclosure on his or her behalf.

Confidentiality is not an absolute obligation – there are circumstances in which disclosure is permissible or even mandatory (see Box 6).

### **Box 6: Circumstances in which disclosure is either permissible or mandatory**

- To meet the terms of a Statutory provision (eg, notification of a communicable disease)
- To comply with a court order
- In the public interest (which includes, but is not limited to, “situations where the patient or other persons would be prone to harm as a result of risk-related contact”.)
- With the patient’s consent.
- With the written consent of a parent or guardian of a minor under the age of 12 years
- With the written consent of the next of kin or the executor of the estate of a deceased patient.

HPCSA, *Confidentiality: Protecting and Providing Information* (2001) para 3.2



## Professional ethics

Confidentiality is considered to be central to the trust between doctors and patients and doctors are held responsible by their professional bodies for protecting personal information that patients share with them.

An unjustifiable breach of confidentiality is taken very seriously by the Council; its booklet, *Confidentiality: Protecting and Providing Information* (2008), sets out detailed guidance on the circumstances in which patient information may be disclosed to third parties. The principles that should be applied are listed in Box 7.

### Box 7: Principles of confidentiality

1. Patients have a right to expect that information about them will be held in confidence by health care practitioners. Confidentiality is central to trust between practitioners and patients. Without assurances about confidentiality, patients may be reluctant to give practitioners the information they need in order to provide good care.
2. Where health care practitioners are asked to provide information about patients, they should :
  - 2.1 Seek the consent of patients to disclosure of information wherever possible, whether or not the patients can be identified from the disclosure; Comprehensive information must be made available to patients with regard to the potential for a breach of confidentiality with ICD10 coding.
  - 2.2 Anonymise data where unidentifiable data will serve the purpose;
  - 2.3 Keep disclosures to the minimum necessary.
3. Health care practitioners must always be prepared to justify their decisions in accordance with these guidelines.

HPCSA, *Confidentiality: Protecting and Providing Information* (2007), para 4.

## Probity

*“Probity requires that the doctor’s conduct at all times justifies patients’ trust and the public’s trust in the profession.”*

*Segen’s Medical Dictionary* (2011) [medical-dictionary.thefreedictionary.com](http://medical-dictionary.thefreedictionary.com)

The term “professionalism” is so widely applied nowadays that its currency has been debased. In many people’s minds the word “professional” can be applied to any skilled worker, and “professionalism” to skilled work of any kind. However,

for the older professions (with the possible exception of the oldest of them all), “professionalism” goes far beyond the mere exercise of skill; indeed, it extends beyond the workplace and into one’s private life. A medical professional is expected, by his colleagues and society, to be a person who can be trusted to act with integrity at all times.

“Integrity is generally defined as wholeness, honesty and ‘uprightness’, being in sound and intact condition; undamaged, untainted. Your professional integrity is a measure of the degree to which your own professional reputation and credibility remain intact. It is more than just clinical or technical excellence alone, since a major element of a person’s integrity derives from the way in which they are viewed by others. Anything which has the potential to reduce a professional person’s reputation in the eyes of another undermines their professional standing.”<sup>5</sup> (See Box 8 for examples.)

### **Box 8: Examples of unprofessional conduct**

- Making misleading or false claims about your practice
- Touting for business
- Succumbing to inducements to provide services to patients that are not clinically indicated
- Accepting perverse incentives
- Over-charging patients
- Fraudulently claiming for services that have not been rendered
- Lack of transparency to patients about financial interests in healthcare facilities or pharmaceuticals
- Impeding patients who wish to seek a second opinion
- Sexual impropriety, particularly with patients
- Involvement in criminal activities
- Continuing to practise when impaired
- Not reporting impaired colleagues
- Not reporting unethical behaviour on the part of colleagues
- Engaging in medical research without the approval of an ethics committee
- Anything that undermines public confidence in the profession
- Anything that undermines the reputation or standing of the profession

(List derived from HPCSA guidance)

# Working environment

## Policies, protocols and guidelines

Doctors have a professional duty to care for the safety and wellbeing of their patients. Although good diagnostic and therapeutic skills are important in this regard, they can be let down by a poorly designed office environment, incompetent or uncaring staff, or an absence of clear and workable policies, protocols or guidelines to support your clinical work. If you arrange lab tests for a patient, for example, you need to feel confident that you will immediately be aware of any significant results.

Years of research and development in clinical risk management have demonstrated how protocols and recognised guidelines can help to control some of the most risky areas of practice (such as repeat prescribing and following up test results). We would advise you, though, not to introduce so many protocols that they become confusing or hard to remember, or prohibit the exercise of judgment where this may be necessary. It is best to introduce a judicious mixture of **policies** (which set out the guiding principles for staff to apply when exercising their judgment), **protocols** (which are a series of steps that must be followed without deviation) and **guidelines** (a description of the practice's preferred method of performing a task, or series of tasks).





## Policies

Policies are broad statements about principles, coupled with guidance for staff on how they're expected to comply with those principles. A confidentiality policy, for example, might start with a statement that the practice respects and upholds the principle of patient confidentiality, and why. It might then go on to describe in broad terms what this means in practice – eg, that all staff must sign a confidentiality agreement and that breaches of confidentiality are treated as serious offences; that patient information is not to be shared with third parties without the patient's consent; that information is only to be shared within the healthcare team on a need-to-know basis; that records are to be kept securely, etc. Try to make the policy as succinct as possible; save the finer details of implementation for your protocol and guideline documents.

Some of the areas for which you will need policies are listed in Box 9.

### Box 9: Policy areas

- confidentiality
- chaperones
- aggressive or violent patients
- child protection
- delegation and supervision
- employing locums
- advertising
- relationships with service suppliers
- complaints from patients and carers

## Protocols and guidelines

The difference between a protocol and a guideline is not always clear, the two words often being used interchangeably. For the purposes of this booklet, however, we make the following distinction:

**Protocols** provide staff with step-by-step rules that they must follow without deviation. They lend themselves to administrative systems that (a) can easily be standardised, and (b) represent an area of high risk for patients. The most obvious of these is test results, which are often implicated in incidents of avoidable harm to patients (see the case report on page 22 for an example).

**Guidelines** are less prescriptive descriptions of the general approach to take when dealing with situations where more variables are likely to be encountered. They

allow more room for personal and professional judgment. A guideline for obtaining consent to treatment is a good illustration of this: as each patient's circumstances is different, a step-by-step rigid protocol would not be flexible enough to accommodate those differences. A guideline, on the other hand, would make sure that you covered essentials like satisfying yourself that the patient has decisional capacity and ensuring that all the material risks and benefits have been discussed and noted in the patient's records, without dictating exactly how you should go about it.

### **Case report: A missed opportunity**

Mrs A, a 34-year-old school secretary, attended a new GP practice when she moved house. As part of her routine new patient health check, she had her urine analysed by the practice nurse and proteinuria +++ was detected.

