



# Practice MATTERS

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## DISCLOSING A POSITIVE HIV STATUS TO A SEXUAL PARTNER

A look at the guidelines for GPs

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Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

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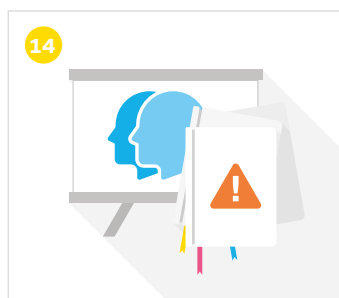
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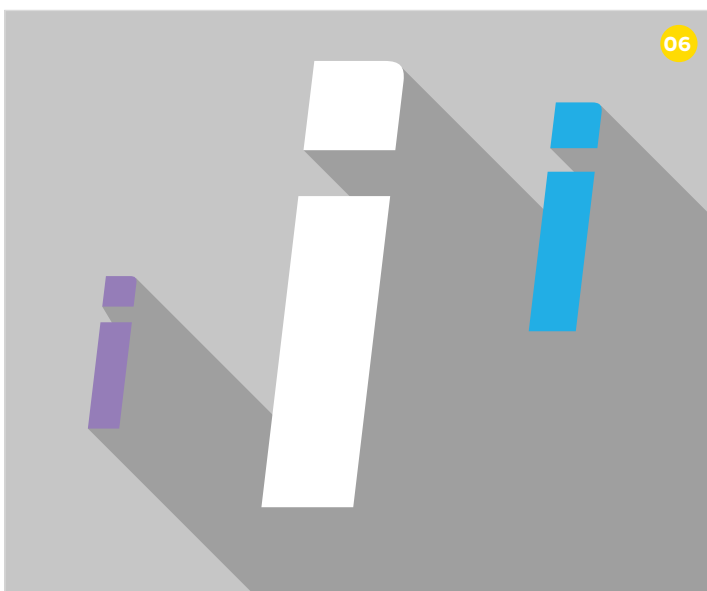
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We welcome contributions to *Practice Matters*, so if you want to get involved, please contact us on **+44 113 241 0683** or email: [rosie.wilson@medicalprotection.org](mailto:rosie.wilson@medicalprotection.org)

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# WELCOME

**Dr Graham Howarth**

Editor-in-chief, Medical Protection Head of Medical Services (Africa)



**W**elcome to the latest edition of Practice Matters, a magazine for the whole general practice team.

When compared to any other country worldwide, South Africa has the largest manifestation of HIV and AIDS and it is therefore likely that, as a general practitioner, you will attend to HIV positive patients during your career. This can lead to some challenging interactions, so on page 6 we identify the guidelines which are available to assist you on the disclosure of a patient's positive HIV diagnosis to a sexual partner.

Day-to-day, we might not always pay much consideration to the administrative aspects of practice. However, problems in this area often pave the way for complaints and claims; a large proportion of the phone calls we receive from members relate to housekeeping. In this issue, we offer guidance on some of the more common pitfalls relating to administration; on page 8, Dr Volker Hitzeroth explains how to deal with billing patients and settling debts, and on page 5 we explore the appropriate action to take when archiving medical records.

Sometimes these aspects of practice are out of our hands though, and in this issue we also take a look at fraudulent prescriptions. Forged prescriptions in a practitioner's name can have a serious impact on his or her practice if not managed correctly, so if it happens to you, you must ensure you take all the appropriate measures to report and quash it. Read more on page 12.

If you're looking to enhance your overall practice, turn to page 15 where you can learn about Medical Protection's in-depth workshop on Achieving Safer and Reliable Practice. The course is free to members and offers the opportunity to gain CPD points.

We hope you enjoy this edition. We would be interested to hear your comments, as well as any topics you would like us to cover in the future.

## ETHICS FOR ALL 2016: ESSAY WINNER ANNOUNCED

Ethics For All was held across three dates in October in locations at Pretoria, Durban and Cape Town. Delegates were invited to attend learning sessions geared towards achieving CEUs in the required ethics, human rights and medical law units.

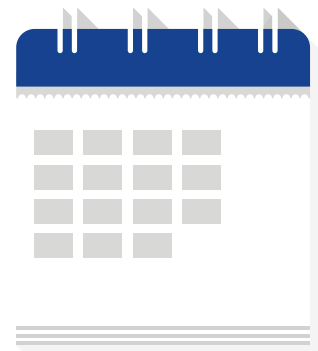
The winner of the annual essay writing competition was also announced. Ryan Jacobs, a fifth year medical student at Stellenbosch University wrote a piece entitled *Legalising physician assisted suicide in South Africa: Should it even be considered?* He attended the Cape Town conference where he was awarded his prize.

