practicematters

Professional support and expert advice for GPs and practice staff

MPS

Putting members **first**

SOUTH AFRICA | VOLUME 1 – ISSUE 1 | JULY 2013

Counting the cost

Are clinical negligence claims changing the face of general practice?

PAGE 8

THIS ISSUE...

www.medicalprotection.org

How to contact us

MEDICOLEGAL ADVICE

www.mps-group.org/za-mla

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

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

MEMBERSHIP ENQUIRIES

South African Medical Association
T 0800 225 677 (toll-free within RSA)
E mps@samedical.org

Ian Middleton
T 0800 118 771 (toll-free within RSA)
E mps@global.co.za

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

THE MEDICAL PROTECTION SOCIETY

Please direct all comments, questions or suggestions about MPS service, policy and operations to:

Chief Executive
Medical Protection Society
33 Cavendish Square
London W1G 0PS
United Kingdom

chief.executive@mps.org.uk

www.medicalprotection.org
www.dentalprotection.org

Editorial Board

What's inside...

We welcome contributions to ***Practice Matters***, so if you want to get involved, please contact us on **+44 113 241 0683** or email: **sarah.whitehouse@mps.org.uk**.

MARKETING
Mo Khan, Alika Maharaj, Ian Middleton

DESIGN
Allison Forbes

PRODUCTION
Philip Walker

Practice Matters
Victoria House, 2 Victoria Place, Leeds, LS11 5AE, UK

Practice Matters South Africa (Print) ISSN 2052-6067
Practice Matters South Africa (Online) ISSN 2052-6075

Cover: © PAULGREGG/ISTOCKPHOTO.COM

Welcome

Dr Graham Howarth –
Editor-in-chief, MPS
Head of Medical Services (Africa)

Welcome to the very first edition of *Practice Matters*, a magazine for the whole general practice team.

Practice Matters aims to provide practical tips on risk management and medicolegal issues for your whole practice. As a not-for-profit mutual organisation, we seek to share our experiences to improve the quality of healthcare and improve understanding about patient safety.

There is a wealth of diversity in the way that primary healthcare is delivered in South Africa, as pages 6-7 highlight. But whether you work single-handedly or as part of a large clinic, in a rural setting or in an urban centre, or in the public or private system, the potential medicolegal pitfalls remain a constant. 'On the record' on pages 12-13 offers tips to reduce your risk by keeping patient records accurate – and securely stored.

Doctors today have to practise in an increasingly hostile, pressurised and uncertain healthcare environment. The rising costs of clinical negligence claims are not only having a financial impact, they are making some GPs, understandably, practise more cautiously and more defensively, as pages 8-9 show.

Doctors are also under a professional obligation to be open and honest. Probity and professionalism go hand in hand, and we look at the consequences of bending the truth on pages 10-11.

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

Graham Howarth

© ALEX ORROW 2011

Inside...
Mastering Your Risk

Sara Williams reports from *Mastering Your Risk*, the first in a series of communication skills workshops provided by MPS, for members in South Africa.

What motivates patients to take action against their doctor?

Most people take action because they are dissatisfied with how their doctor has treated them. Studies have shown that most people have already chosen to take action before their doctor has even made an error. Evidence suggests that the likelihood of receiving complaints and claims may be reduced through effective communication.

Background

Up until the early 1990s there was a simplistic view about preventing risk: if doctors were technically good they would be low risk. This is not true. Several studies turned this on its head by revealing that only 2-3% of patients who suffered negligence actually sued their doctor, and 70% of litigation is related to poor communication after an adverse event.

On the back of this research MPS launched a series of risk management workshops to teach doctors how to prevent complaints and claims by improving their interactions with patients and colleagues.

I recently had the pleasure of attending the first workshop in this series: *Mastering Your Risk*.

Inside *Mastering Your Risk*

Dr Ruth Livingstone, the MPS facilitator for the day, brings with her 30 years' experience working as a GP. She started the first half of the three-hour workshop by exploring why patients sue their doctors, using real comments from patients as examples. The role of communication was explored as the delegates watched a video depicting a very poor consultation.

Lively debate dominated the latter part of the workshop, as the delegates learned how they can improve their interactions with patients and put their new-found knowledge into practice on each other. After a final session on risk-reduction strategies for medical teams, Dr Livingstone ended the workshop on a positive note, reminding delegates that by adopting a range of simple communication skills, their personal risk is reduced.

Her take-home message for delegates was simple: "People are reluctant to sue someone they like."

Don't take our word for it: **"The workshop was, as usual, of high quality and informative. The standard we have come to expect from MPS. It really made me aware of the possible litigation risk lurking, and to keep me on my guard at all times."** Dr Aadil Ahmed, a previous delegate of the *Mastering Your Risk* workshop.

Mastering Your Risk is the first in a series of communication skills workshops provided by MPS. Other workshops in these series are currently available **free** of charge to MPS members. For more information including forthcoming dates, venues and online booking please visit: **www.medicalprotection.org/southafrica/education**.

Save the Date for *Ethics 4 All* 2013

Ethics 4 All

Our annual ethics event provides an opportunity for members to examine ethical challenges and obtain CEU points for the ethical component of their professional development. The events are free of charge for MPS members.

Ethics 4 All has been running for the past five years, and last year more than 2,500 delegates attended across three locations.

