MEDICAL PROTECTION SOCIETY
PROFESSIONAL SUPPORT AND EXPERT ADVICE

MPS

Putting members **first**

Common Problems

Managing the Risks in Hospital Practice in South Africa

www.mps-group.org

Contents

Important – please note

Due to the dynamic nature of medical law we suggest that you access our website at **www.mps-group.org** for the most up-to-date information. August 2012.

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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.

Introduction

At MPS, we have a wealth of experience and expertise in helping doctors and other healthcare professionals with ethical and legal problems, and in reducing the risks that arise from their practice of medicine. This gives us a unique insight into the reasons why things go wrong and why complaints and litigation occur, and into what can be done to reduce this.

In our experience, most incidents leading to medicolegal problems fall into one of the following categories:

- Failure to appreciate legal and professional responsibilities
- Problems in clinical management
- Systems and resourcing problems
- Failure of communication.

Understanding your legal and professional responsibilities

Because the practice of medicine is so intimately concerned with people's bodies, personal vulnerabilites and well-being, 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.

Patients' rights include:

- "a healthy and safe environment
- participation in decision-making
- access to health care services which include:
  - receiving timely emergency care
  - treatment and rehabilitation
- confidentiality and privacy
- informed consent
- refusal of treatment
- be referred for a second opinion
- continuity of care
- complain about health services."

Patients' responsibilites include:

- taking care of their health
- not abusing the healthcare system
- providing healthcare providers "with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes"
- telling their healthcare providers what their wishes are regarding their death
- complying with treatment
- taking care of health records in their 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 healthcare

Abortion and Sterilisation Act 1975

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 the 1924 case *Van Wyk v Lewis*, 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 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. Most of these increases have been seen in the riskier specialties such as obstetrics, spinal surgery, neurosurgery and neonatology.

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 overleaf). If they don't, they may be subject to discipline by the Council.

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.

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.)

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 is to have the doctor's name removed permanently from 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 or 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 four-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 permanently from the register.

(HPCSA, Finalised Matters January to December 2011 www.hpcsa.co.za/conduct_guilty_verdicts.php)

Ethical considerations

The medical profession subscribes to a strict code of ethical conduct; breaching any of its principles 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 bring about a hoped-for improvement.

Those who have researched the subject seem to agree that the most appropriate situations for adopting shared decision-making are 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 may be much easier to defend your position if an allegation of negligence following the development of a non-negligent complication 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, obligations of such refusal.

"The healthcare provider concerned must, where possible, inform the user ... in a language that the user understands and in a manner which takes into account the user's level of literacy."

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 could not make an informed decision in the absence of all the information.

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. 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." [1]

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.

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.)

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.)

Scenario

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 it has become more intense and is affecting his ability to work. His GP refers him to the orthopaedic outpatient's clinic at the local hospital where he is seen by Dr J. Dr J examines Mr H's knee and recommends an intra-articular steroid injection. He is aware that Mr H is self-employed and needs to be able to return to work as soon as possible, so 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 clinic appointment for another two weeks, 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.

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 scenario on page 12 for an example of how easily an attempt to allay a patient's concerns may develop into coercion.

When patients lack capacity

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 (see page 16) 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.

Emergencies

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. Legal action against doctors providing treatment without consent in an emergency is extremely rare. In genuine emergencies, do not hesitate to provide immediately necessary treatment unless there are clear indications that the patient would object to the treatment.

Children

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. 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.)

> *"When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account."*

(UNICEF, *A summary of the Convention on the Rights of the Child*, Article 12)

End of life decisions

When patients are seriously ill and lack the decisional capacity to make medical decisions on their own behalf, healthcare professionals are obliged to make treatment decisions in the patient's best interests. This might include choosing not to intervene if a treatment or procedure would be burdensome and with little benefit to the patient.

Not all terminally ill patients lose their decisional capacity, and in this case the same principle applies as with treatment for all competent adults – healthcare professionals should respect and – as far as possible – comply with the patient's wishes.

There are, however, limits to this obligation. Firstly, healthcare professionals are expressly forbidden – by medical ethics and the law – from honouring a patient's or family's request to intentionally hasten the patient's death. Conversely, the Council states that healthcare professionals are not obliged to comply with requests to continue treatment that they consider futile. In this situation, it advises giving the patient or family the choice of transferring to another institution where the treatment is available. If they refuse, and the futility of the treatment is confirmed by an independent healthcare practitioner, the health team may withhold or withdraw the treatment.[2]

Do Not Resuscitate (DNR) orders

The decision not to institute CPR if it is likely to be successful should not be taken lightly, or in isolation. If the patient is competent, he or she should be involved in the decision-making, as should the family (with the patient's consent). Ideally, the whole healthcare team should also be consulted. Ultimately, though, the decision rests with the senior clinician in charge of the patient's care.[3]

Such decisions should not be made on the basis of assumptions about the patient's age, condition or perceived quality of life, but on a clinical assessment of the potential benefits and burdens of resuscitation on the individual, taking into account what is known about the patient's views, beliefs and wishes and those of his or her close relatives (see Box 6).

If a DNR order is made, this should be clearly documented in the patient's notes, together with the reasons for the decision and the process of decision-making.[4]

Advance directives

An advance directive is a statement made by a competent adult in anticipation of a time in the future when he or she may lack the capacity to make healthcare decisions. Such statements usually take the form of advance refusal of specified treatments, but may also contain information about the patient's values and beliefs.