## HOW TO GET PUBLISHED IN PRACTICE MATTERS

Medical Protection is your organisation and we want you to be part of it. We are currently seeking new contributors to submit well-crafted and informative feature articles for *Practice Matters*. If you would like to have your writing published, or if you have any ideas for content, please contact our editorial team at [rosie.wilson@medicalprotection.org](mailto:rosie.wilson@medicalprotection.org)

# RETAINING PATIENTS' MEDICAL RECORDS: HOW LONG IS TOO LONG?

As a healthcare professional, you will already appreciate the value in keeping detailed and coherent medical records for every patient you see. However, there is traditionally some confusion when it comes to the management of records and when it is permissible to dispose of them. **Rosie Wilson** goes through the basic guidelines

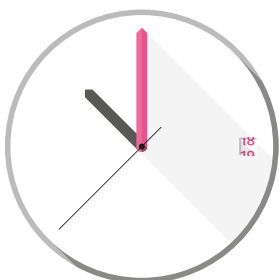


**C**reating a system for successful record keeping is one thing – but what about the ongoing administration? It can be difficult to develop a contingency plan for outdated or archived medical records if you are unsure about what to do for the best. The HCPSA has however developed guidance on the matter. We've summarised the key points below, but for more information, see the HCPSA's *Guidelines on the Keeping of Patient Records*<sup>1</sup>.

## MANAGEMENT

Section 19 of the *Protection of Personal Information Act*<sup>2</sup> stipulates that you must ensure the integrity and confidentiality of the personal information under your control – that is to say, you must ensure that you have done everything within your power to make sure the information is not lost, damaged, obtained or destroyed without authorisation.

To enact this, you should give one individual the responsibility for reviewing your practice's record management system regularly and ensuring it is up-to-date with legislative requirements.



## RETENTION

According to the HCPSA:

- Records should be kept for at least six years after they become dormant
- the records of minors should be kept until their 21st birthday
- the records of patients who are mentally impaired should be kept until their death
- records pertaining to illness or accident arising from a person's occupation should be kept for 20 years after treatment has ended

In extenuating circumstances, such as when a patient has been exposed to conditions that put them at risk of developing a disease, records should be kept for longer.

## DISPOSAL

Your record management system should include guidelines on record retention, and procedures for identifying which records are due for disposal.

The *Electronic Communications and Transactions Act*<sup>3</sup> specifies that personal information held electronically must be deleted or destroyed after it becomes obsolete.

Tangible records – whether that's paper notes or records on electronic storage – must be physically destroyed.

If you use an outside contractor to dispose of archived medical records, you must have a confidentiality clause in place to protect your patients' personal information.

You should keep a signed register of all records that have been destroyed, stating the reference number, patient name and date of birth, as well as the dates the records were created and disposed of.

## PROTECTION

If your practice utilises paper records, you should remain mindful of damage that can be caused by moisture, fire, water or insects. You should carry out a risk assessment in order to ascertain the best way to safeguard them – particularly if you do not have copies. Implementing systems that could save your records in the event of a fire or flood – such as storing your records above basement level and installing chemical fire extinguishers – is wise.

It is important to back up electronic records, and preferably the back-up hard drive or disc should be kept off-site in secure storage.

For more information, please see our factsheet on the Retention of Medical Records at:

[medicalprotection.org/southafrica/factsheets](http://medicalprotection.org/southafrica/factsheets)

## REFERENCES

- HCPSA: Guidelines on the Keeping of Patient Records (2008)
- Section 19 of the Protection of Personal Information Act (2013)
- The Electronic Communications and Transactions Act (2002)



# DISCLOSURE OF A POSITIVE HIV DIAGNOSIS TO A SEXUAL PARTNER

From HIV testing and management of a patient with a positive HIV test result to a disclosure of a positive diagnosis, it is imperative that you are familiar with the legislation and guidelines outlining your duties and obligations, says Medical Protection's Medicolegal Assistant **Ralitsa Sahatchieva**

**S**outh Africa has the largest manifestation of HIV/AIDS in comparison with any other country in the world; it is palpable that HIV/AIDS are an immense health concern in the country, and a cause of social stigma. HIV/AIDS has an impact on the larger community and not just on those infected<sup>1</sup>; it is extremely likely that, as a GP, you will occasionally attend to HIV positive patients during your career.

The following guidelines are available to assist GPs on disclosing a patient's positive HIV diagnosis to a sexual partner.

## CONFIDENTIALITY

Section 14 of the National Health Act (2003)<sup>2</sup> states that all information relating to a patient's health is confidential and no person may disclose any information unless:

- a) they have the patient's consent in writing,
- b) a court order or any law requires disclosure,
- c) not disclosing the information will pose a serious threat to public health.