In 2013 we are delighted to be hosting three events:

DURBAN: Sunday 1 December 2013 (morning event)
Venue: Southern Sun Elangeni Hotel
In conjunction with KZNMCC
Chaired by Dr Mzukisi Grootboom, Chairperson, South African Medical Association (SAMA)

PRETORIA: Monday 2 December 2013 (evening event)
Venue: CSIR International Convention Centre
In conjunction with Ampath
Chaired by Professor Martin Veller, Professor and Head, Department of Surgery, University of the Witwatersrand

CAPE TOWN: Wednesday 4 December 2013 (evening event)
Venue: Cape Town International Convention Centre (CTICC)
In conjunction with PathCare
Chaired by Dr Mark Sonderup, Vice Chairperson, South African Medical Association (SAMA)

2013's programme has been developed to cover core bioethical and medicolegal issues, based on feedback from last year's events, and includes:

- **Walking the Ethical Tightrope – Falling Foul of Ethics** – Trends in Complaints and Claims; MPS Claims Experience in South Africa; Common Problems
- **Ethics of Managed Healthcare Resources** – Squeeze on Private Health; Undercover Reporting and Distributive Justice
- **Adverse Events in Healthcare and the Ethics of an Apology** – The Importance of Being Open; Raising Concerns; Professionalism and Criticising Colleagues
- **Mastering Shared Decision Making** – Unreasonable Patient Demands; Appropriate and Informed Choices about Treatment; Patient Decision Making.

Dr Graham Howarth, MPS Head of Medical Services (Africa) says: "Set against the backdrop of an adverse claims environment and increasing complaints to the HPCSA, providing support and guidance to doctors about ethical issues by way of these conferences is both timely and fulfils a key educational need."

Registration for the events will open in August 2013 and members will be alerted via email once registration is live.

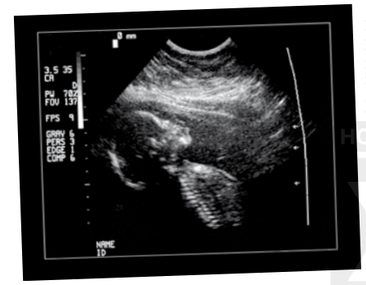
A full copy of the conference programme can be found at: **www.medicalprotection.org/southafrica/events-and-conferences/ethics-for-all**

For more information please contact: **stacey.mack@mps.org.uk**

Changes to scope of MPS indemnity for fetal anomaly scan

MPS will no longer offer indemnity to GPs and other non-specialist healthcare professionals conducting ultrasound scans to check for fetal anomalies. This will affect members who renew their MPS membership from 1 October 2013.

MPS is concerned by the heightened risk faced by healthcare professionals who perform detailed fetal ultrasound scans. A failure to detect abnormalities can be due to deficiencies in equipment, training issues or lack of detail in the scan reports produced, and is expected to lead to a significant increase in the cost of claims.



© PHOTODISC.COM

When members renew from 1 October 2013, only specialists in obstetrics, gynaecology and radiology will continue to be indemnified by MPS for performing detailed scans to detect fetal anomalies, with radiologists being charged a higher subscription rate. Members whose annual renewal date falls before 30 September 2013 will not be affected by these changes until they renew in 2014.

GPs and radiographers will still be able to access indemnity for carrying out basic 'dating' scans, limited to the confirmation of pregnancy, its location and gestational age by measurement of crown-rump length or biparietal diameter in the first trimester of pregnancy, but will now be charged the 'Procedural GP' subscription rate.

These changes have been carefully considered and are in line with MPS policies on ensuring members are appropriately trained and experienced in the procedures they carry out. Specialists who can continue to perform detailed scans have a duty to ensure the equipment they use is fit for purpose.

More information can be found at **www.medicalprotection.org**. Members who will be affected by this change and have concerns about the impact on their practice can contact us for more information: **mps@samedical.org**.

© KUTBERK/ISTOCKPHOTO.COM

Moves for cheaper medicines

South Africa plans to overhaul its intellectual property laws to improve access to cheaper medicines.

This will make it harder for pharmaceutical firms to register and roll-over patents for drugs.

The reforms aim to close a loophole known as "ever-greening", where drug companies slightly modify an existing drug whose patent is about to expire and then claim it is a new drug, thereby extending patent protection – and profits.

If approved by parliament, the changes should mean cheaper medication for cancer and HIV/AIDS in South Africa.

www.fin24.com

The diverse world of general practice

General practice in South Africa is a specialty of contrasts, say *Professor Julia Blitz* and *Dr Zandy Rosochacki*

The different strands of public and private sector and rural and urban practice come together under the term general practice.

Professor Julia Blitz is Associate Professor of Family Medicine at the University of Stellenbosch

Public sector

Following community service, many doctors start to look for a registrar post in their chosen speciality. Others choose the route of general practice, where there is no need to embark on the rigours of postgraduate training.

In the public service, this is not a restrictive choice at all. It can allow you the freedom to move between different disciplines (this might be in the process of deciding which one you might like to specialise in at a later date), or to remain in one discipline developing the practical knowledge, wisdom and experience which make you a very dependable member of the healthcare team (the so-called career medical officer). You can choose to work in any of the full range of public healthcare facilities – large urban hospitals, small rural district hospitals, community health centres (CHCs), or disease specific clinics (eg, HIV), or a non-governmental organisation (NGO). Depending where you choose to work, you may end up using and developing different skill sets – the NGO may require you to develop project management or grant writing skills; the CHC may require you to develop expertise in ambulatory care of patients with chronic diseases and the skill to help people make healthier lifestyle choices; the district hospital may require a skill set that encompasses procedural skills and emergency care; the large urban hospital may require a skill set restricted to a specific discipline, but including outpatient, ward and theatre work. You could also pursue a career as a member of a research team.

One of the options for general practitioners who develop a particular interest in a discipline is to pursue a Diploma through the Colleges of Medicine of South Africa. Almost every constituent College (including the College of Family Physicians) offers a Diploma, which does not require the candidate to be in a registrar position in order to be eligible for the exam. This does give the general practitioner certification of a nationally recognised level of skill in the particular discipline.

Working as a general practitioner in the public sector in South Africa does mean that your potential career and pay progression is capped at a level lower than a specialist might reach, but deciding to pursue this path needs to be weighed up against other choices that you are confronted with about how you want to live life outside work. At least your working hours are set, and you will have a fixed income at the end of each month. However, conditions can be quite difficult if the staff complement is not filled, there is inadequate maintenance of infrastructure, and inconsistent supplies of consumables. There are opportunities to build well-working teams (both inside the hospital and with the community-based healthcare providers) and to improve systems to provide more efficient care, so jobs in the public sector can provide both interesting challenges and chances to problem-solve in unique ways, to really make you feel that you are contributing to improvements in patient care.