The Council states that "Where a patient lacks the capacity to decide, health care practitioners must respect any valid advance refusal of treatment".[5]

It also recommends encouraging patients with terminal conditions to appoint a proxy to make decisions on their behalf in the event of their losing decisional capacity. Moreover, patients should be given the opportunity to write a directive setting out their wishes regarding their future care to guide those who will be tasked with deciding what is in their best interests.[6]

If there is any doubt about the validity or applicability of an advance decision (eg, there is reason to believe that the patient might have had a change of mind since drawing up the directive, or the current circumstances do not correspond to those specified in the directive), the patient should be provided with care to secure his/her best interests while the issue is resolved, if necessary by reference to the courts.

Documentation

All decisions to withdraw or withhold treatment, either with or without the patient's consent, should be fully and clearly documented in the patient's medical record and accessible by all those involved in the patient's care. Such documentation should include:

- the relevant clinical findings
- discussions with the patient and others
- details of treatment or other significant factors which may affect future care.

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 not to have the privacy of their communications infringed.[7]
- Rule 13 of the Council's *Ethical Guide* states that practioners may only divulge confidential information without the patient's consent when specific circumstances apply.
- 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.[8]

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 sent 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 7.

Box 7: 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."

Childrens' 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 8).

Box 8: Circumstances in which disclosure is either permissible or mandatory

- To meet the terms of a Statutory provision (e.g. 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.

Source: HPCSA, *Confidentiality: Protecting and Providing Information* (2007) 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* (2007), 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 9.

Box 9: 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.

Tips to avoid confidentiality breaches

- Do not leave case notes lying around in publicly accessible areas.
- Resist the temptation to look up patients' records out of idle interest (eg, because you know the patient personally, or the patient is a celebrity). If you are not involved in the patient's care you have no more right than any other member of the public to access their records.
- Do not use information contained in the medical records for purposes other than patient care, unless consent has been obtained or the data anonymised.
- For research or audit, anonymise information about patients in such a way that they cannot be identified. If this isn't possible, obtain the patient's consent.
- If you write identifiable information about patients on scraps of paper, post-it notes or in a notepad, keep track of them – don't leave them lying around in your car or in your pockets, etc. When you've finished with them, dispose of them securely.
- Follow the hospital's policies on safe storage of records and their removal from the premises.
- If you download patient information onto a memory stick or flash drive, make sure it's encrypted and that the files are password protected. Keep the memory stick in a secure place.

- Change your computer password regularly, keep it secret, never let anyone log onto the system in your name, and never borrow someone else's ID to log on.
- If you are faxing confidential patient information, call the recipient first to check that you have the right number and to tell them the fax is on the way. Ask them to notify you if it doesn't arrive. You might also consider using a cover sheet warning the recipient that the contents of the fax are confidential.
- Be aware that emails are not secure, so take care not to include identifiable information about patients in emails unless you are confident that the emails are being adequately encrypted.
- Even letters can go astray, so they should be marked "Confidential" on the envelope and care must be taken to ensure that the correct address is used (see Box 10). Consider using registered post for highly confidential letters.

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)

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."[9] (See Box 10 for examples.)

Box 10: 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)

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.

Clinical management

Negligence is a legal concept. It does not mean neglect or wilful misconduct, but a failure to attain a reasonable standard of care. Any doctor can make an error of judgment. Some are legally defensible, others are not; what is important is whether the management can be defended by a responsible body of professional opinion.

In cases of negligence, the only remedy available in law is financial compensation: damages are paid to restore claimants to the position they would have been in had the negligent act not occurred. Before damages are payable, however, the claimant must prove all three of the following:

- They were owed a duty of care.
- There was a breach of that duty of care.
- Damage was suffered as a result.

Adopt accepted practice

Accepted practice is easy to define in some areas – prescribing in accordance with the recommendations of the South African Medicines Formulary is an obvious example. Increasingly, proper practice has to be based on evidence (ie, determined by systematic methods based on literature review, critical appraisal, multidisciplinary consultation and grading of recommendations by strength of evidence). See Appendix 1 for links to evidence-based websites.

Accepted methods of investigation and treatment are often described by clinical guidelines. Such evidence-based guidelines improve the quality of clinical decisions, help replace outdated practices, and provide benchmarks for clinical audit.

Guidelines are not directives, so in theory you may choose to exercise your discretion by deciding not to follow a particular guideline. In reality, however, you should only deviate from the accepted practice embodied in the guidelines if you have very good reasons for doing so. If your judgment is called into question, you will have to demonstrate why you were justified in not complying with the guidelines.

Conversely, if you follow respectable clinical guidelines and base your decisions on evidence, you will be in a very strong position if a complaint is made against you.

Act within your limitations

Although you are not expected to be infallible, the law expects that, as a doctor, you exercise a reasonable standard of skill and care at all times.

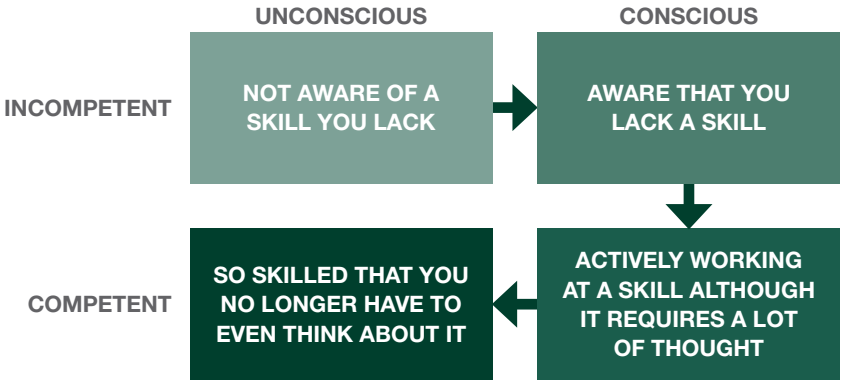
- As a general rule, you should not undertake tasks that are beyond your competence. The exception is if you find yourself in a situation where a patient will die or sustain severe and permanent injury without urgent intervention and you are the only (or most experienced) doctor available.
- Ideally, you should ensure that sufficient help and equipment are available for any procedure you undertake, and for the management of all foreseeable complications.