The HPCSA's General Ethical Guidelines for the Health Care Professions (2008) Booklet 11 'Ethical Guidelines for Good Practice with regard to HIV'<sup>3</sup> provides you with guidelines for the management of patients with HIV/AIDS and is a good starting point as it again impresses upon the fact that an HIV positive diagnosis should be treated with the greatest level of confidentiality.

## CONSULTATION

The guidelines further specify that a decision to disclose a positive HIV result should be reached in consultation with the patient. It is apparent that whether the patient consents to the disclosure or not, he or she should nevertheless be informed that their HIV positive status may be disclosed in certain circumstances.

## DISCLOSURE TO A SEXUAL PARTNER

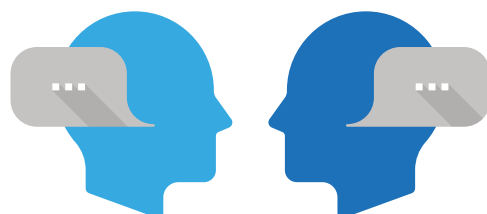
In order to facilitate good clinical practice, a practitioner should encourage patients to disclose their status to their sexual partner<sup>4</sup>.

The experience at Medical Protection indicates that many practitioners remain uncertain whether they are legally or ethically obliged to disclose a patient's positive status to their sexual partner if the patient does not provide consent. This decision is left to the discretion of the GP. In reaching a decision, the practitioner should also bear in mind the risks to the patient if a positive diagnosis is disclosed. For example, the risk of violence against the patient and the risk to the sexual partner if the positive diagnosis is not disclosed. It is imperative to contemporaneously document all relevant conversations, thoughts and decisions.

## STEPS ON DISCLOSING AN HIV POSITIVE STATUS TO A SEXUAL PARTNER WITHOUT CONSENT

You must take all reasonable steps to obtain consent from the patient to disclose their HIV status<sup>5</sup>:

- Impress upon the patient the importance of disclosing this vital information to their sexual partner and on taking other measures to prevent transmission. Provide appropriate support to the patient.
- Should the patient refuse to disclose their HIV status to their sexual partner, explain to the patient that you are under an ethical obligation to disclose this information.
- You may have to then assess the situation, weigh up the risks and benefits, and decide whether to disclose the patient's HIV status.
- The patient's HIV positive status can be disclosed to the patient's sexual partner following the steps above and, once disclosed, you should assist the sexual partner by offering testing and treatment if necessary.
- It is crucial to follow up with the patient and their partner after the disclosure has been made and assist the patient appropriately.



# SCENARIOS



## CASE 1

*Complaint lodged at the HPCSA against a practitioner for non-disclosure of an HIV status to the patient's partner*

Mr and Mrs C have been married for 15 years; Mrs C has been a patient at Dr L's practice for the past eight. Mrs C underwent testing for HIV in the practice of Dr L. She was advised to book an appointment to collect her results the following week in Dr L's practice. The following week, Mr C attends the practice and asks the receptionist to speak to Dr L himself. Dr L agrees to see Mr C, regardless of the fact that he is not a registered patient at the practice. Mr C explains that he is there to collect his wife's HIV test result. Dr L informs him that he is unable to provide him with the test results as he is not in possession of her express consent to divulge such information to Mr C. Dr L then advises that Mrs C should make an appointment at the practice to collect her results. Mr C is displeased and makes yet another attempt to persuade Dr L to disclose the results. Dr L repeats that due to the doctor-patient confidentiality he is unable to disclose this information.

A few weeks later, Mr C lodges a complaint at the regulator expressing dissatisfaction with the fact that the HIV test results of Mrs C were not disclosed to him and alleging that Dr L has acted unprofessionally. The regulator found no evidence of unprofessional conduct against Dr L and held that Dr L has acted professionally in not disclosing the results and thus maintaining the doctor-patient confidentiality at all times.

If the patient had tested positive for HIV, then Dr L would have to follow the guidance on disclosure to a sexual partner, as outlined above.

## CASE 2

*A healthcare practitioner seeks advice on disclosing a patient's HIV status to a sexual partner in error*

Mr F attends an appointment with his GP, Dr G, and requests a full medical check-up, including a request for an HIV test to be performed. Dr G agrees to perform the test on the patient and advises that his results will be sent via SMS. The patient agrees to receive the test results via SMS.