Pursuit of a postgraduate qualification is not an essential requirement for a very fulfilling career in general practice in the public sector.

> One of the options for general practitioners who develop a particular interest in a discipline is to pursue a Diploma through the Colleges of Medicine of South Africa

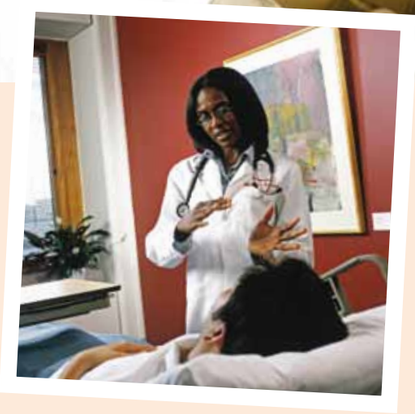
Dr Zandy Rosochacki is currently in a government Family Medicine post in a District Hospital, heading the primary health clinic outreach

Private sector

Working as a GP in private practice, you have a smaller pool of patients you care for than in the public sector, but you have to work very intensively. You are able to provide continuity of care: covering conditions from the cradle to the grave by practising at the level of competence that befits your skill and the needs of your community. So, if you are a rural GP, you may well perform caesarean sections or general anaesthesia as part of your routine workload. In an urban setting, you will more likely become an expert in palliative care, or sports medicine. If you have a gift to teach, there are several family medicine departments to link you to students.

Do you have power over your workload anywhere? Well, here you certainly can set the pace for good quality consultations you and your patients can be proud of. This alone is worth a lot! There are often complaints about third party payers (medical aids that broker the fee for service arrangements), but if you knuckle down and practise good medicine, patients will want your care and the income will take care of itself.

Can it get boring? If you want action work in the country, if you love human interaction and can see a preventive opportunity in a seemingly trivial presentation, there will be endless anecdotes to feed on. Good medicine means treating any patient, any time, with any problem. You embrace them all.



> You are able to provide continuity of care: covering conditions from the cradle to the grave by practising at the level of competence that befits your skill and the needs of your community

Can it frustrate you? Yes, there is a weakness in the current system in that you intellectually know you are only looking after a chosen (their choice and yours) selection of patients in your community. Certain common diseases (eg, HIV, TB) may pass you by unless you make a specific effort to remain competent in these spheres. The good news is that NHI will open the playing fields and though private, your work is now likely to open up. This is one more important skill to retain: remain competent to work in a public sector primary health clinic.

Does it get lonely? Yes, but if you position yourself in long-term real relationships you will be buoyed up. Remarkably, you will always have someone who will happily accept a patient you refer. This is not true for the public sector GP, who may be pushed deep into levels of clinical dissonance and discomfort.

One of the great joys of being a GP is assisting good surgeons. You will remain privy to high-end medicine where all current diagnostic and treatment modalities are at hand. You will see a range of pathology you do not see in the public sector. You may assist your own patient with colon cancer resection, or a hysterectomy, or even a kyphoplasty for a fractured thoracic vertebrae. Assisting in a knee replacement remains a treat. You are paid well for the work and it allows a break from consulting.

Is there a downside? Make sure you keep yourself intellectually and physically involved. Dream up new challenges each year and build on your practice team. This is where negativity and rot can set in and demoralise good work. In public GP work, ever younger and sharper colleagues enter the fray. In private GP work, you all grow old and wrinkled together, patients and staff included!

Can the two roles of public and private sector GP be compared? They are, in many senses very different. In the public sector, you must grow in your supervisory and leadership capacity; in private practice, you must remain faithful to your patient following and your comfortable position in the hierarchy of fellow doctors. Whatever the differences, both public and private sector GPs are generalists, and both want to practise good medicine.

Counting the cost of GP claims

© PAULGREGG/ISTOCKPHOTO.COM

The cost of claims in South Africa is escalating. Not only is such an increase having a financial impact, it is changing the way some GPs practise, says *Sarah Whitehouse*

The cost of clinical negligence continues to rise in South Africa. At the same time, there has been a rise in the number of HPCSA complaints. These increases are so significant that some specialists have been left questioning whether they should even continue to practise. Others have adopted a more defensive approach to try and safeguard themselves against the increased risk of complaints and claims.

In the four years up to 2011, MPS experienced a 30% increase in the frequency of medical negligence claims reported in South Africa. Some of these claims start off as complaints. In the period between April 2011 and March 2012, the HPCSA received 2,403 complaints, many of which related to claims of misdiagnosis, practising outside the scope of practice, and refusal to treat patients.[1] "The cost of an average claim has roughly doubled every five years," says Dr Graham Howarth, Head of Medical Services (Africa). "A claim which would have settled for R1 million in 2002 would cost R4 million in 2012. MPS is concerned that this rising trend will continue."

But why are the volume and costs of claims increasing? It's not necessarily an indicator of poor professionalism, or inadequate clinical skills. There has been an increase in the size of awards for catastrophic neurological damage – technological advances and improved life expectancy mean that the cost of care for affected patients has escalated; which is reflected in the size of financial award. The reaction of lawyers to the Road Accident Fund (RAF) Amendment Act, which capped the amount of compensation payable to road accident victims, and lawyers' more extensive advertising, are likely to have had an effect in increasing the volume of clinical negligence claims, as lawyers have to look for other avenues to generate income. In addition, Dr Howarth explains that patients in a developing country, like South Africa, were always likely to become increasingly aware of their constitutional rights, making them more likely to lodge a medical negligence claim, or a complaint, particularly following the HPCSA's awareness campaign.