Keep up to date

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. It also requires that you keep abreast of developments in your field by regular reading of relevant journals and published guidelines.

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 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.



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.

Take responsibility for your health

If you have an illness, disability or infection that may put patients at risk, you must seek medical advice and, if necessary, stop or reduce your practice. The safety of your patients should be your prime concern.

If you do not already have one, register with a family doctor; apart from simple and obvious conditions such as common colds or sore throats, you should not rely on self-diagnosis and treatment. Your GP will be able to provide a better sense of perspective than you can, and if he/she thinks you are not fit to work you should respect his/her opinion.

Check equipment

Be fully conversant with any equipment you use – ensure that it has been properly serviced and is in working order before beginning any procedure.

This advice applies not only to complex machinery and software, but also to simple components such as tubing. Several deaths have been reported due to foreign bodies occluding anaesthetic tubing, for example. Had the patency of the tubing been properly checked beforehand, the deaths could have been avoided.

Other things to consider are:

- ensuring that you have replacements, such as batteries and bulbs, available if needed
- the cleanliness of the equipment or instrument
- whether you know what to do if a crucial piece of equipment – such as a dialysis machine or a ventilator – fails and whether emergency equipment (eg, a mask and bag) is available
- knowing the whereabouts of back-up equipment
- whether you've been taught how to use the equipment and know how to run operational checks or troubleshoot common problems.

Delegate appropriately

In the context of multidisciplinary and cross-agency teamwork, it can be difficult to distinguish between delegation and shared responsibility. The question is really one of accountability and clarity about who is responsible for each aspect of a patient's care.

As a member of a clinical team, you will have ongoing responsibilities for the care of patients, some of which you might delegate to staff who do not belong to a registered professional organisation. In these circumstances you would be held accountable for the actions of those staff members, so you must satisfy yourself that they are competent to take on the duties you are delegating to them and supervise them if necessary.

The matter is a little different when you delegate to a professional colleague. You would not be held accountable for the actions of another registered professional, but you would still be expected to delegate appropriately (ie, to a colleague with relevant training and skills) and to have provided them with sufficient information to carry out the task assigned to them.

If a colleague delegates tasks to you, make sure that you are properly briefed and if the task lies outside your expertise, say so.

Keep comprehensive up-to-date records

The medical record is an essential component of patient care. A good medical record will contain all the information one clinician needs to take over where another left off – or, to put it another way, to allow a clinician to reconstruct a consultation or patient contact without relying on memory. It should, therefore, provide all the information a newcomer to the care team would need to know about a patient and their treatment plan.

If you ever need to alter the notes at a later date, make it clear that you are introducing a retrospective correction. Any alteration to paper records should be clearly dated and signed. Do not obliterate the original entry – just run a line through it. Never try to rewrite notes at a later date. Do not delete entries in computer records, but add annotations to them if necessary (and date and initial them if the software doesn't do it automatically).

Do not write derogatory statements or criticisms about patients, colleagues or others; be as objective and factual as you can in making your notes. If you record any history provided by someone other than the patient, make sure you include the source – eg, "Has been 'confused lately' (daughter)". Remember, patients have a legal right of access to their records, which can also be scrutinised by the courts.

Though they were written with the UK health service in mind, you may nevertheless find the national standards published by the Academy of Royal Medical Colleges useful (see Box 11). Many of these standards are concerned with the structure of case files, and aimed at hospital medical records administration, but the standards concerned with content provide valuable guidance for doctors. *Part 2 – A Clinician's Guide to Record Standards* contains detailed advice about what to document when clerking, handing over care and writing discharge summaries. It can be downloaded from the Royal College of Physicians website – www.rcplondon.ac.uk.

Box 11: Selected Generic Record Keeping Standards

- Every page in the medical record should include the patient's name, identification number ... and location in the hospital.
- Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed.
- Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded.
- Every entry in the medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made.
- An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why.
- The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.
- Advance Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified.

(Academy of Medical Royal Colleges, *A Clinician's Guide to Record Standards – Part 2: Standards for the Structure and Content of Medical Records and Communications when Patients are Admitted to Hospital* (2008), p4.)

Be aware of the potential for medication errors

Medication errors account for a high level of complaints, claims and adverse incidents. The World Health Organisation estimates that patients suffer adverse events related to the administration of medication in approximately 1% of all hospital admissions. The underlying causes include:[10]

- "inadequate knowledge of patients and their clinical conditions
- inadequate knowledge of the medications
- calculation errors
- illegible handwriting on the prescriptions
- confusion regarding the name of the medication
- poor history taking."

Many of these can be avoided by being conscious of the most risky aspects of prescribing, calculating doses and administering drugs. A good starting point for reducing your own risk of committing a prescribing error is to follow the guidance set out by the Department of Health (see Box 12).

Box 12: Avoiding prescribing errors

"Drugs should be prescribed only when they are necessary for treatment following a clear diagnosis. Not all patients or conditions need a prescription for drugs. In certain conditions simple advice and non-drug treatment may be more suitable.