Dr D saw Mrs A immediately after this and issued a repeat prescription for her long-term antidepressant medication. No comment upon the proteinuria or a plan of investigation was recorded in the notes. Dr D saw Mrs A one month later when she was having difficulty coping in her job due to depression and a family crisis. Again, no comment was passed upon the proteinuria.

Seven months after this, Mrs A came to see Dr E as she had suffered a few days of urinary frequency and urgency with dysuria. Dr E prescribed a course of trimethoprim, but did not ask for a urine sample. Dr E's record made no reference to the proteinuria detected at registration, so presumably he had not noticed. Mrs A saw Drs D and E for a range of unrelated minor complaints over the next three years. After an acute illness she was admitted to hospital and found to be suffering from acute-on-chronic renal failure of uncertain aetiology. Her condition progressed over the next few years to end-stage renal failure requiring dialysis, and ultimately she had a successful renal transplant.

Mrs A started a legal claim against both doctors, alleging negligence in failing to take notice of, or act upon, her significant proteinuria when she first registered with the practice.

### **Expert opinion**

A GP expert thought the practice's system for reporting new patients' abnormal urinalysis results was extremely flawed. Often the nurse wrote up her notes whilst the patient saw the doctor, and this information was placed in the file later.

Dr E was criticised for not looking back to check the recent urinalysis that he knew would have been conducted at the registration visit, when he saw Mrs A shortly after with a urinary complaint. Even if he had not done this, it was felt that repeat urinalysis and urinary culture should have been performed, given Mrs A's symptoms. The case was settled for a moderate sum.



© iStockphoto.com/SJ Locke

### Learning points

- Urinalysis is an extremely useful and inexpensive screening tool in both primary care and hospital outpatient/emergency settings for detecting occult diabetes or urinary-tract pathology. Unfortunately, its widespread use often leads to it being overlooked, being seen as something “that is just done”. It should be considered as an investigation result like any other, and failure to act upon an abnormality can lead to missed opportunities to treat or prevent serious disease.
- It is important to have systems in place that allow all the relevant information from a patient’s previous consultations, diagnoses, medication and recent investigations to be taken into account during a consultation. This is particularly important when patients first attend a practice, as information lost at this stage may cause and compound error in future visits.
- Dr E was criticised for not checking back to a previous consultation. It is good practice to review quickly what happened the last couple of times the patient was seen, particularly when seeing a new patient.

### Further information

A study of 400 clinical risk self-assessments carried out by MPS Risk Consulting in the UK in 2006 found that 84% of practices had risks associated with test results. These risks included:

- Not having a tracker system in place to ensure that patients are followed up.
- Not having a system in place to show when all of a patient’s test results have been returned.
- Not recording test results onto a computer.
- Allowing non-clinical staff to inform patients of their results and the treatment required.

This case report first appeared in *MPS Casebook*, 15(3) September 2007

Box 10 lists some of the functions and behaviours that should be controlled by protocols or guidelines; it is by no means an exhaustive list, but it includes the functions that typically contribute to adverse incidents if they are not running efficiently or effectively. Some functions – infection control, for example – may require a mixture of guidelines and protocols. You could use the list as a starting point for identifying the risks in your own practice. Invite staff to a brainstorming session to assess the level of risk posed by the various systems already in place and to identify where vital systems are lacking. You can then collectively design protocols and guidelines to minimise the risks. An example of the type of issue that might come up is the problem of maintaining patient confidentiality on the telephone. Some practices have solved this problem by issuing patients with unique identifiers, such as codewords or numbers, to use when they call for the results.

Once you've introduced a protocol or guideline, it should be dated and then reviewed at regular intervals to make sure it's working properly and to revise and refine it if any flaws are identified. In addition to scheduled monitoring, you should also carry out ad hoc reviews and adjustments to your protocols and guidelines whenever they're implicated in a complaint or adverse incident.

### Box 10: Examples of protocols and/or guideline-driven functions

Protocols	Guidelines
Prescribing	Obtaining consent to treatment
Elements of infection control such as hand-washing, cleansing and sterilising instruments, etc.	Referrals guidelines
Getting test results and informing patients	Dealing with difficult patients
Security of clinical records	Certificates
Access to records	Root cause analysis
Taking and passing on messages	Dispensing
Telephone consultations	Accommodating cultural differences
Handling pathology specimens	Offering and using chaperones
Referrals and arranging investigations	Infection control
Disposal of medical waste	Dealing with complaints
Storage of dangerous drugs	Confidentiality

It is important, when updating your policies, protocols and guidelines, to archive the older versions, all of which should bear a clear note stating both the date on which they were implemented and the date on which they were superseded. As there is

usually a considerable lag between an adverse incident and an ensuing negligence claim, evidence of the policies, protocols and guidelines in use at the time of an incident may prove to be crucial in defending a claim.

## Incident reporting system

Incident reporting has proved to be a useful tool in preventing error in high-risk industries, such as aviation, nuclear and petro-chemical industries. If an aviation incident occurs it is reported, investigated and lessons are learnt. Reporting when things go wrong is essential, as it explores the underlying causes of patient safety incidents. Your practice should have a systematic approach where staff know what type of incidents to report, what information is required and how to learn from it. Staff should feel they can report incidents without the fear of personal reprimand. A positive patient safety culture is one that has open communication, mutual trust, shared perceptions of the importance of safety and confidence in the efficacy of preventative measures.

## Health and safety

As a workplace, your practice comes under occupational health and safety legislation, which imposes certain obligations on you (even if you work alone). These are briefly set out in Box 11. While health and safety issues lie outside the benefits of MPS membership and have more to do with public liability and work compensation than with clinical negligence claims, we can give the following generic advice.

### **Box 11: Health and safety in the workplace**

Employers and the self-employed must make every effort to ensure health and safety in the workplace. Health and safety incidents must be reported to health and safety representatives and inspectors.

#### **Employer's duties**

All employers must –

- provide and maintain a safe, healthy working environment
- ensure workers' health and safety by providing information, instructions, training, and supervision
- inform health and safety representatives of – incidents, inspections, investigations, and inquiries.

Self-employed people must ensure that they, their workers, or others are not exposed to health or safety risks.

Department of Labour, [www.labour.gov.za/legislation](http://www.labour.gov.za/legislation)

A lack of attention to health and safety often contributes to adverse incidents involving patients, so the separation between this aspect of practice and clinical care is not always clear-cut. If you do not have suitable hand-washing facilities in your consulting and treatment rooms, for example, there will be a high likelihood of cross-infection between patients. Similarly, poorly maintained equipment may cause harm to patients if it malfunctions during a procedure.