Upon receiving the test results, Dr G's practice sends an SMS to the patient informing him of his results. The following day, Mr F telephones the practice of Dr G and demands an explanation as to why his test results were disclosed to the patient's wife – Mrs F. Dr G is surprised to hear that this has happened and investigates the matter further. Dr G finds that the patient had provided his wife's telephone number and informs Mr F of the same. Mr F advises that this was done in error and he is nevertheless dissatisfied with the fact that a disclosure occurred. Dr G explains to the patient that it is his intention to always protect his patients' confidential information. Dr G reassures the patient that he has taken measures to ensure such unfortunate situations will not occur in the future.

This case has not escalated into a complaint to the HPCSA yet; however may be considered a breach of confidentiality. If the patient had tested positive for HIV it is important that the healthcare practitioner follows this situation up to ensure no adverse outcome has occurred as a result of the disclosure in error.

*The cases mentioned in this article are fictional but based on true clinical scenarios and are used purely for illustrative purposes.*

## REFERENCES

1. AIDS Foundation of South Africa, [www.aids.org.za/hivaids-in-south-africa/](http://www.aids.org.za/hivaids-in-south-africa/)
2. The National Health Act 2003 (Act 61, Section 14)
3. HPCSA, General Ethical Guidelines for the Health Care Professions, Booklet 11 (2008) [www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct\\_ethics/rules/generic\\_ethical\\_rules/booklet\\_11\\_hiv.pdf](http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_11_hiv.pdf)
4. Ibid
5. Ibid

# BILLING AND BAD DEBT

Medicolegal Adviser, **Dr Volker Hitzeroth**, highlights common pitfalls relating to billing and debt collection for medical services

**N**umerous claims and complaints made to the regulator are triggered by a practitioner's pursuit of owed payment. One of the common reasons that a patient might turn to the HPCSA or consult a personal injury attorney is upon receiving a bill from their doctor after a (subjectively) unsatisfactory consultation. A patient might choose to simply walk away from a consultation that they found unhelpful, unsatisfactory or unprofessional, but if they then receive a bill demanding payment, they may respond with dissatisfaction. They might escalate the matter by not only disputing the account, but also lodging a complaint with the HPCSA, or in some cases even seeking legal redress. Should this happen, members can turn to Medical Protection in order to seek advice and assistance with the matter.

There are a few common billing errors that trigger the majority of financial complaints and claims.

## POOR UNDERSTANDING OF THE FINANCIAL ASPECTS OF PRIVATE PRACTICE

Whilst some practitioners have a good grasp on their billing obligations, others seem to demonstrate a lack of understanding with regards to payments for consultations. Practitioners should have knowledge of the correct coding, claiming and billing processes, and should also ensure that their administrative/accounting team is well informed and follows the correct procedures, communicating with the practitioner about any ongoing billing issues. From legal and ethical perspectives, the ultimate responsibility for all billing queries resides with the practitioner. Whilst some practitioners choose to outsource their accounting, this does not reduce their responsibility, risk or accountability.

## INFORMED FINANCIAL CONSENT

Section 6 of the National Health Act, 61 of 2003<sup>1</sup>, states that every practitioner must inform the patient of: their health status; the range of diagnostic procedures available; treatment options; the benefits, risks, costs and consequences associated with each treatment option and the implications of refusing treatment. Similarly, the HPCSA's guideline on patient consent<sup>2</sup> expects practitioners to explain the details of any costs or charges that a patient may have to meet.

It is therefore imperative that, prior to treatment, a patient has a clear understanding of the costs of a consultation or procedure, and the contribution they are expected to make personally if medical aid co-funds the costs. This information should be shared in rand and cent values. It may also be useful to have explicit documentation available for the patient to read and sign prior to the consultation or procedure. Financial consent must be updated regularly if costs escalate, ongoing treatment progresses or new procedures are undertaken.

## BILLING FOR MISSED APPOINTMENTS

Unless timely steps were taken to cancel an appointment, the patient may be charged the relevant consultation fee. In the case of a specialist, "timely" would mean 24-hours prior to the appointment, and for a general practitioner, it would mean two hours before. Each case should be considered on merit however, and the fee should be waived in the case of adequately mitigating circumstances. A bill for a missed appointment should not be sent to the medical aid provider for payment, but should be sent to the patient (or person responsible for payment) directly.

## DEBT COLLECTING

Debt collecting seems to have become part and parcel of private practice. While a practitioner is entitled to pursue outstanding fees, it is imperative that a reasonable debt collecting protocol is in place. Prior to pursuing a debt, the practitioner should ensure that their position and processes are legal. At the outset of the process, the practitioner must notify the patient of his/her intention to pursue the debt, and offer the patient an opportunity to settle it. Practitioners are strongly advised to make use of a registered, appropriately qualified and experienced debt collecting firm. Whilst such a firm would be able to advise on the debt collection process (and follow the agreed procedures), the ultimate responsibility for this remains with the practitioner.