"In all cases carefully consider the expected benefit of a prescribed medication against potential risks. This is important during pregnancy where the risk to both mother and fetus must be considered.

"All prescriptions should:

- be written legibly in ink by the prescriber with the full name and address of the patient, and signed with the date on the prescription form
- have contact details of the prescriber e.g. name and telephone number."

"In all prescription writing the following should be noted:

- the name of the drug or preparation should be written in full using the generic name and
- no abbreviations should be used due to the risk of misinterpretation. Avoid the Greek mu: write mcg as an abbreviation for micrograms
- Avoid unnecessary use of decimal points and only use where decimal points are unavoidable. A zero should be written in front of the decimal point where there is no other figure, e.g. 2 mg not 2.0 mg or 0.5 ml and not .5 ml
- Frequency. Avoid Greek and Roman frequency abbreviations which cause considerable confusion – qid, qod, tds, tid, etc. Instead either state the frequency in terms of hours (e.g. 8 hourly) or times per day in numerals (e.g. 3x/d)
- State the treatment regimen in full:
  - drug name and strength
  - dose or dosage
  - dose frequency
  - duration of treatment

e.g. amoxicillin 250 mg 8 hourly for 5 days

- In the case of "as required" a minimum dose interval should be specified, e.g. every 4 hours as required
- Most monthly outpatient prescriptions for chronic medication are for 28 days; check that the patient will be able to access a repeat before the 28 days are up.
- After writing a script, check that you have stated the dose, dose units, route, frequency, and duration for each item. Consider whether the number of items is too great to be practical for the patient, and check that there are no

redundant items or potentially important drug interactions. Check that the prescription is dated and that the patient's name and folder number are on the prescription card. Only then sign the prescription, and as well as signing provide some other way for the pharmacy staff to identify you if there are problems (print your name, use a stamp, or use a prescriber number from your institution's pharmacy)."

Department of Health, *Standard Treatment Guidelines and Essential Drugs List for South Africa* (2006), pp. xvii-xviii.)

Checking procedures

- Be particularly careful when choosing the dose for a drug you are not familiar with.
- If a pharmacist or nurse questions a drug order or prescription, check it carefully – many problems are prevented by helpful interaction between colleagues.
- Always read the label on the bottle or vial before administering a drug or other substance, such as water for injection.
- Establish the identity of the patient and double-check the prescription before administering medication.

Communication

It is often necessary to order medications over the telephone, but this is a notoriously risky practice because your instructions may easily be misheard or misunderstood (see the case report on page 32). When ordering drugs or other treatment over the telephone, you should always ask the recipient to repeat your instructions back to you so you can be sure they were received correctly.

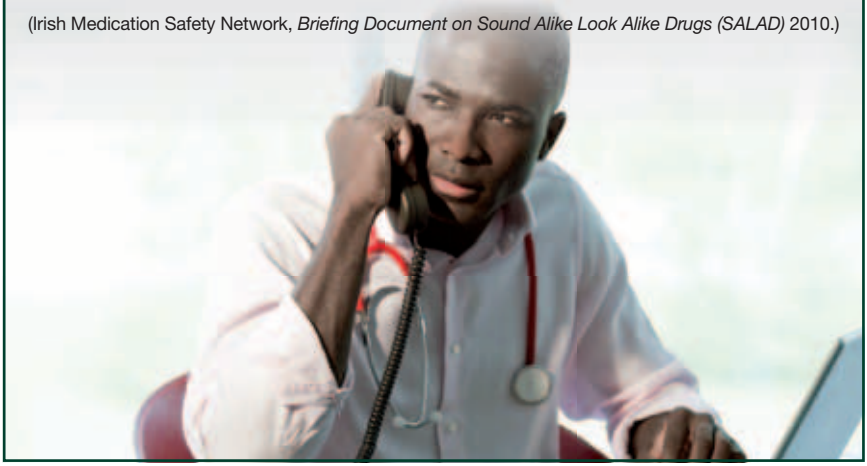
Case report: Misheard verbal prescription leads to patient's death

A patient, in the course of treatment in an acute hospital, was given parenteral morphine. The patient was sensitive to the drug and developed respiratory depression. The patient's doctor called in an order for an ampoule of naloxone to be administered. A dose was prepared from ward stock and given but there was no response. A repeat order for a second ampoule of naloxone was also given and again the patient showed no improvement.

The nurse then questioned the doctor: "How much of this Lanoxin do you want me to give?"

Instead of NaLoxone, the nurse heard LaNoxin. The patient subsequently died. Contributing to the error, the nurse had not repeated back the verbal order to the doctor, and the doctor had prescribed an ampoule of the drug rather than a metric weight dose. The nurse had accepted the incomplete order and administered an ampoule of LANOXIN® (digoxin) both times.

(Irish Medication Safety Network, *Briefing Document on Sound Alike Look Alike Drugs (SALAD)* 2010.)



General advice regarding communication

- If you are prescribing medication to be administered by other members of the healthcare team, issue clear and unambiguous instructions – answer fully any queries they may have.
- Make sure that your outpatients understand how to take the medication you prescribe, and that you warn them of any possible serious side-effects or effects that would make driving or operating machinery dangerous.
- Document the administration of drugs and infusions (name, time, dose) in the appropriate place in the medical records.