Another possible factor is the increasingly stressful, hostile and pressurised environment in which doctors today have to practise medicine. Higher patient expectations and the fear of the consequences of making an error can, paradoxically, lead to more errors occurring. There is uncertainty around National Health Insurance, relationships with private medical schemes are increasingly trying, resources are being stretched, and the gap between patient expectations and the reality of what can be delivered continues to widen.

> "We are forced to do unnecessary tests that drive costs of healthcare up because of pressure from medicolegal actions"

Defending the risk

Against this backdrop, it is no wonder that some doctors feel they must practise defensively to minimise the increased risk of receiving a complaint or a claim. In an MPS survey of private GPs in 2012, 76% of members said they were very aware of significant growth in medical negligence claims and complaints in South Africa.[2] Fifty eight per cent said they had changed the way they practise as a result.

Some of the changes cited are undoubtedly positive: 86% of doctors revealed that they keep more detailed medical records as a result of increased complaints and claims.[3] Good medical records are the cornerstone of a successful defence, but equally provide the basis for quality and consistent clinical care. One MPS member said: "I have improved my note taking of a patient's condition; even the time of day that I saw the patient is written down in the file. I keep copies of referral letters and other administrative papers that patients request of me. I use computer-based recordings of sent SMS-messages."

Eighty three per cent said they are more careful to ensure that suitable follow-up arrangements are in place.[4] Another member described a heightened awareness of the need for good communication: "I spend more time with patients. Consultations are taking longer as I try and explain risks, benefits, and complications with patients."

Perhaps an increase in claims has helped to focus minds on the importance of following existing HPCSA guidance. Mindful medicine does have its advantages.

Yet not all the changes in practice in an increasingly litigious world are as positive, or in the patient's best interests. It is important not to create a culture of fear, or a culture of practising medicine defensively for the doctor's, rather than the patient's, sake. Defensive medicine is different from defensible practice, which is good practice. Defensive medicine is commonly defined as the ordering of tests or treatments to help protect the doctor rather than to further the patient's diagnosis. Professor David Studdert, ARC Laureate Fellow at the University of Melbourne, identified two types of defensive medicine:

- **Assurance behaviour** (positive defensive medicine) – providing services of no medical value with the aim of reducing adverse outcomes, or persuading the legal system that the standard of care was met, eg, ordering tests, referring patients, increased follow up, prescribing unnecessary drugs.
- **Avoidance behaviour** (negative defensive medicine) – reflects doctors' attempts to distance themselves from sources of legal risk, eg, forgoing invasive procedures, removing high-risk patients from lists.[5]

Sixty five per cent of GPs interviewed acknowledged that they conduct more investigations as a result of increased complaints and higher value claims, with 67% revealing that they now refer more patients for a second opinion – typical assurance behaviour.[6]

One MPS member said: "We are forced to do unnecessary tests that drive costs of healthcare up because of pressure from medicolegal actions." Some tests may be invasive and have their own inherent risks, and doctors could potentially be criticised for ordering investigations that are not in patients' best interests (eg, if the risks associated with the procedures outweigh any potential benefit to the patient).

Avoidance behaviour is evident in the fact that 61% have chosen to stop dealing with certain conditions or performing certain procedures. Twenty nine per cent say they had a lower threshold for removing patients from the practice list.[7] Such decisive action may resolve a difficult situation with a challenging patient quickly in the short term, but it may also encourage complaints from those who feel they have received poor care, or who have not been given an open and honest explanation of what went wrong, and why, if there has been an adverse event.

What is defensive medicine to one person may be high quality care to another.[8] A good rule of thumb is to remember the HPCSA's advice that all doctors should: "Always regard concern for the best interests or well-being of their patients as their primary professional duty."[9] Dr Howarth says: "If a claim for clinical negligence is brought against a doctor, they will be asked why they did or did not do something. A defence will not be based on the number of tests they did, but the clinical reasoning behind their actions. As long as a doctor can look back and justify their decision in accordance with a responsible body of opinion, they are safeguarding their practice."

Action *is* being taken to address the costs and causes of clinical negligence. MPS has met with the Department of Health to discuss working together to control these rising costs. Change won't be immediate, however. In the meantime, it remains important for all general practitioners to ensure that their indemnity arrangements cover their area of practice, and to ensure that they start each new consultation from a principle of defensible practice – rather than defensive medicine.

> "I have improved my note taking of a patient's condition; even the time of day that I saw the patient is written down in the file"

STRATEGIES TO MINIMISE DEFENSIVE MEDICAL PRACTICES

- Communicate effectively with patients, explaining what you are doing and why
- Have robust systems for follow-up
- Be open about risk
- Offer an appropriate standard of care
- Only order tests based on a thorough clinical history and examination
- Discuss difficult cases with colleagues
- Keep clear and detailed documentation
- Know what it is you seek to exclude or confirm with a test to determine if it's necessary
- Identify learning needs (find a good mentor)
- Undertake courses or independent study.

REFERENCES

1. Malherbe J, Counting the cost: The consequences of increased medical malpractice litigation in South Africa, *S Afr Med J* 103(2):83-84, (2013)
2. South Africa Member Survey – 2012 GPs (695 private GPs)
3. Ibid
4. Ibid
5. Studdert D et al, Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, *J Am Med Assoc* (2005)
6. South Africa Member Survey – 2012 GPs (695 private GPs)
7. Ibid
8. Kravitz R et al, Omission-Related Malpractice Claims and the Limits of Defensive Medicine, *Med Care Res Rev* (1997)
9. HPCSA, *General Ethical Guidelines for the Healthcare Professions*, Section 5.1.1 (2008)

PRACTICE MATTERS | VOLUME 1 – ISSUE 1 | 2013 | **www.medicalprotection.org**

Tell the truth

General practitioners are seen to be honest, upright members of a community, yet probity issues are becoming more widespread. *Dr Carmen Gerber* looks at why probity and professionalism go hand in hand

Dr Carmen Gerber is a GP based in the Eastern Cape

Service provider fraud is on the increase, with the two most common causes being code manipulation and services not rendered.[1] Some healthcare practitioners are acting unprofessionally and unethically by loading patients' bills with multiple codes instead of using one billing code for a procedure; claiming fees for services that were not rendered; or by performing unnecessary investigations. Alarmingly, R221 million was attributed to medical aid fraud over the period 2007 – 2009 in a report by KPMG.[1] These fraudulent activities have significant financial implications for South African citizens by further adding to the high cost of membership fees, making private healthcare unaffordable and inaccessible for many citizens. Fraudulent activities also harm the patient's and the public's trust and compromises a healthcare practitioner's integrity, honesty and independence.