## DOS AND DO NOTS

- **Do** have clear terms and conditions covering all aspects of the billing process.
- **Do** ensure that the patient is well-informed on the financial aspects of the consultation or procedure.
- **Do** ensure that your administrative/accounting team keep clear and contemporaneous records of all patient interactions with regards to billing queries.
- **Do not** bill for services before they are rendered.
- **Do not** bill for services not rendered.

## REFERENCES:

1. National Health Act 61 of 2003
2. HPCSA Guidelines for Good Practice in the Health Care Professions Booklet 9: Seeking patients' informed consent: the ethical considerations



# CASE STUDY

Dr T consulted with Mr U in his office after Mr U presented with acute chest pain from 05h00. In order to assist in the diagnosis and management of the patient, Dr T performed an ECG. Dr T then submitted his account to the patient's medical aid for the costs of the consultation and ECG. The patient's medical aid declined to pay for the visit or the ECG, due to the fact that Mr U only had a hospital plan. The account was thereafter forwarded to Mr U for payment.

However, Mr U never responded to the correspondence, so Dr T decided to hand over the account to his debt collecting firm about three months after the consultation. Mr U received the Letters of Demand from the debt collecting firm and responded in a scathing letter to Dr T's offices, denying liability for the account and alleging unprofessional conduct and negligence in that he was never informed of the costs of the consultation and ECG. He also alleged that Dr T had poor manners and a bad attitude.

Mr U also consulted with a prominent firm of personal injury attorneys and counterclaimed for payment of R782,000 in negligence. Dr T requested advice and assistance from Medical Protection, in relation to both the claim of negligence and the debt collecting process.

Whilst Medical Protection was able to assist Dr T with the claim of negligence, upon perusal of his terms and conditions it became increasingly clear that the informed financial consent procedure was inadequate. Dr T never recovered the costs of the initial consultation and ECG; he was left disillusioned by the experience and shortly after left the profession.

Practitioners should be aware that even if they have followed all the relevant legislation and ethical guidance on the billing process, there is no guarantee that the patient will not lodge a complaint to the HPCSA or initiate a counterclaim. Every patient has the right to complain or seek legal redress. Every practitioner therefore has to ensure that their approach to informed financial consent, billing and debt collecting is clear, defensible and justifiable.

*The cases mentioned in this article are fictional and are used purely for illustrative purposes.*

# CLOSING DOWN AND HANDING OVER A PRACTICE

*A healthcare practitioner can, for various reasons, decide to close down their private practice at any time. Ralitsa Sahatchieva covers the main scenarios in which this is the case, and provides guidance for each*

**M**edical Protection frequently deals with queries on closing down private practice, most commonly in the event of retirement, leaving the practice, emigrating or the death of the practitioner. Should you make the decision to cease working in private practice, we can offer guidance to aid the process.

In the event that you need to close down or handover a private practice, it is important that you remain mindful of the principles outlined below. A healthcare practitioner has a legal and ethical duty to inform their patients of the closing down of the practice or the change of ownership; you need to ensure the effective continuation of patient care, and guarantee that another practitioner will be able to take over their ongoing treatment. You also need to develop adequate arrangements for the retention or transfer of the patients' medical records.

## THE DEATH OF A PRACTITIONER

In the guidelines for Good Practice in the Health Care Professions<sup>1</sup>, the HCPSA has several guidelines for cases where a practitioner has passed away or where the practice is being closed down. It states: "Should a health care practitioner in private practice (both in single practice and in a partnership) pass away, his or her estate, which includes the records, will be administered by the executor of the estate."

This means that the practice should be taken over by another practitioner, to whom all the medical records must be transferred. The onus then lies with the new practitioner to notify all of the patients in the practice of the change in ownership. The patients should be given the option to remain with the new practitioner or to request their records to be transferred to another practitioner of their choice.<sup>1</sup>

In cases where a practice is not taken over by another healthcare practitioner, the executor should notify all of the patients in writing and transfer the records to the patients who have requested them. The remaining patients' records should be kept by the executor for a period of 12 months<sup>1</sup>.

If there is a specific partnership agreement that has explicit provisions for the administration of a deceased partner's portion in the practice, this agreement should be taken into consideration.

## CLOSING DOWN A PRACTICE

The HCPSA booklet also provides guidance for healthcare practitioners who decide to close down their practice. It states that the practitioner should inform all of their patients in writing within three months of closure that<sup>1</sup>:

- "The practice is being closed as from a specific date"
- "Requests may be made that records are transferred to other healthcare practitioner of their choice"
- "After the date concerned, the records will be kept in safe-keeping for a period of at least 12 months by an identified health care practitioner or health institution with full authority to deal with the files as he or she may deem appropriate, provided the provisions of the rules of professional confidentiality are observed."