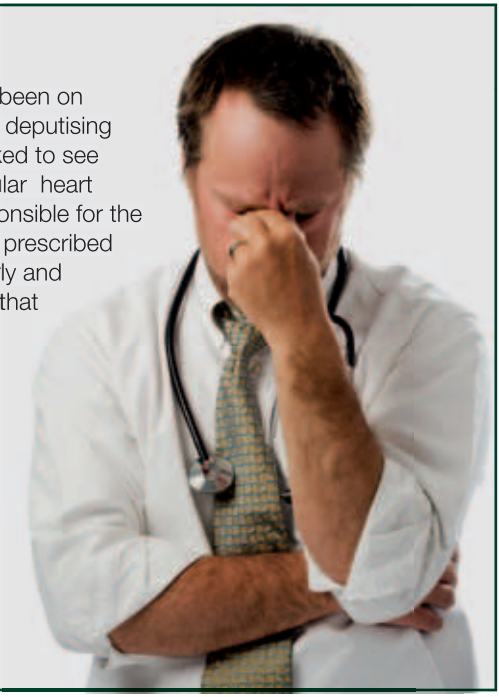
Prescribing for children

While all the foregoing 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 slower metabolism and excretion. At MPS we see many examples of errors occurring because a doctor failed to check the appropriateness of a drug and its route of administration for children or infants, or to prescribe the correct dose. We have also seen tragic cases (such as the one recounted in the case report below) in which infants have died or been seriously and permanently impaired because doses of drugs were miscalculated or a decimal point misplaced.

Case report

An overworked doctor, who had been on duty for 11 hours overnight while deputising for a colleague on leave, was asked to see a premature infant with biventricular heart failure. He was not normally responsible for the care of premature infants, but he prescribed digoxin to be given intramuscularly and calculated (by mental arithmetic) that the dose should be 0.6 mg.

Just as he was settling down for a well-earned rest, the ward nurse phoned to ask whether the dose shouldn't be 0.06 mg as she had had to open two ampoules. Without thinking, he told her to "Give it as I ordered". An hour later he was called to the ward because the baby had suffered a cardiac arrest.



Advice for safer paediatric prescribing

- Refer to a paediatric formulary when appropriate and always seek advice from colleagues if you are not sure.
- 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 get a competent colleague to check your arithmetic.
- When writing dosage, take special care in placing the decimal point and putting a zero in front of it.
- If you are prescribing in very small amounts of less than 1 milligram, prescribe in micrograms (written out – not abbreviated) 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.

Parents must always be warned about side-effects, particularly those that will be distressing to the child (eg, alopecia with cytotoxic drugs). It is also helpful to remind them of the importance of storing drugs in their labelled containers, and well out of children's sight and reach.

Systems and resources

Systems

Errors have a tendency to compound themselves, so it is worth taking the time to ensure that essential tasks are carried out carefully. Many complaints arise from simple mistakes that could have been easily avoided. The most common systems failures are:

- failure to pass on important information
- failure to arrange appointments, investigations or referrals with the appropriate degree of urgency
- failure to review the results of investigations
- failure to arrange follow-up and monitoring
- mislabelling, misfiling and failure to check labels.

Box 13: Minimising administrative risks

Transfers of care

This includes shift handovers, transfers to other wards and departments, transfers between hospitals and discharge home. In all these scenarios it is crucial that those taking over the patient's care be equipped with up-to-date key information. At a minimum, it should include diagnosis, treatment plans, medications, outstanding tests and test results.

Tests and investigations

When arranging urgent tests and investigations, let the lab know who they should contact with the results, especially if you are likely to be off-duty by the time they are available (and be sure to let the incoming shift know). Make a note in the patient's record whenever tests and investigations are arranged, and record the results once they are available. Any abnormal results should be acted upon, not just filed in the notes.

Patient identification

Make a habit of checking a patient's identity – either by asking the patient or by checking the wristband – before administering any treatment. Don't rely on names on bedheads or on the charts at the foot of the bed as patient may have got – or been put – into the wrong bed. For handover, use a combination of identifying information (eg, name, age, DOB, diagnosis, bed number) to avoid confusion over patients with the same or similar-sounding names. Do not rely solely on bed or bay numbers to refer to patients as these may change.

Record keeping

Record any crucial information as soon after the event as possible.

Follow appropriate systems

Every hospital should have policies and procedures in place for checking medications, identifying the site of an operation, counting swabs and instruments, and so on. Even so, there are numerous incidents, complaints and negligence claims to show that these checks are far from foolproof; if you place too much trust in them, you may easily become complacent and assume that they have been carried out competently.

- Before carrying out a procedure, always check the patient's identity and look at the case notes and relevant images to establish the nature and site of the procedure, even if someone else has already prepared or marked the site.
- Familiarise yourself with your hospital's policy on ordering and administering blood products.
- Make sure that any specimens and accompanying forms or reports are accurately and fully labelled.
- See that all hazardous substances and waste are labelled with appropriate warnings.
- Be conscious of health and safety issues, eg, disposal of sharps, etc.

No-one is perfect, so you will occasionally overlook, forget, or not be aware of crucial information that has an important bearing on a patient's wellbeing. Patients therefore have an important role to play in the information system. If they are kept well informed and are encouraged to voice their concerns, they can act as a vital failsafe in the information system. Patients usually know what they're in hospital for; they know their medical history, they're usually familiar with their medication, they have their own welfare high on their agendas, and they rarely mistake themselves for another patient. It therefore makes good sense to stop and listen to them if they express concern about an intended procedure or treatment.

