counting the cost

Are clinical negligence claims changing the face of general practice?

this issue… www.medicalprotection.org

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Why probity and professionalism go hand in hand

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Top tips for good medical records and how to store them safely

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ETHiCS 4 all 2013
Save the date for MPS’s free ethics event and earn CEU points
Welcome

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. Proximity 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.

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 Livinston, 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 debates dominated the latter part of the workshop, as the delegates learned how they can improve their interactions with patients and put their newly acquired 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.

She took 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 standard. The workshop 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 Aarti Ahmad, 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

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 KZNMECC
Chaired by Dr Mouliki Goodlack, Chairman, South African Medical Association (SAMA)

PRETORIA: Monday 2 December 2013 (evening event)
Venue: CSR International Convention Centre
In conjunction with Amathla
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, Chairperson, South African Medical Association (SAMA)

2013’s programme has been developed to cover 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 Destructive 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: “Tiet 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 risks 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.

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 indemnify 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 assuring members are appropriately trained and experienced in the procedures they carry out. Specialists who can 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

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 sell over-the-counter drugs for patients.

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

Public sector
Following community service, many doctors start to look for a role both in their chosen specialty. 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 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 practitioners 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 means that you will be weighed up against other choices that you are confronted with about how you want to live your 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.

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.

Public sector GP, who may be working in a theatre work. You could also pursue a career in private practice, where there is no need to embark on the rigours of postgraduate training.

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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.

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. 2 Good medical records are a 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. 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 defensive medicine. When the rate of medical negligence claims is rising at such a rapid rate, doctors may feel they must defend themselves against the increased risk of claims.

In the period April 2011 to March 2012, the HPCSA received 2,403 complaints, many between April 2011 and March 2012, the claims start off as complaints. In the period reported in South Africa some of these frequencies of medical negligence claims experienced a 30% increase in the themselves against the increased risk of 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. Fifty-eight per cent said they had changed the way they practise as a result.

Defending the risk

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“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.

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REFERENCES

2. South Africa: Survey data – 2012 GPs 856 private GPs 2012; 2012 GPs 856 private GPs 2012
3. Ibid
4. Ibid
7. Ibid
Probity implies that a doctor will, investigations. Alarmingly, R221 million was claiming fees for services that were not patients’ bills with multiple codes instead unprofessionally and unethically by loading independence. healthcare practitioner’s integrity, honesty and the public’s trust and compromises a fees, making private healthcare unaffordable further adding to the high cost of membership. reveals that probity is on the increase, why probity and professionalism go hand in hand yet probity issues are becoming more widespread. General practitioners are seen to be honest, upright members of a community, performing their duties with professionalism allows doctors the allows a relationship of mutual trust between independence to perform their duties with professionalism allows doctors the healthcare practitioner’s decision-making process and actions. The HPCSA states that professionalism allows a relationship of mutual trust between patients and healthcare practitioners. 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. If a doctor’s behaviour does not conform to the HPCSA’s ethical and professional code of conduct, it is seen as unprofessional, compromising quality healthcare and risking patient safety. Doctors should act with integrity in all financial interactions with patients and medical schemes. 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”. The HPCSA also cautions healthcare professionals on over-servicing patients, referring to unnecessary tests, scans, procedures or care. Some healthcare practitioners are acting unprofessionally and unethically

Medical aid probes

Medical schemes are identifying more doctors suspected of fraudulent activities through probes. 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. 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 will be unlikely to provide assistance; and the relevant healthcare practitioner will also probably be investigated by the HPCSA. Medical aid fraud is classified as ‘personal misconduct that does not directly relate to the practice of medicine’10. 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”13. MPS encourages healthcare professionals to keep accurate medical records. These records reflect what has taken place in the consultation and the quality of care of the patient. 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.2

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

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ervice provider fraud is on the increase, with the two most common causes being code manipulation and services not rendered. Some healthcare professionals 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. These fraudulent activities have significant financial implications for South African citizens by 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?

Some doctors have a contractual relationship with the healthcare provider, willing at all times, act with integrity to protect patient and public trust in the medical profession. Medical professionalism allows doctors the independence to perform their duties with integrity and can be defined by qualities such as “humility and altruism” (including ethical principles such as beneficence, respect, integrity, truthfulness and placing patients’ needs first) and ‘excellence and accountability’ (including continuous education and providing 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. The HPCSA states that professionalism allows a relationship of mutual trust between patients and healthcare practitioners. Thus medical professionalism can be viewed as a contract between

References

8. Dr Carmen Gerber is a GP based in the Eastern Cape
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11. Dr Carmen Gerber is a GP based in the Eastern Cape
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

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

On the one hand, 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’s 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 dangers, 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 patient records need to be captured in a format that permits only one writing, 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 tanning.

What not to write is as important as what is, to use highlights. Disparaging comments indicating the doctor’s irritation or dislike of a patient must never be reflected in a patient’s notes. The use of written leaflets is even more valuable.

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. For example, 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 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.

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

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’s notes must be kept in 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.

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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 ’93) 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 only one 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.
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What is vicarious liability?

This scenario is not just limited to healthcare provision, but to all instances where the employer is the course of their employment, the employer may be held to be liable. If an employee commits a negligent act or omission while acting in the role that an employer has directed them to perform, they are doing so on the employer’s behalf. This article considers how vicarious liability relates to our own personal practice; what we do ourselves. We are rarely autonomous in our clinical practice. Despite our best efforts to take a look at the concept of vicarious liability, it is difficult to avoid knowing of how our employees can affect our risk. But vicarious liability subscriptions to an indemnity or insurance scheme in their own right, as it is unlikely that MPS will extend the benefits of membership to 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 mistaking 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. Localities generally are employed 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 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. This stage may 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 employees. It is also important to ensure that all 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. 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


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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 as 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.

Things to consider other than your own personal MPS cover

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