## LEAVING A PRACTICE

The HCPSA guidelines do not provide specific guidance with regards to leaving a practice permanently. However, Medical Protection's advice on the matter is based on an interpretation of the above mentioned guidelines.

A healthcare practitioner should inform patients that he or she is leaving their practice permanently, and it is prudent that a new health practitioner is appointed to take over the practice. The practitioner should notify the patients that they can either remain with the practice under the care of the new practitioner, or request their medical records to be transferred to a practitioner of their choice. It is sensible to keep the original medical records in the practice and provide the patients who request their notes with a copy. A healthcare practitioner who is leaving their practice should take all reasonable steps to inform the patients that they are leaving and give them the option to request a copy of their medical records.

## REFERENCES

1. Booklet 14, HCPSA Guidelines for Good Practice in the Health Care Professions

# CASE STUDY

The following is an example of the sort of query that we receive, and the advice that is provided to the practitioner

## SCENARIO

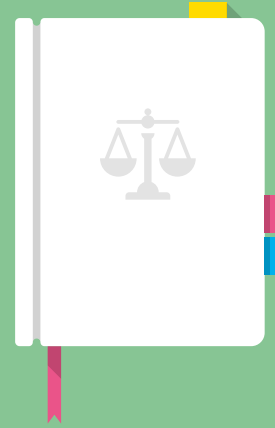
Dr F has taken the decision to retire and is considering closing down his practice. He therefore requires guidance on the ethical and legal responsibilities associated with informing his patients and the appropriate retention and storage of their medical records.

## ADVICE

As referenced above, Dr F was advised to adhere to the HPCSA Guidelines for Good Practice in the Health Care Professions (specifically with regards to Booklet 14 on Keeping of Patient Records<sup>3</sup>). The practitioner was advised to follow the below steps:

- Dr F should notify all of his patients in writing that the practice is being closed and provide the date of the closure;
- He should advise them that they have the right to request a copy of their medical records to be transferred to a practitioner of their choice.
- Dr F should ensure the safe-keeping of the records of the remaining patients for a period of 12 months by an identified healthcare practitioner of an appointed health institution.

Dr F was also advised to make all reasonable attempts to reach all of his patients and inform them of the closure of the practice. If possible, Dr F should place a notification of the closure of the practice in local newspapers, and put a notice near local hospitals and pharmacies to extend the range of his statement. Dr F was advised that if patients follow him on social media, he could use his Twitter account, Facebook page or website to make a statement informing the patients of the change.



The cases mentioned in this article are fictional and are used purely for illustrative purposes.

# FORGED PRESCRIPTIONS

Fraudulent prescriptions for medication can occur for a number of reasons; **Ralitsa Sahatchieva & Dr Volker Hitzeroth** explain what steps to take if it happens to you

**A**t Medical Protection, we are often contacted by practitioners who have been informed that a forged prescription has been made in their name, and are seeking advice on what steps to take next. Our experience has taught us that fraudulent prescriptions can occur for a number of reasons, which range from a patient who wants to avoid paying a consult fee for a repeat prescription, to a patient who suffers from substance abuse and wishes to exploit the prescription provided by a practitioner.

In the event that a practitioner is informed of a forged prescription in their name, they should follow the steps outlined below. This will ensure compliance with the law as well as the relevant ethical guidelines.

The HCPSA Guidelines for Good Practice in the Health Care Professions<sup>1</sup> states that:

- A practitioner must be “authorized in terms of the Medicines and Related Substances Act, 1965 (Act No. 101) to prescribe medicines”
- “such prescriptions may be issued only under his or her personal and original signature.”

Furthermore, the Medicines and Related Substances Act<sup>2</sup> stipulates that a patient should not be in possession of a medicine unless it is provided on legal prescription, supplied by an authorised practitioner and dispensed from a pharmacy. It stands to reason then, that a forged prescription classes as fraudulent conduct – and consequently imposes certain ethical and legal responsibilities on the practitioner who prescribed the medicine.

If a practitioner is alerted by a pharmacy or a third party that his/her prescriptions have been forged, it is imperative for them to report the incident to the relevant authorities as soon as possible for prevention of fraud purposes.

The practitioner should first of all report the matter to South African Police Service. If the practitioner is, for some reason, unaware of the patient’s name, he/she should still report the matter as an incident, and an investigation will be opened by SAPS.