Adverse incident reporting system

What do you do if something goes wrong, or you have a close call? Do you think about reporting the incident? Many hospitals have an adverse incident reporting system to help them identify safety hotspots and to learn from experience. If your hospital has such a system, you should report any adverse incidents or "near misses" as soon as possible after the event.

Resources

If you have concerns about the effects of under-resourcing on patient safety, you should formally notify the hospital management, explaining why you are concerned and outlining the possible consequences of continued under-resourcing. In some respects this is a "back-covering" exercise. If you are involved in litigation following an adverse incident due to resourcing problems, the fact that you had alerted managers to the problem may assist your defence. On a less cynical note, it is important that managers who are trying to balance limited budgets know where the risks to patient safety lie so that they may direct the hospital's finite resources where they are most needed.

Staffing levels

If you work in an under-staffed hospital, you probably work excessively long hours. You will know from direct experience the effects this can have on your ability to function effectively, but you may still be interested to know that after only one night of missed sleep your cognitive performance may decrease by 25% and, after a second night of missed sleep, you will probably be functioning at only 40% of baseline. If you accumulate a sleep debt (getting two to three hours' less sleep than optimal in 24 hours) over five to ten days, you will not only find it difficult to function cognitively, but your response times will be lowered and your mood altered. You will also probably find your morale and sense of initiative adversely affected.[11]

Obviously, all of the above have implications for the safety and wellbeing of your patients. So is there anything you can do to miminise the risks? Yes, there is. Although you cannot eliminate all the risks associated with fatigue, there are things you can do to improve your performance or to guard against some of the worst effects of fatigue.

- You should guard against a natural tendency to be short-tempered, irritable or rude when you are over-tired. The case report on page 33 is a good illustration of what can happen if you give in to the temptation to just snap at a colleague rather than consider what they are trying to tell you.
- Try not to rely on caffeine and sugar to see you through. Both of these substances will give you a short-term boost but then bring you crashing down a couple of hours later. They have the additional disadvantage of making it difficult to sleep when you do finally get off duty. Although your over-tired body will probably start nagging at you to feed it something sweet, you will do better to give it a piece of fruit or a homemade sandwich rather than something from a vending machine.
- When it comes to meals, frequent snacks will serve you better during a long shift than large dinners, which require a lot of digestion and can make you sleepy. Try not to go too long without eating, and try to stick to complex carbohydrates and proteins. Drink plenty of water.

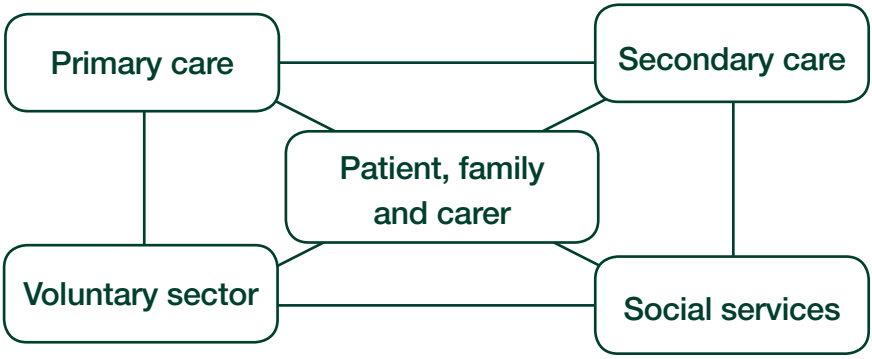
- There are some indications from research that taking a prophylactic nap before you go on duty can effectively reduce feelings of fatigue. Maintenance naps during your shift may also be useful, but there is a risk of "sleep inertia" after being woken. Sleep inertia is the term used for that awful feeling of complete disorientation when you're awoken from a deep sleep. It may last for up to 30 minutes, so this is not ideal if you are working on call where you are likely to have to deal with emergency situations.
- Off duty, it's important that you catch up with your sleep so that you don't end up chronically sleep-deprived. This may be difficult if you're trying to sleep during the daytime, when the quality of your sleep may be reduced by light, noise and temperature. You should do your best to replicate night-time conditions by using blackout curtains or an eyemask, earplugs and a fan or airconditioner to keep the room reasonably cool. Here are some techniques for promoting sleep:
  - "go for a short walk, relax with a book, listen to music and/or take a hot bath before going to bed
  - avoid vigorous exercise before sleep as it is stimulating and raises the body temperature
  - avoid caffeine, 'energy' drinks and other stimulants a few hours before bedtime as they can stop you going to sleep
  - don't go to bed feeling hungry: have a light meal or snack before sleeping but avoid fatty, spicy and/or heavy meals as these are more difficult to digest and can disturb sleep
  - avoid alcohol as it lowers the quality of sleep."[12]

Failures of communication

Underpinning good patient care is good communication, and this goes beyond establishing good relations with patients. In today's team approach to delivering healthcare, communication has to extend to more people and there are therefore more opportunities for it to fail.

Communication between primary care, secondary care and social and voluntary services should be seen not as a chain, but as a communication net, within which any one member may need to communicate with any other (see Figure 1). Good management requires all members of the communication net to be conscious of who is doing what – an adequate standard of continuing medical care can be achieved only if all participants – both medical and non-medical – understand their roles.

Figure 1: The communication net



Keeping people informed in the interests of continuity of care must be balanced against the need to maintain confidentiality, and both these issues should be borne in mind when sharing relevant information about patients. Unless the patient asks you not to, it is entirely appropriate to share information about patients with people involved in their care.

