MEDRISK
Liability Protection

SURGEONS SURVIVAL MANUAL

5 ESSENTIAL TECHNIQUES TO MINIMISE MALPRACTICE RISKS

2023

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INTRODUCTION

A note from Medrisk CEO, Jamal Ismail:

Over the course of my extensive experience collaborating with surgeons, I have witnessed firsthand the challenges you face in a highly pressurised environment, constantly threatened by malpractice lawsuits.

While it is true that many claims may seem frivolous or lacking substantial grounds, it is crucial to acknowledge the significant number of avoidable cases that arise. By delving into this topic, Medrisk aims to shed light on the importance of prevention and provide practical insights to reduce these avoidable claims, ultimately benefiting both the medical community and patients alike.

The importance of familiarising yourself with HPCSA booklets and guidelines prescribed in the Health Act is well-known among doctors. However, despite having read these guidelines, many doctors still struggle to fully identify the essential requirements for their specific medical practice. This can be attributed to the overwhelming amount of information available. While medical school prepares doctors to be skilled health practitioners, few doctors are equipped with a deep understanding of the medicolegal aspects involved in running a medical practice. It is crucial for doctors to recognize the importance of bridging this gap to ensure the smooth operation of their practices.

At Medrisk, we deeply empathise with and comprehend the challenges faced in running a safe and successful medical practice. In an effort to assist you, we have curated vital and concise information to provide you with the necessary knowledge. Medrisk's aim is to ensure that you are better equipped to navigate the complexities of the medicolegal requirements confidently and efficiently.

Finally, as the information provided here is of a general nature, we do encourage you to reach out to us directly for personalised advice and assistance. Our experienced team is more than willing to assist you.

Jamal Ismail
Medrisk CEO

PATIENT RECORDS

The keeping of patient records is required in terms of the HPCSA Guidelines (Booklet 9) however it is also one of the most important aspects for the prevention of medical malpractice lawsuits. It is becoming more frequent that a patient's health care records are being used to evaluate the professional conduct of a health practitioner when a complaint is made to the HPCSA.

WHY KEEP RECORDS?

Records are the primary point of reference for a patient's medical history. Accurate records provide a platform for continuity as patients move between health practitioners as well as evidence as to the standard of care provided.

WHAT SHOULD BE IN RECORDS?

All clinical findings and interactions with the patient should be recorded in a patient's health records.

The following checklist includes the compulsory elements of a patient's health records, listed in the HPCSA Guidelines, Booklet 9, Guideline 3.2:

1. *"The personal (identifying) particulars of a patient;*
2. *Full biopsychosocial history of a patient, including allergies and idiosyncrasies;*
3. *Time and date and place of the consultation;*
4. *Assessment of the patient;*
5. *Proposed management of the patient;*
6. *Medication and dosage prescribed;*
7. *Details of referrals;*
8. *Investigations ordered and results;*
9. *Details of times patient was booked off work or similar and the reasons for same;*
10. *Written proof of informed consent.* (Exceptions in terms of Ethical Rule 27A)."

CAN RECORDS BE AMENDED?

A patient's record may only be amended if the reason for the amendment or error is specified. The HPCSA Guidelines recommend that any late or

additional entries into a patient's records are dated and signed in full by the person making the entry. The reason for this is that all records must be attributable to a particular person. This is important particularly where there are multiple health care practitioners working with the same patient so it can be identified which practitioner made a particular entry.

STORAGE OF RECORDS

Section 17(1) of the National Health Act, No.61 of 2003, requires that patient health records must be stored securely. Securely refers to putting access control methods in place to avoid unauthorised access. In terms of the HPCSA Guidelines, all patient health records must be protected from unauthorised access and improper disclosure, irrespective of whether the record is electronic or hard copy.

It is of utmost importance to ensure the protection of patient confidentiality when transferring patient records to other Healthcare Practitioners or between facilities, particularly when doing so electronically.

ACCESSIBILITY OF RECORDS

A patient's healthcare record must be accessible by the patient, healthcare facilities and other healthcare practitioners.