It is therefore important that you make sure your physical work environment is a safe place not only for you and your staff and visitors, but also for patients. If you wish to carry out a risk assessment of your premises, you might find the NHS guide at [www.nice.org.uk/nicemedia/documents/has\\_riskassgps.pdf](http://www.nice.org.uk/nicemedia/documents/has_riskassgps.pdf) useful. Although it was written in the context of UK legal requirements, its focus is on assessing common hazards in general practices, so much of its content would be applicable in any country. The five steps to risk assessment are set out in Box 12 (these apply equally well to a clinical risk assessment).

### **Box 12: Five steps to risk assessment**

#### **Step 1** – Look for the hazards

A walk around the premises is useful here, but this step may also be informed by records of injuries or threats of violence, etc.

#### **Step 2** – Decide who might be harmed and how

Staff, patients, children, contractors and other visitors. Be particularly aware of risks to children – e.g. corrosive substances or sharps left within their reach, the condition of toys provided in the waiting room.

#### **Step 3** – Evaluate the risks arising from the hazard

Are existing precautions adequate? Are there shortcomings? Is it possible to eliminate the hazard altogether? Is staff training required (e.g. lifting techniques)?

#### **Step 4** – Record your findings

Make a record of each hazard identified, who is at risk, what precautions are in place, what needs to be done to improve or eliminate the risk.

#### **Step 5** – Assess the effectiveness of precautions

Undertake periodic reviews and investigate the underlying causes of untoward incidents, near misses and complaints.

NHS Health Education Authority, *Health and Safety in General Practice: A Guide to Risk Assessment for GPs and Practice Managers*, 1998)

# Clinical management of patients

## Diagnosis

A misdiagnosis is not necessarily negligent if the diagnosis seems reasonable, but doctors are expected to put themselves in a position to make a reasoned deduction to explain a patient's signs and symptoms. It is not always the rare-but-serious conditions that escape clinicians' diagnostic skills (although these probably account for a disproportionate number of claims); common conditions such as myocardial infarction can also be missed.

The overwhelming majority of clinical negligence claims in general practice arise from a failure to arrive at the correct diagnosis in a timely manner. There are many reasons for this. Sometimes the presentation is atypical or a disease is masked by another condition. Sometimes the patient is unco-operative or fails to turn up for appointments. Or the patient may have a rare disease whose symptoms mimic a common and less serious condition.

All of the above are understandable reasons for failing to reach a diagnosis, so a diagnostic failure in these circumstances can often be defended as long as the doctor applied reasoning based on the information available to him and made comprehensive notes. There are other reasons for failure to diagnose, however, that are less easily defensible, and that is usually because the doctor failed to gather the right information on which to base the diagnosis. The essential requirements for making a reasoned diagnosis are:

- Reviewing the most recent entries in the patient's records.
- Taking a relevant history.
- Carrying out an appropriate physical examination when necessary.
- Arranging appropriate investigations or a referral when necessary.
- Making adequate arrangements for follow-up.
- Being willing to revise your (or a colleague's) initial diagnosis if the clinical picture changes or the patient doesn't respond to treatment.

## Reviewing the most recent entries in the patient's records

It is good practice to review the last few entries in a patient's records just before a consultation. Sometimes there may be outstanding issues that should be followed up, but there will also be cases where you are seeing the patient for an ongoing problem that is not responding to treatment. As signs and symptoms may evolve between consultations, being able to compare earlier presentations with the current one can provide invaluable clues to a diagnosis.



## Eliciting a relevant history

This may include past medical history and family history as well as the history of the patient's presenting condition.

“The great majority of medical diagnoses, up to 90% in the case of chest pain, for example, are made on the basis of the history alone.”<sup>6</sup> By the same token, a great many diagnoses are missed simply because the doctor concerned didn't elicit a full history, thus missing crucial clues to the correct diagnosis (see the case report on page 29 for an example of the consequences of not asking the right questions or giving sufficient credence to the patient's reported symptoms).



### Case report: The red eye

Mrs O, a 54-year-old secretary with a history of migraine, developed a severe frontal headache, noticing flashing lights and cloudiness in her field of vision. These symptoms came on over about 24 hours. She consulted Dr R, who noted the symptoms of headache, 'misty' vision and red eye and diagnosed conjunctivitis, prescribing fusidic acid ointment.

By the next day Mrs O was much worse; she had an excruciating headache, photophobia and vomiting. Her vision was worsening and she requested a home visit. Dr M attended and noted that there was inflammation of the right conjunctiva.

Both corneas appeared normal and the pupils were equally reactive. She diagnosed migraine and gave Mrs O an intramuscular injection of diclofenac. Dr M advised Mrs O to attend the emergency department of her local hospital if things didn't settle within 48 hours.

Mrs O went to hospital two days later where acute angle-closure glaucoma was diagnosed. After pharmaceutical treatment she underwent a right-sided trabeculectomy a few days later. Mrs O's vision was seriously and permanently impaired in both eyes. She was registered partially sighted and her ophthalmologist anticipated that she would be registered blind within five years.

Mrs O made a claim naming Drs R and M, alleging a failure to suspect or diagnose acute glaucoma as the cause of her symptoms. A GP expert discussed the case with Dr M, who reported that Mrs O had not mentioned any problems with her vision; this, combined with the absence of corneal or pupillary signs, had led her to reject a diagnosis of acute glaucoma.

Despite this, the expert felt that Dr M's actions would be difficult to defend; even if this symptom was not volunteered, it should have formed part of Dr M's routine assessment, been directly asked about and documented in the notes.

Mrs O had given a clear history of visual cloudiness to Dr R on the preceding day. The expert felt that the combination of severe pain, visual impairment and red eye should have prompted Dr R to seek an emergency ophthalmological opinion after Mrs O's first presentation.

An ophthalmology expert concluded that the 48-hour delay in Mrs O's ophthalmological assessment had led to severe and irreversible damage to both eyes with no prospect of recovery.

The claim was settled out-of-court, and liability shared equally between the two GPs.

Based on *The Red Eye?* MPS *Casebook* 13(4) 2005.

## Carrying out a physical examination

This is usually a crucial component in formulating a reasoned diagnosis. It may seem that the patient has told you all you need to know in order to make a diagnosis, but a physical examination may provide you with more information, or at least confirm your initial impressions from listening to the history.

The cases we see at MPS where a failure to examine has proved crucial are usually where the practitioner has avoided a rectal or genital examination (as in the case reported below), but there are also plenty of cases where the doctor failed to examine a patient's throat or the fundus of the eyes, or to palpate an abdomen or listen to chest sounds, and therefore missed important clues.

### Case report: Lax examination

Mr B, a 46-year-old taxi driver, consulted his GP, Dr K, about pain in the rectum and constipation.

He mentioned that he had had infected piles before, for which he'd been prescribed antibiotics. Dr K was satisfied by the explanation of symptoms and wrote a prescription for laxatives and antibiotics. She did not examine the patient.

Three days later Mr B visited Dr K again, complaining of worsening pain and feeling unwell.