Case report: Dual system causes communication breakdown

Mr A, a 67-year-old hotelier, was referred to A&E with a suspected transient ischaemic attack. He was seen by Dr K, the junior doctor on duty, who arranged a CT scan for the following morning.

Mr A was transferred to a medical ward for observation overnight and the scan was performed later the next day by Dr E, the radiologist on-call. Dr E was not able to report the scan straight away, but Mr A was told that he could go home and that his GP would be contacted in due course with the result of his tests.

Two weeks later, Mr A was found collapsed in the hotel dining room. He was readmitted to A&E where an emergency CT scan showed a large cerebellar tumour with evidence of recent haemorrhage. There were signs of ventricular dilatation and raised intracranial pressure. Unfortunately, Mr A died before he could be transferred to a neurosurgical centre for specialist treatment.

It later came to light that no-one on the ward had followed up Mr A's first CT scan, which showed a mass in the cerebellum that the radiologist reported as "consistent with a primary or secondary neoplasm". At the time, the hospital had been operating a mix of electronic and paper records. The radiologist had lodged his report in the electronic system, but this had not been transferred to the patient's case notes, which had been filed away after the patient's discharge.

Recording essential information

Inadequate medical records are the underlying cause of many failures of communication – the records are the essential tool of communication between members of the multidisciplinary team. Subtle but significant changes may be missed when several different doctors see a patient over many days, unless adequate information is available from previous examinations.

What you include or leave out of the record is a matter of professional judgment, but you should take care to include all information that other members of the team will need to continue care of the patient safely. As months or years may elapse between treatments or illnesses and staff may have changed in the meantime, the records should also serve to reconstruct events at a later date without recourse to memory. Advice on what to include in the medical record can be found on page 28.

Handover

Responsibility for the average patient's care passes between numerous healthcare teams during the course of one episode of hospitalisation. And to shift changes and transfers between departments and specialty units must be added the transfer of the patient from primary to secondary care and back again. Each transition from one setting to another, or from one team to another, represents a heightened risk for the patient. One of the most common root causes of medical mishaps is communication failure during the transfer of care.

Given the potential for communication breakdown at each transfer, it's little wonder that poor handover has been identified as a root cause of so many medical mishaps (see Box 14). The World Health Organization recommends that handovers between shifts and between units should:

- "Use a standardized approach to minimize confusion.
- Allocate sufficient time for staff to ask and respond to questions.
- Incorporate repeat-back and read-back steps as part of the hand-over process.
- Limit the exchange to information that is necessary to providing safe care to the patient."[13]

Box 14: An international concern

"Breakdown in communication was the leading root cause of sentinel events reported to the Joint Commission in the United States of America between 1995 and 2006 and one USA malpractice insurance agency's single most common root cause factor leading to claims resulting from patient transfer. Of the 25 000 to 30 000 preventable adverse events that led to permanent disability in Australia, 11% were due to communication issues, in contrast to 6% due to inadequate skill levels of practitioners."

(WHO Collaborating Centre for Patient Safety Solutions, Communication During Patient Hand-Overs, *Patient Safety Solutions*, vol. 1: solution 3 (May 2007))

One communication technique that seems to be finding wide favour globally is SBAR (Situation – Background – Assessment – Recommendation). SBAR is in many respects an ideal communication model in healthcare because it's not only simple and easy to remember, but is also flexible, and therefore as applicable for a nurse phoning the on-call doctor with concerns about a patient in the middle of the night as it is for a formal handover between shifts.

Organisations that have adopted SBAR report that it's played a vital role in overcoming the traditional communication barriers between professionals of different status. This is absolutely crucial. There have been too many instances where nurses and junior doctors have known perfectly well that something is amiss, but haven't felt able to voice their concerns in unambiguous terms to senior clinicians. Classically, in these situations, they adopt a "hinting and hoping" mode of communication – ie, hinting at what they think needs attention and hoping that the hint will be taken.

To be truly effective, SBAR should be adopted by a whole team (and preferably throughout the hospital) and everyone should be given training in its use. However, there's nothing to stop individuals using it independently as an efficient means of structuring information. Its advocates have also found it useful for structuring reports, letters and medical notes. The description in Box 15 sets out the essential structure of the model, but further information can easily be found on the internet.

Box 15: SBAR

S – Situation: What is happening at the present time – ie, who you are, who the patient is, the patient's location and current condition. Briefly state the problem and/or your concern clearly at this point.

B – Background: The circumstances leading up to this situation, ie, a brief summary of relevant past medical history, the admitting diagnosis, date of admission, prior procedures, current medications, allergies, pertinent laboratory results and other relevant diagnostic results. Include most recent vital signs, important observations outside normal parameters and your clinical impression.

A – Assessment: What you think the problem/diagnosis/appropriate management is, – eg, patient is deteriorating/stable, requires monitoring, is at risk of haemorrhage/shock.

R – Recommendation: What should be done to correct the problem/manage the patient/monitor the situation/maintain continuity of care – eg, awaiting lab results which must be acted upon as soon as they're available, keep an eye on fluid balance, set up IV if necessary, watch for signs of internal haemorrhage.

(The SBAR tool originated in the US Navy SEALS and was adapted and developed for a healthcare setting by Kaiser Permanente.)

Case report: Poor communication with blinding results

A diabetic clinic in a teaching hospital diagnosed TB in a diabetic patient with a history of weight loss. He was admitted to hospital and, on discharge, was prescribed three months' supply of ethambutol, rifampicin, pyrazinamide, isoniazid and pyridoxine.

A month later, he was seen in the diabetic clinic but there was no discussion of his TB treatment. He failed to attend his next appointment.