Section 10 of the National Health Act, No. 61 of 2003, Healthcare Practitioners must provide a written discharge report when the patient is discharged from a health facility. The only exception is with outpatients however, it is still recommended to be in writing.

When patients of 12 years and older request their health record regarding medical treatment, healthcare practitioners shall provide them with a copy of, abstract of, or direct access to their own record.

With patients under 16 years old however, a parent or legal guardian may make an application for access to records, but they will need to provide written authorisation from the patient in order to gain access to such records.

An exception to the above is that any information regarding termination of pregnancy may not be divulged to any third party, regardless of age.

A general rule to follow is that healthcare practitioners shall **not make patient information available to any third party**, **except** under one or more of the following instances:

- A court order has been issued;

- The patient provides their written authorisation to do so;
- Where non-disclosure of such information would result in a serious threat to public health and safety;
- In certain instances where the information is required for disciplinary or legal proceedings (HPCSA Booklet 9, guideline 9.3);
- The health practitioner is under a statutory obligation to do so.

As with all things these days, patient information must be processed in compliance with POPIA (Protection of Personal Information Act) and PAIA (Promotion of Access to Information Act).

PRIVACY AND SECURITY OF RECORDS

Any healthcare establishment must make use of control measures to store patient records in order to ensure the security and confidentiality of the records and prevent unauthorised access. In addition to this, patients have the right to secure and timely access to their health records. Healthcare establishments must use a storage facility to store patient health records which utilises methods to protect against improper access and disclosure.

HOW LONG MUST RECORDS BE KEPT FOR?

Where records are stored in an electronic format and where possible, health records should be kept indefinitely. However, this is not always possible.

The general rule is that patient health records should be securely stored for a **minimum of 6 years** from the date of last treatment.

There are a number of **exceptions** to this rule:

1. When dealing with minor patients, their health records should be kept at least until the patient's 21st birthday;
2. With mentally incapacitated patients, their health records should be stored for the duration of their life;
3. Health records for treatment of patients falling under the Occupational Health and Safety Act 85 of 1993, must be kept for 20 years;
4. In certain instances, patient health records must be kept for longer periods of time that will allow the patient fair and sufficient access to health care at a later stage, given the circumstances of their health condition (example: Asbestosis can take a long time to manifest). It is recommended by the HPCSA Guidelines that the period for keeping records in such instances shall not be less than 25 years;
5. When complying with statutory obligations.

WHAT DOES THIS MEANS FOR MY MALPRACTICE INSURANCE?

It is a common occurrence for patients to institute a claim against a health practitioner claiming that they were not adequately advised of all the risks, possible complications and information in order to make an informed decision in respect of their health care options. The easiest way to repudiate this claim is for the health practitioner to show proof that such advice was given as it ought to be recorded in the patients health records.

INFORMED CONSENT

Before proceeding with the provision of health care, all health practitioners must obtain informed consent from their patients. The below information is designed to summarise and assist health practitioners in complying with the Guidelines contained in the HPCSA Booklet 4 and Section 7 and Section 9 of the National Health Act.

WHAT IS INFORMED CONSENT?

Informed consent is when a patient agrees to the provision of specified health care **AND** has been fully informed of their health condition, treatment, risks and costs **AND** has the legal capacity to consent.

Informed consent must be obtained in the patient's language and the information must be communicated to the patient in a manner that the patient understands.

Consent may be withdrawn by a patient at any time.

*Note that special rules apply regarding obtaining consent for treatment in respect of minors, mentally ill persons and persons who are subjects of medical research or donating human tissue.

WHY DO WE NEED CONSENT?

Consent provides confirmation that a health practitioner has carried out their duties in the best interests of their patients, and that the patient is fully aware of what they are getting themselves into when having treatment. Further to this, it is a method to prevent misunderstanding, misinformation and malice between health care practitioners and patients.

For this reason, it is important to demonstrate that informed consent was obtained through signed consent forms. However, the consent form alone is not sufficient. There must be evidence of a discussion with the patient regarding the information. This could be shown through patient records as well as information leaflets that have been provided to a patient.