How are probity and professionalism linked?

Probity implies that a doctor will, at all times, act with integrity to protect patient and public trust in the medical profession.[2] Medical professionalism allows doctors the independence to perform their duties with integrity[3] and can be defined by qualities such as "humanism and altruism" (including ethical principles such as beneficence, respect, integrity, truthfulness and placing patients' needs first) and "excellence and accountability"[4] (including continuous education andproviding healthcare services of a high standard). These ethical principles, as specified by the HPCSA, should form part of a doctor's conduct with patients in practice. They should guide a healthcare practitioner's decision-making process and actions.[5]

The HPCSA states that professionalism allows a relationship of mutual trust between patients and healthcare practitioners.[6] Thus medical professionalism can be viewed as a contract between the medical profession and society, with the doctor–patient relationship at the heart of this relationship. Society's trust in doctors is dependent on the integrity of the individual doctor and the integrity of the medical profession as a whole.[7]

If a doctor's behaviour does not conform to the HPCSA's ethical and professional code of conduct, it is seen as unprofessional behaviour, compromising quality healthcare and risking patient safety.[7] Doctors should act with integrity in all financial interactions with patients and medical schemes.[8] The HPCSA states clearly that "healthcare practitioners shall not charge or receive fees for services not personally rendered, except for services rendered by another healthcare practitioner or person registered in terms of the Health Professions Act (Act No.56 of 1974), which regulates the particular profession with whom the healthcare practitioner is associated as a partner, shareholder or locum tenens".[9] The HPCSA also cautions healthcare professionals on over-servicing patients, referring to unnecessary tests, scans, procedures or care.[9]

Signing forms

In signing sick notes, death certificates, insurance claims, claims for consultations from medical aids or any other forms, reports or documents, doctors should adhere at all times to the principles of probity and professionalism. Doctors need to ensure that they are familiar with the content of documentation which they sign for and be certain that the information is not false or misleading. Doctors should remember that it is illegal to deliberately omit relevant information from certificates. All documentation should always be completed honestly and with integrity.[2]

> Some healthcare practitioners are acting unprofessionally and unethically

Medical aid probes

Medical schemes are identifying more doctors suspected of fraudulent activities through probes.[8] Doctors are being probed by medical schemes that send investigators (wired) as undercover patients for consultations to practices. Attention is paid to what the doctor prescribes, dispenses, bills and claims for the consultation. In certain situations, doctors will dispense cheaper drugs and claim for more expensive drugs from the medical scheme or add additional procedural codes (not performed during the consultation) to the bill.[8]

Doctors should ensure they act with probity and professionalism when submitting claims and never submit inappropriate, false or inflated claims. If such claims are made intentionally it is regarded as fraud, in which case MPS would be unlikely to provide assistance; and the relevant healthcare practitioner will also probably be investigated by the HPCSA.[8] Medical aid fraud is classified as "personal misconduct that does not directly relate to the practice of medicine".[8] The HPCSA protects the public and guides healthcare professionals. Nowadays, patients are more informed of their rights and responsibilities and the HPCSA encourages them to report doctors that are unprofessional in their conduct.

Furthermore, it is the responsibility of healthcare practitioners to report any activities relating to fraud or misconduct. The HPCSA stipulates that "a student, intern or practitioner shall report any unprofessional, illegal or unethical conduct on part of another student, intern or practitioner".[6]

MPS encourages healthcare professionals to keep accurate medical records. These records reflect what has taken place in the consultation and the quality of care given to patients. Good records can also form the basis of a doctor's defence in future litigations.

To protect doctors' independence and the medical profession's credibility, doctors should act with professionalism and probity. To prevent fraud, unprofessional behaviour should not be tolerated, doctors should be trained and educated on professionalism during their undergraduate training, they should reflect on their own behaviour and modify it appropriately in their daily practice and continue to learn about professionalism throughout their career.[7]

TOP TIPS FOR ACCURATE RECORD KEEPING

- Sign and date all written and electronic notes.
- Never change your notes, rather add a signed and dated amendment to it.
- Corrections in notes must be shown as alterations and have to be signed and dated.
- The relevant history and clinical findings, as well as decisions, discussions, information provided, investigations performed, results thereof, consent, referrals and patient progress should all be documented.
- Never write any offensive comments in your notes.
- Remember patients do have the right to access their own medical records (The Promotion of Access to Information Act 2000).

CASE STUDY

After sustaining a burn injury to his forearm on a Sunday afternoon, Mr C went to the local hospital, where he was received by Sister A. As Mr C was a private patient, Sister A conscientiously attended to obtaining his medical aid details and covered his arm with a burn shield, without obtaining a medical history from the patient or information on the events around the accident. Sister A then telephonically informed Dr Y, the doctor on duty for that day, of Mr C's condition. Dr Y did not come to the hospital to see Mr C that day. However, a few weeks later Mr C was surprised to find that a claim was made to his medical aid for an emergency consultation at the hospital for Dr Y (this was in addition to the costs claimed for the burn shield and hospital fee). Mr C felt this was unacceptable to be charged for a doctor's consultation when the doctor did not consult with him at all. Mr C reported the matter to the HPCSA and an investigation was launched into his complaint.

Learning points:

- Doctors should not charge patients for services they did not render.
- Fraudulent activities should be reported to the HPCSA.