Three months after starting TB treatment, the patient began to complain of deteriorating vision and his GP made an urgent referral to the eye clinic. The GP had not yet received a discharge letter about the patient's last hospital admission for the treatment of TB, nor had the diabetic clinic informed him of the diagnosis, so his referral letter to the eye clinic made no mention of the fact that the patient was taking ethambutol.

The patient attended the eye clinic several times over a month, but no history of TB or treatment for TB was obtained – his visual loss being attributed to diabetes. However, his vision continued to deteriorate and by the end of this period he was only capable of counting fingers. A week later, the patient attended the diabetic clinic. Only then was the diagnosis of ethambutol eye toxicity raised.

The patient was seen immediately in the eye clinic where the diagnosis was confirmed and the ethambutol stopped, but by then he had sustained a permanent loss of 90% of his vision.

Referrals

Referrals are another form of transfer of care, so you should ensure that all the essential information about the patient is conveyed to the receiving consultant. A tool like SBAR can be used for structuring the referral letter. Include an indication of the level of urgency of the referral.

Remember to tell the patient (or the patient's carer) why you are making the referral and let them know what they can expect.

Communication with colleagues in primary care

The divide between primary and secondary care is an area where communication can easily break down, particularly when patients are receiving long-term treatment. If the patient is being given ongoing care as an outpatient it is particularly important to keep the GP informed about his or her progress and treatment, as they may have a bearing on the GP's own treatment of the patient (see the case report on page 44).

Delays in mailing discharge summaries to GPs are another common cause of adverse incidents. Patients' GPs should be notified whenever their patients are seen in secondary care, and especially if they've referred the patient themselves. As the GP is often familiar both with the patient's past medical history and with relevant family history, their concerns and suggestions should be taken seriously.

Communicating with patients

The patient's agenda	**The doctor's agenda**
Ideas, concerns, expectations (ICE)	Signs and symptoms
Feelings, thoughts, effects	Investigations
Understanding of his/her feelings	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.[14]

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 disappointed 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,[15] 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[16] 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%).[17]

Apart from the obvious risk of missing important and relevant information, when consultations are conducted along these lines they 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 used 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."[18]

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 (2002) 1567-8)

General advice about communicating with patients

- Patients who are kept informed about their condition and are involved in deciding on the appropriate treatment are more likely to comply with the treatment you suggest, and less likely to complain if things go wrong.
- It is particularly important that you tell patients about the possible side-effects of drugs or treatment you are ordering, and that they know what complications to look out for and what to do if they develop.
- Warn patients about the risks before carrying out any procedures or prescribing medication. "Informed" consent is dealt with in more detail in the MPS booklet, *Consent to Medical Treatment in South Africa. An MPS Guide*, which can be downloaded from our website or ordered through our Communications Department.
- When you are discharging patients from your care, tell them about arrangements you have made for follow-up care and give them appropriate advice about what to do if symptoms recur or complications develop. It they are receiving long-term therapy, tell them when to return for review and what symptoms or signs of adverse effects or changes in their condition to report. If possible, give them an indication of when they might expect to see an improvement in their condition, and when to seek medical advice if no progress is made within a certain timescale.
- Document any advice you have given the patient. It is useful to document in the record any supporting literature or written information given to the patient.

If things go wrong

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 counter-threats. The hospital will handle the complaint, but you should be prepared, if it turns out that 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 might still consider seeing the patient to 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.

References

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4. HPCSA, *Guidelines for the Withholding and Withdrawing of Treatment*, second edition (2007), para 2.7.
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13. WHO Collaborating Centre for Patient Safety Solutions, Communication During Patient Hand-Overs, *Patient Safety Solutions*, vol. 1: solution 3 (May 2007).
14. NICE, *Medicines Adherence: Quick Reference Guide* (January 2009).
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16. Ibid, p 286.
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18. Ibid

Appendices

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

Booklet 1: Guidelines for Good Practice in Health Care Professions

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 for 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.hpcsa.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:

- **Understand** it.
- **Retain** it.
- **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.

Appendix 3: Sources of guidelines, research and evidence-based care

Bandolier

www.ebandolier.com www.jr2.ox.ac.uk/Bandolier
A monthly journal, based in Oxford but with a global perspective, Bandolier is a trustworthy and well-recognised source of evidence-based healthcare information.

Centre for Evidence-based Medicine

www.cebm.net
An Oxford-based centre established with the aim of developing, teaching and promoting evidence-based healthcare and providing support and resources to anyone who wants to make use of them. Its website has useful links to specialty-specific EBM sites.

Clinical Evidence

www.clinicalevidence.bmj.com
BMJ Clinical Evidence publishes systematic reviews summarising the current state of knowledge and uncertainty about the prevention and treatment of clinical conditions. Athens users and subscribers can access the reviews online via a PC or PDA. There is also a handbook available for purchase.

The Cochrane Collaboration

www.cochrane.org
An international organisation that aims to help people make well-informed decisions about healthcare by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions.

National Guideline Clearinghouse

www.guideline.gov
A comprehensive database hosted by the US government of evidence-based clinical guidelines and related documents from around the world. It has a useful facility for comparing guidelines.

The Trip Database

www.tripdatabase.com/index.html
Clinical search tool designed to allow health professionals to rapidly identify the highest quality clinical evidence for clinical practice. Registration is free.

Other MPS publications

- *Common Problems in General Practice*
- *Medical Records in South Africa*
- *Consent to Medical Treatment*
- MPS Factsheets (various topics)

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