GENERAL RULE: A health practitioner cannot treat a patient without their informed consent.

Treating a patient without their informed consent is a violation of their right to bodily and physical integrity.

FALSE → When a patient signs the hospital 'consent form' the patient has also consented to the services provided by the private health practitioner.

TRUE → Very often, a hospital 'consent form' does not provide sufficient consent for the private health practitioner as it is merely a confirmation that consent has already been obtained from the private health practitioner.

HOW MUCH INFORMATION IS SUFFICIENT?

The National Health Act stipulates the requirements of information that must be given to patients:

1. Their health status, except where there is substantial evidence that disclosing their status would be contrary to the patients best interests.
2. The different treatment options available and all the different diagnostic procedures.
3. The benefits, risks and consequences involved in the treatment process.
4. The costs of the different options.
5. Their right to refuse health care and the consequences of their refusal.

PRESENTING INFORMATION TO PATIENTS

- Ensure that when giving the information to patients, it is up-to-date and detailed.
- When giving distressing information to patients, always try to deliver it in a considerate manner, taking their feelings into account and giving them time to reflect on the information.
- Where necessary, provide patients with details for counselling and support groups.

WHO MUST OBTAIN THE CONSENT?

The responsibility of obtaining informed consent belongs to the primary health practitioner and should not be delegated. In the event that the health practitioner appoints another person to obtain consent, for whatever reason, the primary health practitioner will continue to remain the responsible party.

EMERGENCIES

In emergency situations, there will be times where consent cannot be obtained. During these situations, a health practitioner may provide treatment

but such treatment must be limited to only what is necessary to save the patient's life or prevent them from deteriorating further.

The health practitioner must respect any previous and valid refusal of treatment given in advance and shall be restricted by such refusal.

As soon as the emergency treatment is complete and the patient is sufficiently recovered to understand, the health practitioner should advise the patient of the details of the procedure including why and how it was carried out.

EXCEPTIONS

The following are examples of when the patient's informed consent is **not** required. When:

- Authorised by any law or a court order;
- Failing to treat the patient will result in a serious risk to public health;
- Any delay in treatment may result in serious or life-threatening risk to the patient;
- Consent is obtained from a person who is mandated by the patient in writing to give consent on their behalf;
- No person is mandated or authorised to give consent and the consent is then obtained from the patient's spouse, partner, parent, grandparent, adult child, brother or sister, in that specific order (Section 7 of the National Health Act).

WHAT DOES THIS MEAN FOR MY MALPRACTICE INSURANCE?

It is common cause for patients to bring a case against a health practitioner claiming that they did not consent to a procedure or were not made fully aware of the complications and/or risks surrounding a procedure and therefore their consent was not fully informed. The solution to these claims is two fold:

1. **Preventative** - Ensuring that all patients are provided with the necessary information about their treatment/procedure as well as ensuring all consent forms are signed prior to the procedure. Remember, as a private health practitioner, the hospital 'consent form' is very unlikely to be sufficient to cover you should a claim be instituted.
2. **Responsive** - Once the claim has been instituted, you will be required to respond to the claim with evidence. This is when you may choose to

submit the consent form for proof of such. Again, a reminder that the hospital's confirmation of consent may not be sufficient in this instance.

REPORTING OBLIGATIONS

One of the most common reasons why insurance providers reject claims is the failure to report incidents in a timely manner. It is not uncommon for practitioners to be unaware of the reporting obligations associated with their insurance policies. That's why it is crucial for healthcare practitioners to understand and adhere to the specific reporting requirements of different types of insurance policies.

In the following sections, we will break down the reporting obligations for each type of policy available, ensuring that you have the knowledge and understanding to report incidents promptly and avoid potential claim denials

CLAIMS MADE POLICIES

Under a claims-made policy, it is crucial to understand and adhere to the specific guidelines outlined in your policy. A claims-made policy requires you to report any adverse incidents, which may give rise to a claim under the contract of insurance, whether or not you consider yourself to be at fault in respect thereof. Typically, this timeframe is around 30 days, but it can vary depending on the policy and insurer.