He reported profuse sweating and rigors. He said he had passed a small amount of motion, but was still experiencing rectal pain. Dr K checked his temperature and examined his abdomen, chest and ENT, which were all unremarkable.

She diagnosed resolving constipation and coincidental viral infection and advised Mr B to continue the antibiotics. She thought that the sweating might be a side effect of the Prozac Mr B was also taking and changed his prescription.

The following evening, Mr B's wife drove him to the emergency department as he was experiencing intense pain in his rectum. The cause was quickly diagnosed as a rectal abscess. Admission to hospital was organised and aggressive surgical treatment was required.

Mr B subsequently sued Dr K. A GP expert was critical of Dr K for her failure to carry out a rectal examination, which delayed the discovery of the abscess. The claim was settled for a substantial sum because Mr B would have required less radical surgery if he had been referred earlier.

## Chaperones

While their role is ostensibly to reassure patients, chaperones also protect doctors from false allegations of sexual abuse. You should, therefore, out of respect for the patient and for your own protection, always offer a chaperone when you intend to carry out an intimate physical examination, even if you and the patient are the same sex. Intimate examinations include examination of the breasts as well as the genitalia and rectum.

The issue of chaperonage is not always straightforward. For example, many patients reject the offer of a chaperone because they find it embarrassing to have another person present during an intimate examination. In most cases this is not a problem – just record in the patient's notes that a chaperone was offered and the patient declined the offer. Sometimes, though, you may feel that it is personally risky for you to proceed without a chaperone present. Although this is a difficult situation to deal with (to insist on a chaperone implies that you distrust the patient), you should trust your instincts and simply tell the patient that, because of the nature of the examination, you would prefer a chaperone to be present. If the patient still refuses, then you must decide whether to proceed without a chaperone or to suggest that the patient see another doctor. Such decisions are not an easy judgment call, but you should be particularly wary of carrying out an unchaperoned intimate examination if the patient has any of the following problems:

- a history of sexual abuse
- apparent difficulty in recognising professional boundaries
- mental impairment
- mental instability.

If you do decide to go ahead, be scrupulous in your documentation.

In all cases, you should explain carefully to the patient what the examination entails and why it is necessary. You should also take care to preserve the patient's dignity and privacy by the use of gowns, drapes and screens.

If a chaperone is present during an examination, record their identity and status in the patient's notes. If you offer a chaperone, and the patient declines, you should record this fact too.

Ideally, the chaperone should be someone with clinical training, such as a nurse. If no clinically trained assistant is available, it may be necessary to use a member of the patient's family as a chaperone, but this is far from ideal.

If a suitable chaperone is not available, you will have to make a judgment as to whether the examination can be postponed until appropriate arrangements can be made. In an emergency you may have to proceed without a chaperone. If so, record your decision and the reason for it in the patient's notes.

You may sometimes find yourself seeing patients when no-one else is present on the premises at all. Although this is a less than ideal situation that you should avoid if at all possible, you should place your patients' needs first.

## Maintaining an open mind – being willing to revise an initial diagnosis

This is an aspect that cannot be overstated. MPS case files stand testimony to the many instances in which a patient’s failure to respond to treatment is plainly indicating that it is time to review the diagnosis, yet the patient’s doctors blindly persist with it (the case report on page 32 is a good example). This is a cognitive weakness that all clinicians should be aware of and guard against. Experts in human factors call the phenomenon “diagnostic fixation”, and have described it in the following terms:

*“When examined in retrospect, the factors that led to a missed or significantly delayed medical diagnosis often seem starkly conspicuous:*

- *a quick, confident diagnosis was made*
- *contrary evidence that kept presenting was ignored.”<sup>7</sup>*

The “quick, confident diagnosis” is usually made by employing heuristics (in other words, a “rule of thumb”). Heuristics, while useful, may easily lead one astray because they depend on a range of cognitive biases, a few of which are described in Box 13. So, if you diagnose using heuristics (which almost all doctors do), it is imperative that you do not fixate on your initial diagnosis and remain open to new information that may contradict it.

### Box 13: Heuristics-based diagnosis

Shortcuts in reasoning occur on a subconscious level, employing a variety of heuristics. Some of those commonly used in diagnosis are:

- **Availability heuristic** – likelihood is judged by how easily examples spring to mind.
- **Anchoring heuristic** – the tendency to stick with initial impressions.
- **Premature closure** – failure to pursue several alternatives.
- **Framing effects** – different decisions made depending on how information is presented.

Redelmeier D, The Cognitive Psychology of Missed Diagnosis, *Annals of Internal Medicine* (2005)

### Case report: Turning a deaf ear

E was a 12-year-old girl who had been complaining of earache for a week after coming back from an activity holiday. Despite taking paracetamol suspension, the pain persisted and her mother, Mrs K, brought her along to be reviewed by

her regular GP, Dr T. E was well known to Dr T as he had seen her on a number of occasions with mild asthma. Dr T documented the history of pain in her right ear. She was noted to be afebrile and systemically well, with a normal appetite.

The only abnormal examination finding was debris and inflammation in the right external auditory meatus. E was diagnosed with otitis externa and prescribed topical antibiotic drops, as well as regular paracetamol suspension. Mrs K was given advice about helping E to avoid getting water in her ear, and to avoid swimming until the symptoms had cleared up.

Despite the drops the earache continued and Mrs K brought E to the practice again four days later to see another GP, Dr A. The history was recorded as persistent, offensive discharge from the right ear as well as continuing pain. A swab was taken and sent for culture. A course of oral antibiotics was prescribed for what was felt to be persistent otitis externa.

Unfortunately, despite both topical and oral antibiotics E's symptoms continued over the ensuing weeks. During this time E was brought in by her parents on multiple occasions and she was reviewed by a number of different GPs at the practice. Mr and Mrs K became increasingly concerned regarding their daughter's ongoing symptoms.

Six weeks after E had seen Dr T for the first time, he reviewed her again. Dr T checked the swab result, which had shown a growth of pseudomonas. It was noted that the pseudomonas was sensitive to the antibiotics that had been given to E at the last consultation. On this occasion Dr T documented that the ear discharge had persisted for several weeks and noted it to be blood-stained on otoscopy. Dr T then prescribed both antibiotic ear spray and drops.

Finally, eight weeks after the first presentation, E saw Dr S who referred her to an ENT consultant. Detailed otoscopy suggested an abnormality in the appearance of the tympanic membrane, and an urgent CT was requested. Sadly this revealed a cholesteatoma and surgical treatment was necessary. E was left with permanent hearing loss in her right ear. A claim was started against several of the doctors involved in this case.

### **Expert opinion**

On reviewing the notes it was found that none of the doctors had documented whether or not the tympanic membrane was visible, and no-one had commented on any associated hearing loss. GP experts were highly critical of the care provided by the GPs involved. It was felt that such a long history of discharge (especially blood-stained) should have raised suspicions of a cholesteatoma. Prompt specialist opinion should have been sought when the symptoms failed to resolve. The case was settled for a moderate sum.