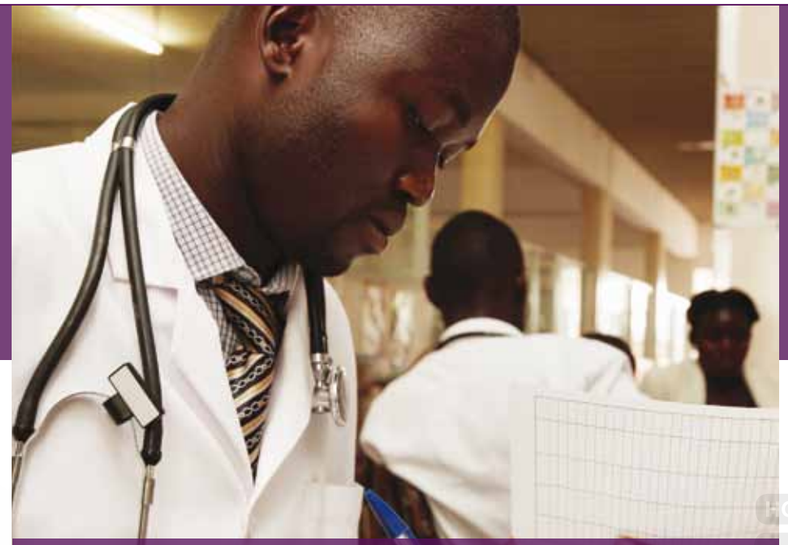
REFERENCES

1. KPMG Services (Proprietary) Limited 2011, *Medical Schemes Anti Fraud Survey* www.kpmg.com/ZA/en/Issues AndInsights/ArticlesPublications (accessed 18.5.13)
2. MPS, Probity, *Avoiding Easy Mistakes: Five Medicolegal Hazards for Junior Doctors* (2011) www.medicalprotection.org/uk/booklets/medicolegal-hazards/record-keeping (accessed 23.5.13)
3. Irvine D, The Performance of Doctors, I: Professionalism and Self-regulation in a Changing World, *BMJ*, 314(7093):1540-1542, 1997 www.ncbi.nlm.nih.gov/pmc/articles/PMC2126755/pdf/9183205.pdf (accessed 20.5.13)
4. Buchanan AO, Stallworth J, Christy C, Garfunkel LC, Hanson JL, Professionalism in Practice: Strategies for Assessment, Remediation and Promotion, *Pediatrics*, 129(3): 407-409 (2012) http://pediatrics.aappublications.org/content/129/3/407.long (accessed 18.5.13)
5. HPCSA, *General Ethical Guidelines for the Health Care Professions, Booklet 1* http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_1_guidelines_good_prac.pdf (accessed 25.5.13)
6. HPCSA, *Ethical and Professional Rules of the Health Professions Council of South Africa*, Government Gazette. Report number: 717 (2006) http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_2_generic_ethical_rules_with_anexures.pdf (accessed 25.5.13)
7. Eisele DW, Professionalism: Why it Should Matter to Us (Presidential address at 2011 American Head and Neck Society Annual Meeting) *Archives of Otolaryngology Head Neck Surgery* 137(11):1071-1077, 2011 http://www.ncbi.nlm.nih.gov/pubmed/22106229 (accessed 20.5.13)
8. Hudson C, Practice Management: The Fight Against Fraud, *Medical Chronicle* (5.3.13) http://www.medicalchronicle.co.za/the-fight-against-fraud/ (accessed 18.5.13)
9. HPCSA, *Guidelines on Overservicing, Perverse Incentives and Related Matters, Booklet 5* http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules /booklet_5_perverse_incentives.pdf (accessed 25.5.13)

On the record

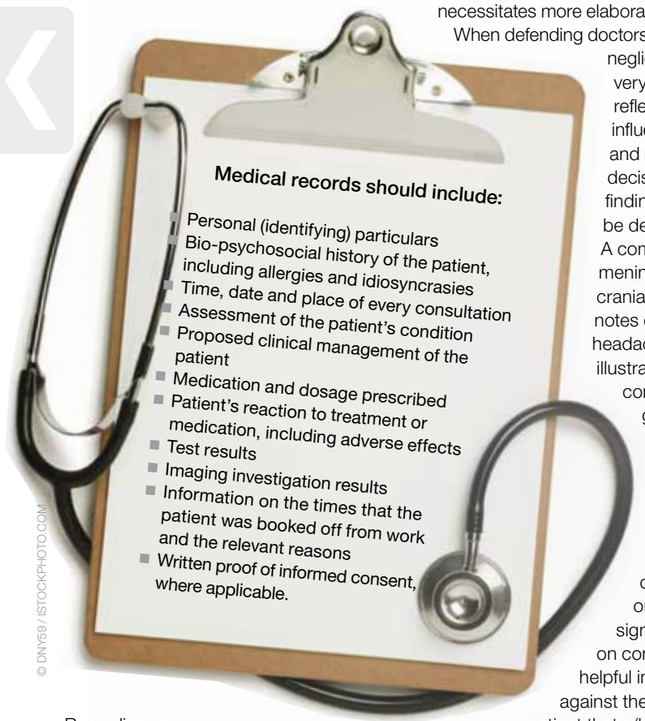
Professor Selma Smith provides practical tips to help ensure you record what is necessary and helpful in patient notes – and that you store records safely

Professor Selma Smith is Adjunct Professor, Department of Family Medicine, University of Pretoria



When defending doctors against negligence claims, it is very valuable if notes reflect findings that influenced diagnostic and management decisions

What makes a comprehensive medical record? A good place to start is the HPCSA's *Guidelines on the Keeping of Patient Records (Booklet 14)*.



Recording an "assessment of the patient's condition" might seem straightforward. Yet often, when patient records are examined in response to a clinical negligence claim, this detail is interpreted in many different ways. Interpretations vary from detailed notes on history, examination and diagnosis, to just the noting of a diagnosis, eg, "tension headache".