The practitioner should then also report the case to the Pharmaceutical Society of South Africa. The Pharmaceutical Society will issue a warning to the pharmacies in the area in which the forged prescription was attempted to be used; the warning will simply inform the pharmacies to be diligent of any further prescriptions under the practitioner’s name. When reporting an incident of forged prescriptions to the Pharmaceutical Society, always remember to include the name of the South African Police officer the incident was reported to, and the office to which they belong.



**Fraudulent prescriptions can occur for a number of reasons, from a patient who wants to avoid paying a consult fee, to someone who suffers from substance abuse and wishes to exploit the prescription provided by a practitioner.**

By following these steps, you will adequately comply with your legal and ethical obligations regarding forged prescriptions.

If you are concerned that you have been the victim of a forged prescription and would like personalised advice on the steps to take, please contact our advice line.



## CASE STUDY 1

Medical Protection received a request for assistance from Dr H, who was based at the local university's Student Health Centre. He said that the university photocopying shop had contacted him to report that a student was found to have made numerous photocopies of a prescription from Dr H for Ritalin. The prescription did not reveal the patient's name; this section of the prescription had been left blank. The shop staff confronted the student, but he ran away, leaving behind the original script on the photocopying machine panel.

As Dr H consults with numerous students for a variety of conditions, including adult ADHD, it was impossible to identify a named patient of the practice. Dr H recalled that, six months ago, another student patient had disclosed to him that prescriptions on his letterhead were sold online. At the time, Dr H had not acted on this and had since forgotten about it. However, upon hearing from the staff at the photocopying shop, Dr H made contact with the university administrative office and was told that they were already investigating the matter due to a tip-off from another student. Dr H contacted Medical Protection in order to mitigate the potential damage to his practice, and to receive further guidance on the next steps available to him.

*The cases mentioned in this article are fictional and are used purely for illustrative purposes.*

## CASE STUDY 2

Dr R is a general practitioner who had recently qualified and moved to a new area in order to open a private practice. Dr R contacted Medical Protection requesting advice as she had received a call from her local pharmacy, informing her that they had received a seemingly forged prescription on her letterhead. She was told that the script was written for a Mrs X and requested the pharmacy to issue Ativan 4mg sublingually three times daily for 12 months. The pharmacist was suspicious of the amount and duration of the medication, and also indicated that the prescription seemed altered.

Dr R could not recall this patient but did check her medical records, which confirmed that she had consulted with Mrs X about three months before for panic attacks and benzodiazepine and alcohol dependence. At the time, Dr R requested Mrs X to return within two weeks and had prescribed Ativan 1mg sublingually for two weeks to be used as needed. Mrs X never returned for her follow-up visit. It would therefore seem that the prescription was altered to reflect a higher dose and longer duration.

Dr R was extremely distressed; she was concerned that this turn of events would reflect on her new practice. She was advised to request a copy of the forged prescription from the pharmacy and thereafter to report the matter to the South African Police Service (ensuring that a case number was issued to her) and the Pharmaceutical Society of South Africa (quoting the case number).

### REFERENCES

1. Booklet 2 of the HPCSA's Guidelines for Good Practice in the Health Care Professions
2. Medicines and Related Substances Act (Act no. 101 of 1965) Section 22a (1)



# HOW TO ACHIEVE SAFER AND RELIABLE PRACTICE

Higher reliability promotes safer healthcare for patients, as well as potentially decreasing medicolegal risk for clinicians. **Vanessa Perrott**, Head of Educational Development and Delivery at Medical Protection and Honorary Lecturer in Obstetrics and Gynaecology at the University of Cape Town, looks at how a new workshop for members aims to make patients' healthcare experience more reliable

Safe healthcare requires both the expert knowledge and technical skills of healthcare professionals, as well as reliable delivery and application of that knowledge and skill.

In the new Medical Protection workshop *Achieving Safer and Reliable Practice*, reliability is defined as minimal unwanted variability in the care we have determined our patients should receive. Any figure below 80% reliability would be termed 'chaos' in other safety critical sectors, and yet in some areas of healthcare we can struggle to achieve and sustain consistency at levels of 80% or higher.

Examples of the variation in reliability in healthcare are readily available. The Health Foundation's report in 2010<sup>1</sup> found that in nearly one in five operations, equipment was faulty, missing or used incorrectly; around one in seven prescriptions for hospital inpatients contained an error and full clinical information was not available at just under one in seven outpatient appointments. The report also commented on the wide variations in reliability between and within organisations.

## HOW RELIABILITY IS QUANTIFIED

Reliability is often expressed in terms of failure rate as a power of 10. For example, a procedure that is reliable nine times out of ten fails 10% of the time, or has  $10^{-1}$  reliability. A procedure that fails 20% of the time has a reliability of  $>10^{-1}$ .