## Keeping comprehensive and contemporaneous clinical records

Thorough documentation is crucial, not only in the interests of good continuity of care, but also to show (in the event of a claim) the facts on which you based a decision. At MPS we have also seen many cases where the doctor did examine the patient, but either did not document it at all, or did not document the important findings – especially significant negative findings.

Many serious illnesses do not start out as typical presentations but can develop quickly, so a note in the records that a diagnosis was excluded because specific signs or symptoms were absent can provide crucial evidence in defence of a claim in negligence. Examples might be the absence of neck stiffness in a young person with a severe headache and fever, or the absence of muscle guarding in a case of abdominal pain.

Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should therefore be comprehensive enough to allow a colleague to carry on where you left off.





Poor-quality medical records are not only a major cause of iatrogenic injuries, they also make it difficult to defend a clinical negligence claim or a Council disciplinary inquiry; it is axiomatic that poor note-keeping is evidence of poor clinical practice. All of the following can compromise patient safety or lead to medicolegal problems:

- Not recording negative findings.
- Not recording the substance of discussions about the risks and benefits of proposed treatments.
- Not recording drug allergies or adverse reactions.
- Not recording the results of investigations and tests.
- Illegible entries.
- Not reading the notes when seeing a patient.
- Making derogatory comments.
- Altering notes after the event.
- Wrong patient/wrong notes.

To be useful, the medical records should contain all the significant information that members of the healthcare team, or future carers, will need in order to be sufficiently informed about the patient's past and current clinical assessments and treatment and relevant family and social history, lifestyle and beliefs. The Health Professions Council considers the following as the absolute minimum necessary for each patient's records:

- Personal (identifying) particulars of the patient.
- The bio-psychosocial history of the patient, including allergies and idiosyncrasies.
- The time, date and place of every consultation.
- The assessment of the patient's condition.
- The proposed clinical management of the patient.
- The medication and dosage prescribed.
- Details of referrals to specialists, if any.
- The patient's reaction to treatment or medication, including adverse effects.
- Test results.
- Imaging investigation results.
- Information on the times that the patient was booked off from work and the relevant reasons.
- Written proof of informed consent, where applicable.<sup>8</sup>

To this we would add, from a medicolegal and risk-management perspective:

- All important positive and negative findings from the consultation with the patient. Information about the presence or absence of certain signs or symptoms at different stages in the course of a patient's illness is not only important for forming a picture of the development of the patient's condition, but can be crucial in defending any future medicolegal challenges.
- Differential diagnosis, including reasons for ruling out (or preferring) a potential diagnosis.
- Details of discussions with the patient about the risks and benefits of proposed treatments, including the risks of no treatment, costs and any information given to them in this regard (eg, patient information leaflets).
- Any advice or warnings given to the patient – not to drive while taking certain medication, for example.
- Arrangements for follow-up tests, future appointments and referrals made.
- Any instructions or advice given to the patient. It is particularly important to make a note of any instructions you give to patients about what to do if their symptoms change, persist or worsen, such as returning for another consultation.

For the sake of good continuity of care, patients' records should be kept as up to date as possible, which means that information should be added to the patient's notes as soon as it becomes available. It is good practice to make a habit of noting information as it arises so that it is not lost if something happens to distract your attention – eg, an emergency, a phone call, or an interruption by a colleague.

## Abbreviations

Abbreviations are commonly used in medical records but can be misinterpreted and lead to mistakes in diagnosis or management. So the rule is, when in doubt, write it out – in full. Sarcastic and derogatory abbreviations have no place in medical records – acronyms like FAS (Fat and Stupid) are gratuitously offensive and sure to destroy any therapeutic relationship if the patient discovers their meaning.

## Alterations

Once an entry has been made in a medical record, it should not be deleted or obliterated, even if it is later found to be erroneous or misleading. If you need to make a correction, use a single black line to cross out the error and then add the amendment and your signature, name (in block capitals) and the date and time.

## Follow-up arrangements

British GP, Roger Neighbour, introduced the notion of “safety-netting” in his 1987 book, *The Inner Consultation*, and a great many GPs have since incorporated this simple technique into their daily practice. In essence, safety-netting is the art of managing uncertainty by developing the habit of asking yourself three questions and making contingency plans based on the answers.

The three questions are:

- If I’m right, what do I expect to happen?
- How will I know if I’m wrong?
- What would I do then?

One of the more obvious – and effective – strategies for dealing with this sort of uncertainty is to tell the patient what sort of changes to look out for (eg, side-effects, no improvement, condition worsening, etc) and what to do about them if they occur. It might even be as simple as saying “If it’s no better in ten days, come back and see me”.

On the subject of informing patients about side-effects, sometimes you may need to issue a warning to the patient. For example, a patient taking warfarin should be warned not to take St John’s Wort, which is known to interact with warfarin. Patients should also be warned not to drive or use machinery when taking drugs that cause drowsiness.

You should make a note in the patient’s records about any warnings or instructions you give the patient.



## Safe prescribing

### Time

It takes time to make sure that the patient understands what the medication is intended to do, how to take it properly, what side-effects it may have and what to do if they appear, etc. Gaining informed consent for medication is as important as it is when discussing a procedure. And the issue is not “giving information” but ensuring that the patient has received the information, absorbed it and acquired it as knowledge. Compliance rates are much higher when patients understand why their medication was prescribed and how to take it properly.

### Prescribing for children

While all the general advice on avoiding medication errors applies to both children and adults, special care is needed when prescribing, preparing and administering drugs to children. Drugs that are relatively innocuous in adults may have adverse effects in children. Variations in height, weight and body mass can make them more susceptible, or they may quickly accumulate toxic levels as a result of lower metabolism and excretion. In many cases referred to MPS, errors occurred because the doctor failed to check the appropriateness of the drug and its route of administration in children or infants, or to prescribe the correct dose.



## Advice for safer paediatric prescribing

- Refer to a paediatric formulary when appropriate.
- Limit the drugs you use to a well-trying few and familiarise yourself with their dosages, indications, contraindications, interactions and side-effects.
- When writing a prescription, include the child's age and write the exact dose in weight and (if liquid) volume required for administration.
- Always calculate doses on paper and, if possible, get a competent colleague to check your arithmetic.
- Check the units – eg, should it be micrograms or milligrams?
- When writing the dosage, take special care not to lead with a decimal point – put a zero in front of it, eg, 0.2mg.
- Never abbreviate micrograms.
- For amounts less than 1 milligram, prescribe in micrograms to avoid confusion over the placing of decimal points.
- When prescribing for a child, it is particularly important to give the parents all relevant information such as:
  - The name of the drug.
  - The reason for the prescription.
  - How to store and administer the drug safely (if appropriate).
  - Common side-effects.
  - How to recognise adverse reactions.