The latter version is not of much help if a doctor needs to defend him/herself against a complaint of negligence for missing a slow growing meningioma.

On the one hand is the need to write concise notes to save time, whilst on the other hand, doctors need to be able to justify their clinical actions and diagnoses, which necessitates more elaborate note keeping.

When defending doctors against negligence claims, it is very valuable if notes reflect findings that influenced diagnostic and management decisions. These findings do not have to be described in detail. A comment of "no meningial irritation/ no ↑ cranial pressure" in the notes of a patient with headache is helpful in illustrating that due consideration was given to so called "red flag" conditions at the time of consultation. If patients were given information on their condition, or possible danger signs, a note "advised on condition" is very helpful in defending against the complaint of a patient that s/he was not informed. The use of written leaflets is even more valuable.

Problems can also arise with information that is noted, but gets "lost" within the patient file. An example of this is the note of "blood tests taken", which can easily be overlooked. Although all practices should have a system by which new results are evaluated as they are received this is not always fail proof. A useful tip, as a backup, is to write all special investigations requested in a contrasting colour ink such as red ink, or to use highlighters. This is very easily seen when paging through a file before a consultation. The doctor can then ensure that tests are appropriately reacted on during the consultation.

Correcting an error as described by the above guidelines is specific to paper records: an error or incorrect entry discovered in the record may be corrected by placing a line through it with ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible. Additional entries added at a later date must be dated and signed in full. The reason for an amendment or error should also be specified on the record. When considering electronic patient records, the HPCSA instructions on retention of records on CD Rom gives some indication of principles to follow: electronic records need to be captured in a format that permits once only writing, so that old information cannot be overwritten, but new information can be added. Previous notes kept in the rooms must be in read-only format. A backup copy must be kept and stored in a physically different site in order that two discs/sources can be compared in the case of suspicion of tampering.

What not to write is as important as what to write. Disparaging comments indicating the doctor's irritation or dislike of a patient must never be reflected in a patient's notes. Remember, notes may be read in open court.

Keeping patient records safe

Simply put, the storage and safekeeping of patient records is about access control and protecting data against loss or corruption. All systems that handle personal information are subjected to security and privacy issues. The Protection of Personal Information Bill (POPI) – soon to be passed as an Act – endeavours to establish and formalise minimum requirements to be adhered to in the handling of personal information. POPI affects all private and public organisations that process personal information. The Bill places an extra responsibility on doctors to monitor, preserve and self-report the flow of personal information in their practices to help protect patient privacy.

Access control ensures confidentiality; one of the cornerstones on which the doctor–patient relationship is built. Because the patient is assured that information disclosed during a consultation is confidential, intimate information about his/her life can be shared with his/her medical practitioner. The privilege to have access to such information comes with great responsibility to the practitioner, who has an ethical and legal duty to keep accurate records and to keep this information confidential as stated in the National Health Act (no 61 of 2003). Such a duty of confidentiality relates not only to sensitive health information, but to **all** information that is held about patients. This information includes demographic detail and even the fact that the patient is registered as a patient of the practice. Electronic data needs virus protection. Electronic clinical records need to be encrypted and password protected to prevent unauthorised access.

All employees need to sign confidentiality agreements and must be trained in security awareness as part of the induction process, eg, access control also entails not letting patient records lie around, face up or open and not having computer monitors display information to all passing by. Access to electronic data must be gained by a personal password – do not share passwords. Local networks need to be protected by firewalls. Beware of unsecured memory sticks and mobile devices carrying patient information. When sharing data electronically outside the local office network, data needs to be encrypted. Doctors need to look closely at the security practices of contractors and service providers, and contracts with contractors need to have data protection clauses.

Disclosing information

Doctors are only permitted to release information about their patients in certain circumstances:

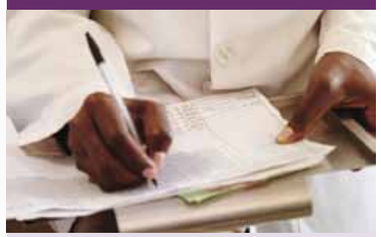
- With consent of the patient
- When disclosure is required by statute, for example the requirement to notify certain communicable diseases
- At the instruction of a court
- When it is in the public interest, for instance when there is a risk of death or serious harm to a patient or others
- In the case of a deceased patient, with the written consent of the next of kin or the executor of the deceased's estate.

Whether or not consent was legally required, the patient/next of kin must be informed that information was released.

Storing patient records

The HPCSA requires patient information to be stored in a safe place for at least six years from the date it becomes dormant. Under some circumstances, such as the records of minors, mentally incompetent patients and in terms of the Occupational Health and Safety Act (Act No 85 of 1993) this period can be even longer. Records must be kept physically secure: records need to be stored in rooms or cabinets that can be locked and preferably are fireproof. All data critical to running the practice has to be archived safely and backed up if electronic.

IN SUMMARY:



- **Notes should reflect findings that influenced diagnostic and management decisions.**
- **Records must be protected against unauthorised access by passwords, firewalls and encryption.**
- **Electronic clinical records need to be captured in a format that permits once only writing.**
- **Contracts with employees and contractors must include confidentiality and data protection clauses.**
- **Employees need to be trained to ensure security awareness.**
- **All records need to be kept in a safe place – dormant records should be kept for six years or more.**

Being an employer – it's a risky business

© MONKEYBUSINESSIMAGES/ISTOCKPHOTO.COM

You can't be held responsible for someone else's mistake. Or can you? *Dr Graham Howarth* and *Dr Mamsallah Faal* take a look at the concept of vicarious liability

As GPs, we often think of our risk in medical practice in terms of our own personal practice; what we do ourselves. We are rarely aware of how our employees can affect our risk. But vicarious liability concerns just that – instances where we may be liable for the actions of our employees. This article considers how vicarious liability relates to our risk as general practitioners, the circumstances in which it may arise, and what we can do to reduce the risks.