Systems that fall below  $10^{-1}$  reliability are generally considered 'chaotic'.

## WHAT LEVEL IS ACHIEVABLE?

Research suggests that implementation rates in healthcare for standard procedures that impact on patient safety are between 50% and 70%, or  $>10^{-1}$ .

Other industries, such as aviation and nuclear power, have achieved reliability levels of  $10^{-6}$  in critical processes. In healthcare, anaesthetics have been successful in achieving this level of reliability during the induction of anaesthesia. This and other reliable practices, such as blood transfusions and pathology labelling, can inspire and lead the way for all of us, whether practising in primary or secondary care.

## STANDARDISATION

Standardisation can help achieve reliability, particularly where a specific intervention is desired and required for every patient, every time. Of course, 100% standardisation is unachievable and, in fact, undesirable; some variability will be required due to the incredible complexity of clinical medicine. Standardisation of the routine allows professional autonomy and desired variability to flourish, and ensures best care is delivered to each individual patient in increasingly complex clinical situations.

Eliminating unwanted variability is the goal.



## WHAT DOES THE WORKSHOP COVER?

The workshop takes time to tease out the concepts of Reliability Science and it is designed to equip every clinician with skills that can be used immediately to reduce risk in practice.

An *AlwaysChecking™* approach is explored, which comprises five steps that offer manageable evidence based measures to raise reliability in any healthcare setting.

### MOVING TO 10<sup>-2</sup>

The MPS *AlwaysChecking™* approach

Principle - We always check	Strategy
each other and welcome being checked	Speaking up
what we've agreed should be done	Checklists
message sent is message received	Repeatback/Readback
we know how to work together	Briefing and Simulation
always means always	Measurement and Accountability

## SPEAKING UP

Perhaps the most important strategy is that of 'Speaking Up'. Safe cultures train and insist on respectful assertive communication. In healthcare, we often find that following an error, one member of the team had 'seen it coming' but felt unable to say anything. There are often complex reasons for this and simple steps by individual clinicians can transform safety.

Speaking up is only possible in a culture that accepts that everyone will make mistakes - some of which may be catastrophic.

## MEASUREMENT AND ACCOUNTABILITY

Another area of the *AlwaysChecking™* approach focuses on Measurement and Accountability.

Within many organisations and teams, there will be some clinicians who do not conform to agreed safety procedures. Allowing 'special rules' for some is toxic and it can sabotage success.

Challenging these individuals can be extraordinarily difficult and yet without doing so, high reliability and safety cannot be achieved. The hand washing success story<sup>2</sup> from Vanderbilt University Hospital system in the USA demonstrates the importance of measurement, feedback and accountability - highlighting the power of insisting that 'always means always'. This healthcare system employs thousands of doctors across all disciplines.

The results achieved in 2009 (>10<sup>-1</sup>) were achieved using strategies based on individual memory and diligence. In 2010, the centre moved to a detailed monitoring and individualised feedback and benchmarking process, leading to 10<sup>-1</sup> levels of reliability. In 2011, the centre moved to implement increased personal accountability and the level of compliance has been maintained (and even increased towards 10<sup>-2</sup>).

### EXAMPLE

Hand washing programme

Year	Hand Washing Rate
2009	58%
2010	80%
2011	92%

- 30% reduction in serious hospital infections
- Estimated annual net savings of \$4.5m
- Tenfold reduction in ICU central line infection rate (now one quarter of national benchmark)

The benefits to patients, in terms of morbidity and mortality reduction, along with the economic benefits to the hospital and the decreased risk of complaint and claim for the clinicians, is a testament to the value of measurement and accountability in achieving 10<sup>-2</sup> reliability.

The workshop concludes by offering a simple tool for introducing improvements to systems and processes. This incorporates Human Factor prompts and allows novices and experts alike to reflect on the various stages and challenges that each of us face when introducing safer and reliable practice. Delegates often have inspirational stories of success to share, and it is hoped that a combination of taught science, peer learning and discussion will generate confidence; and in turn, that each and every delegate can contribute towards achieving safer and reliable care for patients.

For further information and bookings go to  
[medicalprotection.org](http://medicalprotection.org)

#### REFERENCES

1. The Health Foundation, How Safe are Clinical Systems? Primary research into the reliability of systems within seven NHS organisations and ideas for improvement. May 2010
2. Vanderbilt University Medical Centre, VUMC HH Program Observer Recognition Nov 2012 [PowerPoint slides], VUMC (2012) Available: <http://www.mc.vanderbilt.edu/documents/handhygiene>



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# FACE-TO-FACE LEARNING



The Mastering workshops  
should be compulsory.  
Very informative.



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