## Acting within your competency

Unless the situation is a life-or-death emergency, you should not carry out procedures or treatment on patients if you lack the necessary skills or knowledge. This is particularly relevant for purely elective surgical procedures such as cosmetic surgery.

## Non-clinical attributes

While a combination of safety-aware systems and good clinical skills will go a long way towards creating a safe service for your patients, there is a third, crucial, component that glues it all together. This sphere of practice is commonly referred to as non-technical skills and is defined as “The cognitive, social and personal resource skills that complement technical skills and contribute to safe and efficient task performance”.<sup>9</sup>

While much of the research carried out to date on non-technical skills for clinicians has focused on high-risk specialties, generic attributes such as good communication skills and the ability to reflect and learn are applicable in any healthcare setting.

## Communication skills

### The patient’s agenda

Ideas, concerns, expectations (ICE)  
Feelings, thoughts, effects  
Understanding of his/her feelings

### The doctor’s agenda

Signs and symptoms  
Investigations  
Differential diagnosis

As the above table illustrates, patients and doctors tend to approach the consultation with markedly different agendas – a situation that can easily lead to misunderstandings, frustration and disappointment unless the needs of each party are met.

Most experts in the art of communication with patients agree that it’s important to find out what the patient’s ideas, concerns and expectations are (ICE). Patients hold all sorts of beliefs – about the nature of illness, about their bodies and about treatments – about which their doctors are often blithely unaware. These hidden attitudes and beliefs may determine the degree to which they comply with treatment. In the UK, for example, it has been estimated that between 30% and 50% of patients do not take their prescribed medicine as recommended and, very often, the prescribing doctor is completely unaware of the fact.<sup>10</sup>

Patients may also harbour unrealistic expectations about the outcome of treatment. If there’s little chance of returning a patient to full health without any residual problems, you should discuss these limitations openly so that the patient is spared the experience of unfulfilled hopes (or at least experiences them early enough to come to terms with the news while treatment is still ongoing). Quite apart from your professional obligation to obtain informed consent to treatment, preparing patients for less than optimal outcomes is not only humane but also an effective risk-management measure. Angry, disappointed patients are far more likely to sue when the outcome of clinical care fails to meet their expectations.



## Taking time to listen

An often-quoted study from the 1980s<sup>11</sup> in which researchers observed GP consultations, found that doctors were interrupting patients an average of 18 seconds into a consultation. A second, and larger, study carried out 12 years later by Marvel et al<sup>12</sup> found that the mean time before the patient was 'redirected' by the doctor was 23.1 seconds. Most of the redirections occurred after the patients had expressed their first concern, and this then became the focus of the ensuing consultation regardless of whether the patient considered it the most important of the concerns he/she wished to raise. "Once the discussion became focused on a specific concern, the likelihood of returning to complete the agenda was very low (8%)."<sup>13</sup>

Apart from the obvious risk of missing important and relevant information, consultations conducted along these lines often take longer than they need to.

Assume that each patient attends the consultation armed with at least three concerns that they want to address (research indicates that this is about right). Most people will rehearse in their heads what they want to tell you, and the order in which they want to tell it – ie, they have an agenda. If you interrupt that agenda, or divert them from it, the likelihood is that the patient will, in attempting to deliver the pre-rehearsed story, start repeating him/herself, forcing you back over ground already covered. It is also likely that the first concern mentioned is inconsequential compared to others, and if you seize on it as the reason for the consultation you will be using up valuable time that could be better employed exploring the real problem.

It may seem risky just to let the patient talk until he/she runs out of steam, but in fact Marvel et al found that when patients with one or more concern were given the opportunity to give a full account at the outset of the consultation, the time taken averaged only 32 seconds.

Marvel et al concluded that: "Given the relatively small proportion of the interview needed to clarify the patient's concerns, the related decreased likelihood of late-

arising concerns and the difficulty of exploring new concerns late in the visit, our data support complete agenda setting as an efficient manner to open the medical encounter.

“Despite concern that a patient-centered approach will take more time, our study further reinforces that soliciting all of the patient’s concerns does not decrease efficiency. Using a simple opening solicitation, such as ‘What concerns do you have?’ then asking ‘Anything else?’ repeatedly until a complete agenda has been identified appears to take six seconds longer than interviews in which the patient’s agenda is interrupted.

“One style that seemed useful was to follow each open-ended solicitation with a focused open-ended question (eg, ‘Tell me more about the leg pain’), then revert back to another open-ended solicitation (eg, ‘Anything else?’) before moving into closed-ended questioning and the examination.”<sup>14</sup>

### **Box 14: Active listening skills**

**Open ended questions** – Questions that cannot be answered in one word require patient to expand.

**Open-to-closed cones** – Move towards closed questions at the end of a section of the consultation.

**Checking** – Repeat back to patient to ensure that you have understood.

**Facilitation** – Encourage patient both verbally (“Go on”) and non-verbally (nodding).

**Legitimising patient’s feelings** – “This is clearly worrying you a great deal,” followed by, “You have an awful lot to cope with,” or, “I think most people would feel the same way.”

**Surveying the field** – Repeated signals that further details are wanted: “Is there anything else?”

**Empathic comments** – “This is clearly worrying you a great deal.”

**Offering support** – “I am worried about you, and I want to know how I can help you best with this problem.”

**Negotiating priorities** – If there are several problems draw up a list and negotiate which to deal with first.

**Summarising** – Check what was reported and use as a link to next part of interview. This helps to develop a shared understanding of the problems and to control flow of interview if there is too much information.

Gask and Usherwood, ABC of Psychological Medicine: The Consultation, *BMJ* 324 1567–8 (2002)





© Alex Orrow (2011)

## Update your skills

If you think your communication skills could do with some work, you may be interested in attending one of the following MPS workshops.

*Mastering Your Risk* – A highly interactive and internationally renowned workshop attended to date by 10,000 doctors in eight countries. International research shows doctors can reduce the risk of litigation by improving communication skills and better managing patient expectations.

*Mastering Adverse Outcomes* – This workshop highlights the importance of recognising patient expectations when an adverse outcome occurs, and how failing to address them can increase the risk of the patient turning to legal and disciplinary processes for answers and accountability.

*Mastering Professional Interactions* – Learn how to reduce the incidence of communication breakdown between doctors, which is one of the commonest causes of patient harm.

All of the above workshops are free for MPS members in South Africa. They were developed specially for doctors by the Cognitive Institute in Australia and are an effective and engaging way of improving your communication skills. And, as an added bonus, you can earn yourself six CEU (CPD) points by attending the course.

You can find out more about the workshops either by going to the MPS website – [www.mps-group.org](http://www.mps-group.org) – and clicking on the Advice and Education tab, or by emailing Enid Dettmer at [enid.dettmer@mps-group.org](mailto:enid.dettmer@mps-group.org).