What is vicarious liability?

If an employee commits a negligent act or omission while acting in the course of their employment, the employer may be held to be vicariously liable for a resulting claim. This scenario is not just limited to healthcare provision, but to all instances where the employer is ultimately deemed responsible for the services provided by an employee on the employer's behalf.

It is in members' interests to ensure that any employee, locum, or independent contractor working for them with a high level of clinical autonomy subscribes to an indemnity or insurance scheme in their own right, as it is unlikely that MPS will extend the benefits of membership to assist with claims resulting from vicarious liability for such staff.

Partners are jointly and severally liable in legal actions brought against the partnership, and it is essential that each partner and every assistant is a member of a recognised protection or defence organisation, and/or appropriately indemnified/insured.

Who can be considered an employee where vicarious liability is concerned?

Where does the responsibility of the employer end with respect to acts of negligence and omission on the part of the employee? As with all things related to risk, there are no absolutes.

Most of the work that has been done on this considers the role of control as the defining factor for deciding liability. In a typical employer-employee relationship, the locus of control lies with the employer and the employee acts within the parameters that have been set by the employer. In the healthcare setting, typical employee examples would include in-house practice staff such as non-clinical administrative staff, dispensers, practice nurses and phlebotomists. It is assumed that as they have been recruited, trained and retained by the employer, the employer may be deemed liable should there be a claim against them. For example, there have been documented cases where claims have arisen because of a failure by non-clinical staff to communicate patient complaints to their employer, communicate patient update information from hospital personnel to their employer, and because of the loss and/or misfiling of patient documents. In these cases, the employer has been found to be liable.

Remember, professional staff working autonomously need to have their own insurance or indemnity

Liability for locums

However, the situation is less clear cut when we look at relationships where the locus of control lies outside the employer and this would typically occur with employment of a locum. Locums are generally considered to operate independently and whose service provision is solely to provide cover for a limited period of time. The quality of service a locum provides is not determined by the employer; they exercise their own professional judgment in treating patients and as such are not subject to the same routine management as other employees. In this scenario, it could therefore be assumed that should there be a claim the employer is not liable, because they do not define the method and manner by which the locum works. On the contrary, the reverse is true insofar as the employer could be deemed liable in the first instance, until the independent contractor status of the locum is clarified.

In the process of clarification, legal practitioners may seek to confirm or discount the independent contractor status and could explore the terms of contract between employer and locum, the hours worked, whether the locum works for the one or one of many facilities and so on. Furthermore, questions could be raised as to how the role of the locum is understood within the practice by patients, who could well argue that they thought the locum was an employee of the practice.

Undoubtedly, this can be an onerous and tiresome process for both the employer and the locum and the aim is to avoid reaching that stage.

So how can we reduce our risk of vicarious liability?

Firstly, it is important to recognise that regardless of the status of the contract that exists between the employer and the 'employee', attention should be paid to addressing this risk. This can be done by instituting policies which define how employees should function in providing care to patients, be they independent contractors or not.

Secondly, it is equally important to ensure that the practice has comprehensive professional liability coverage for both clinical and non-clinical regular employed staff. It is also important to ensure that employees are adequately supervised and keep their skills up-to-date is necessary. When delegating work, reflect on whether this is appropriate and if the recipient is able to perform the task.

Finally, when it comes to employing locums, having a clear policy that defines the working relationship and is specific about the service that will be provided is essential. In particular, make certain that the independent contractor status of the locum and the requirement that they have their own indemnity arrangements is emphasised and that there is documentary evidence of their professional indemnity arrangements. Furthermore, patients need to be made aware of the presence of the locum in the practice – this is best done by the reception staff. The locum should also make sure that the patient is aware of his/her role within the practice and that this is clearly documented in the medical records.

THINGS TO CONSIDER OTHER THAN YOUR OWN PERSONAL MPS COVER

© PCD 2009

- Vicarious liability and professional employee cover
- Ensure that partners are covered, ie, joint and several liability
- Public liability cover.

Public liability insurance

In addition to professional indemnity, it is important to remember that you will also require public liability insurance for your clinic, to protect you against claims for injury other than a result of clinical negligence sustained on your premises – for example, if a patient or visitor slips on a wet floor. This can be arranged through any commercial insurer.

Summary

In summary, these simple but effective measures will not only mean that your practice is operating at a high standard, but can be your defence in the event of a claim of vicarious liability. Remember, professional staff working autonomously need to have their own insurance or indemnity.

FURTHER READING

MPS, *Vicarious Liability* http://www.medicalprotection.org/southafrica/guide/limitations-of-membership (Accessed 3.6.13)

Thornton RG, Responsibility for the Acts of Others: Proc (Bayl Univ Med Cent) 2010 July; 23(3): 313–315

Shoulkin ED and Smith TJ, *Vicarious Liability: Let the Master Answer* (AAOS) http://www.aaos.org/news/bulletin/jun07/managing6.asp (Accessed 3.6.13)

Dr Graham Howarth is MPS Head of Medical Services (Africa)

Dr Mamsallah Faal is currently studying for a Masters in Global Health Policy. Previously, she worked as a clinical lecturer in Family Medicine at University of the Witwatersrand Medical School, Johannesburg

MEDICAL PROTECTION SOCIETY
PROFESSIONAL SUPPORT AND EXPERT ADVICE

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

MPS

EDUCATION AND RISK MANAGEMENT

Reduce your risk with education from MPS

MPS runs highly interactive educational workshops across South Africa as a benefit of membership, aimed at reducing your exposure to complaints and litigation.

Workshop features:

- **Three hour workshops**
- **FREE OF CHARGE to MPS members**
- **Attract six ethical CEU points**

Excellent – a must for all doctors from all medical backgrounds

Recent MPS delegate

Just one of the many benefits of being a member of the world's leading medical defence organisation

For more information visit
www.medicalprotection.org/southafrica/education