## Ability to reflect and learn

Under the terms of your registration with the Health Professions Council, you are obliged to continually update your professional knowledge and skills. This usually means enrolling in some kind of formal learning programme on a subject relevant to your clinical practice in order to earn credits.

Successful CPD depends to a great extent on planning, and good planning is predicated on an accurate assessment of learning needs. Before you can assess your learning needs, however, you need to identify them – something that’s not always that easy to do because it means finding out what you don’t know that you don’t know or, as Maslow put it, your unconscious incompetence.

Abraham Maslow published his model of the four stages of learning back in the 1940s, and it’s still widely employed by educationists. It’s a simple model – two axes (unconscious – conscious and incompetent – competent) give rise to a matrix comprising four quadrants, as illustrated below. In many respects, getting from the first stage – unconscious incompetence – to the second stage – conscious incompetence – is the most difficult transition because, by definition, we’re not conscious of the deficits in our competence.

### Box 15: Maslow’s four stages of learning

	Unconscious	Conscious
Incompetent	<b>Not aware of a skill you lack</b>	<b>Aware that you lack a skill</b>
Competent	<b>So skilled that you no longer have to even think about it</b>	<b>Actively working at a skill although it requires a lot of thought</b>

Many of these deficits will naturally advance into the realm of conscious incompetence as you come face to face with them in your daily practice, or because you’re made aware of new information through reading journals and talking to colleagues. Others, though, are harder to uncover and you will need to employ various techniques to identify your shortcomings. The best ways to find out where you’re falling short are either to measure your performance against an accepted standard (auditing), or to get feedback from colleagues and patients. Sources of information might be formal or informal, planned or unplanned, and although some might arise from solitary reflection, most require some form of feedback from colleagues, patients or others.

## Keeping mistakes in perspective

Even though we all know that to err is human, few of us can easily accept our own mistakes. This is probably more the case in healthcare than in most other occupations, because errors can have such serious consequences. In a survey of MPS members who had experienced untoward incidents in their practice, almost all of them found that it shook their confidence and eroded their job satisfaction. Complaints from patients tended to be taken as personal attacks, with the doctor feeling angry, hurt and betrayed. Some of these effects lasted for years.

The intensity and duration of the emotional aftermath does not seem to relate closely to the seriousness of the error or the nature of the complaint; the crucial factor is the ability of the individual doctor to put the experience into perspective and seek out practical and emotional support. Lessons can be drawn from this:

- Assess the circumstances realistically – don't blow an error or a complaint out of all proportion; remind yourself of all the things you do get right and all the patients who are satisfied with your care.
- Talk the matter through with trusted colleagues and friends who can both empathise with you and give you a realistic assessment of the situation.
- Contact MPS for practical assistance in dealing with a complaint or claim and for advice about handling the emotional repercussions.
- Learn from the situation. If you did make a mistake, acknowledge it. Report it as an adverse incident and engage with your colleagues in developing strategies to prevent similar errors occurring in the future.
- If you have been unjustly accused of substandard care, think what may have brought the accusation about – was it a communication problem, for example? How might you have handled it differently?
- If a patient has complained about you, try not to react defensively by avoiding the issue or making counterthreats. Comply with your practice's complaints procedure and be prepared, if you have made a mistake, to give the patient their due – a full face-to-face explanation, a sincere apology and an assurance that you will take steps to avoid a repetition of the problem.
- If, after the complaint has been investigated, it is evident that the complaint has no foundation, you should still see the patient and explain the outcome of the investigation, give a full account of events and try to ascertain whether the complaint has been caused by a misunderstanding that you can put straight.
- Patients expect a great deal from their doctors, not least of which are superhuman abilities. This means that you are almost certain to disappoint some of your patients some of the time. All you can hope to do in the circumstances is to try and turn negative experiences into positive learning opportunities, thus refining your skills and building, rather than eroding, your confidence.

## Appendices

### Appendix 1: List of ethical rules, regulations and policy guidelines published by the HPCSA

Booklet 1: *Guidelines good practice*

Booklet 2: *Generic Ethical Rules with annexure*

Booklet 3: *Patients' Rights Charter*

Booklet 4: *CPD Guidelines Final*

Booklet 5: *Perverse Incentives*

Booklet 6: *Generic Ethical Guidelines for Researchers*

Booklet 7: *Medical Biotechnology Research*

Booklet 8: *Biological Warfare*

Booklet 9: *Informed Consent*

Booklet 10: *Confidentiality Protecting and Providing Information*

Booklet 11: *Guidelines for good practice with regard to HIV*

Booklet 12: *Guidelines withholding and withdrawing treatment*

Booklet 13: *Reproductive Health*

Booklet 14: *Keeping of Patient Records*

Booklet 15: *Canvassing of patients abroad*

Booklet 16: *Health care waste management*

Copies of the booklets may be ordered directly from the HPCSA by calling **+27 12 3389300** or downloaded from the HPCSA's website at **[www.hpcs.co.za/conduct\\_generic\\_ethical\\_rules.php](http://www.hpcs.co.za/conduct_generic_ethical_rules.php)**

## Appendix 2: Assessing decisional capacity

When assessing a patient's decisional capacity, you should be seeking to answer three questions:

### **Question 1 – Does the patient have a mental disorder?**

Bear in mind that a mental disorder may be permanent, temporary or fluctuating. If it is temporary, and the decision is not urgent, then defer it until the patient has regained capacity.

Look for and treat any underlying physical conditions that might be causing temporary incapacity (eg, an elderly patient with a urinary tract infection is confused, but regains her lucidity once the infection has been treated).

If the patient's mental capacity fluctuates, try to time your assessment to coincide with his most lucid periods. The patient's carers will probably be able to help you identify the best time of day for such a discussion.

### **Question 2 – Is the patient able to make the decision in hand?**

Assuming you have reasonable grounds for believing that the patient has a mental disorder, your next task is to decide whether, on the balance of probabilities, it has rendered the patient incapable of making a decision.

While a checklist might be useful for guiding you through the process and for recording your main findings as you go, the assessment itself is not a tick-box exercise. It is a dialogue in which you and the patient impart information to each other and on which you base your judgment of the patient's understanding and thought processes.

Unless the patient is limited to yes/no answers (eg, blinking), you should try to frame as many of your questions as you can in an open-ended format.

Bear in mind that you are not judging the patient's eventual decision; you are assessing the thought processes that led to the decision. In other words, it is not what patients decide that determines their capacity, but how they reached the decision. If the decision-making process is consistent with the patient's beliefs and values and is logically coherent, the patient is demonstrating mental capacity, even if the decision may seem unwise.

You should make all reasonable efforts to help the patient make a decision. It is important to document any measures you take to help the patient in this regard. This would include things like choosing an appropriate, non-threatening location, allowing sufficient time to explain the issues carefully and to listen to the patient's response, the presence of someone the patient trusts, the assistance of a speech therapist or any communication tools and visual aids you employ.

Remember, mental capacity is decision-specific, so the assessment should focus on the patient's understanding and processing of information relevant to the decision in hand. Relevant information includes the nature of the decision, why a decision is needed and the likely effects of deciding one way or another, or making no decision at all. How you convey such information is important. It should be formulated in such a way as to make it as easy as possible for the patient to understand, using whatever tools and media are necessary to aid the patient in accessing the information.

To arrive at a decision, the patient must be able to do three things with the information:

1. **Understand** it.
2. **Retain** it.
3. **Weigh** it.

The patient must then be able to communicate his or her decision.

It is not always necessary to go into detail when explaining the relevant facts and options. Where the decision is unlikely to have serious consequences, if the patient can grasp the essentials in broad terms, they can be considered to meet the first criterion of understanding. The more serious the nature of the decision and its consequences, the more detailed the information you will need to share and the patient to comprehend.

The issue of retention of information can be difficult, especially if a patient has problems with short-term memory. There are two aspects of retention that you might need to address.

1. Is the patient able to retain the information for long enough to weigh it in the balance and arrive at a decision? This might not be a problem if the decision in hand is quite straightforward and can be made quickly, but if it is a question that needs mulling over, the patient might be incapable of retaining the information for long enough to do so. Aids such as photographs, audio and video recordings, notebooks and posters may help the patient with the process. If it's appropriate, enlist the help of relatives and carers to support the patient through the decision-making process.
2. Is the patient able to make a decision, but then forgets about it? If so, all is not lost as long as the patient is consistent in their decisions. Consistency is tested by seeing if the patient makes the same decision when re-presented with the relevant information.

If you are satisfied that the patient has a sufficient understanding of the relevant information, and can retain it long enough to make a decision, the next thing to assess is his or her ability to weigh the information. What you should focus on here is not the outcome – ie, the actual decision, but on the process of getting there. Is

the patient weighing the options in the context of his or her personal preferences, values and beliefs? Are those expressed values and beliefs consistent? (Remember, family members and close friends can be an invaluable source of information about the patient's previously held beliefs, values and likely wishes.)

When questioning the patient during this part of the test, you will probably focus more on ascertaining his or her feelings than you did in your earlier testing of understanding. Try to arrive at an understanding of the patient's own priorities (eg, how important is it to the patient to preserve his or her dignity? How highly does the patient value his or her independence? Is mobility a high priority? How about pain control?). Does the patient take these priorities into account when weighing his or her decisions in the balance?

### **Question 3: Can the patient communicate their decision?**

Communication really belongs at the top of the list because it is not just the end point of the process (ie, the patient must be able to communicate his or her decision), but is a prerequisite of everything else that occurs. If you can't communicate in a way that the patient understands, or if the patient can't communicate with you, it's just not possible to test his or her understanding, retention or weighing of information. The most extreme example of this would be a patient in a coma, or in a persistent vegetative state. But in the vast majority of cases where the patient has a degree of mental capacity, some means of establishing communication is possible, even where the patient is severely incapacitated physically. They may be limited to indicating "yes" and "no", but this limited means of communication should not, of itself, be considered sufficient reason to decide that they lack mental capacity.

## References

1. Constitution of the Republic of South Africa 1996, section 14(d).
2. National Health Act 2003, section 14(1).
3. MPS, *MPS Guide to Ethics: A Map for the Moral Maze*, p18. (2011).
4. CRICO, *Strategies for Patient Safety* (Oct 2008).
5. HPCSA, *Guidelines on the Keeping of Patient Records*, (2007) para 4.
6. Flin RH (2008), quoted in Long S, Arora S, et al, Qualities and Attributes of a Safe Practitioner: Identification of Safety Skills in Healthcare, *BMJ Qual Saf* 20: 483-90 (2011).
7. NICE, *Medicines Adherence: Quick Reference Guide* (January 2009).
8. Marvel MK, Epstein RM, Flowers K et al Soliciting the Patient's Agenda, *JAMA* 281 (3): 283-7 (1999).
9. Ibid, p286.
10. Marvel et al, p286.
11. Ibid
12. Van Wyk v Lewis 1924 AD 438 444.
13. HPCSA, *Seeking Patients' Informed Consent: The Ethical Considerations*, second edition (May 2007), para 3.1.4.
14. Hasnain M, Bordage G et al, History-taking Behaviors Associated with Diagnostic Competence of Clerks: An Exploratory Study, *Academic Medicine* 76(10) October Supplement (2001).



# Notes

A series of 20 horizontal dotted lines for writing notes.

# Notes

A series of horizontal dotted lines for writing notes.

Helping members in **South Africa**  
for more than **50 years**



Putting members **first**



## Medicolegal advice request form now online for MPS members in South Africa

[www.mps-group.org/za-mla](http://www.mps-group.org/za-mla)

**To help us provide you with assistance  
as quickly as possible please use the  
medicolegal contact form on our website.**

The form is secure and confidential – allowing you to give us your MPS membership details and a brief explanation of an incident. The information you provide comes directly to MPS and the receipt of the form will be acknowledged by email immediately.

On the next working day we will open a new case for you and we will contact you as soon as possible to discuss the matter further.

If you need immediate advice please call our toll free telephone: **0800 982 766**.

MPS ONLINE REPORTING FORM  
[www.mps-group.org/za-mla](http://www.mps-group.org/za-mla)

You can scan this quick  
code to access the incident  
form on your mobile device



For questions about your MPS membership you can continue  
to call **0800 225 677** or email your query to [mps@samedical.org](mailto:mps@samedical.org)

To find out more visit [www.mps-group.org](http://www.mps-group.org)



**MPS** Putting members **first**

**www.mps-group.org**

### **South Africa medicolegal advice**

**www.mps-group.org/za-mla**

To help us to provide you with assistance as quickly as possible please use the medicolegal contact form on our website.

The form is secure and confidential – allowing you to give us your MPS membership details and provide a brief explanation of an incident. The information you provide comes directly to MPS and the receipt of the form will be acknowledged by email immediately.

On the next working day we will open a new case for you and we will contact you as soon as possible to discuss the matter.

**T** 0800 982 766 (toll-free within SA)  
**E** medical.rsa@mps-group.org

In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

### **South Africa membership enquiries**

Ian Middleton

**T** 0800 118 771 (toll-free within SA)  
**E** mps@global.co.za

Alika Maharaj

**T** 083 277 9208 (cell phone)  
**E** mps@iburst.co.za

South African Medical Association

**T** 0800 225 677 (toll-free within SA)

The Medical Protection Society is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

The Medical Protection Society Limited. A company limited by guarantee.  
Registered in England No. 36142 at 33 Cavendish Square, London, W1G 0PS