Reporting incidents promptly is essential to ensure compliance and mitigate potential risks. Failure to report incidents within the specified timeframe may lead to denial of coverage or increased financial exposure.

WHAT TYPE OF INCIDENTS MUST BE NOTIFIED?

1. **Requests for records:** Any formal or legal requests for medical records related to a potential claim should be reported.
2. **Letters of Demand:** If you receive a letter of demand from a patient or their representative, it is crucial to report it promptly. These letters often indicate an intent to pursue legal action, and timely reporting allows the insurance company to initiate appropriate measures.
3. **Complaints:** Any formal complaints made against you or your practice should be reported. This includes grievances filed with regulatory bodies, professional associations, or licensing boards.
4. **Claims:** All claims made by patients or third parties must be reported promptly. This includes incidents where a patient alleges harm or injury as a result of your professional services.

5. **Writs, Summons, or Process:** Any legal documents, such as writs, summons, or legal process papers, should be reported immediately.

Moreover, it is essential to **report any adverse health outcomes** that could potentially lead to a claim.

EXAMPLES OF NOTIFIABLE INCIDENTS:

1. Complications resulting in the patient's or the relative's dissatisfaction.
2. Unexpected complications, for which the patient or healthcare provider were not prepared.
3. Incidents that result in significant adverse outcomes and permanent disabilities.
4. Outcomes where healthcare providers may still be concerned about the management or treatment of the patient, even if a patient does not complain.
5. Failure or delay in diagnosis, leading to a significant compromise in patient health and delayed treatment.
6. Breach of patient confidentiality.
7. If a healthcare provider fails to adequately warn a patient of the risks associated with a procedure and those risks materialise.
8. Perforation during an operation, causing increased pain and suffering and extended hospital stays.
9. Burns or infections resulting from procedures.

Please note the examples above are not exhaustive, and reporting requirements may vary for different healthcare providers. It is recommended that you consult your insurer or protection society for specific guidance regarding your reporting requirements.

OCCURRENCE BASED POLICIES

Under this type of policy, incidents or claims are **covered if they occur during the policy period**, irrespective of when they are reported. However, failure to report incidents in a timely manner can hinder the insurer's ability to investigate and defend claims effectively, potentially jeopardising your coverage.

Even if you have an occurrence-based policy, reporting these incidents in a timely manner can still provide you with the best possible outcome. By promptly reporting adverse incidents, you ensure that your insurer is aware of the situation and can offer guidance and support throughout the process. This

proactive approach not only demonstrates your commitment to patient safety but also helps protect your practice in case any potential claims arise in the future.

HYBRID POLICIES

Certain insurance companies offer policies that combine traits of both claims-made and occurrence-based policies. These unique hybrid policies provide an extended reporting period after incidents like death or retirement.

Typically, claims-made policies require **claims to be reported within a 30-day period**. However, at least one local insurer's hybrid policy allows for up to 90 days to report adverse incidents, offering an advantageous time frame.

We would like to emphasise the need for individuals to familiarise themselves with their own insurance provider's specific reporting obligations.

POPIA GUIDELINES FOR HEALTH PRACTITIONERS

In addition to the HPCSA Guidelines surrounding informed consent and the storing of data, the Protection of Personal Information Act, No. 4 of 2013 (POPIA) is also a regulatory framework for the collection, storage and protection of personal information.

The below is not an exhaustive list of obligations under POPIA, it does not constitute legal advice and should not be considered a substitute for legal advice.

WHAT IS POPIA AND WHAT DOES IT DO?

POPIA is the Protection of Personal Information Act (also referred to as POPIA or POPI Act). It protects and prevents the misuse of personal information. Personal information is defined as any information that can be used to identify or reveal an individual's identity.

POPIA ensures that any responsible party (an individual or a company) processes data responsibly and lawfully. It also dictates how information is stored, modified and removed.

WHY SHOULD HEALTH PRACTITIONERS COMPLY WITH POPIA?

The type of information being collected by health practitioners is particularly sensitive as it relates to health information that patients are often hesitant to share elsewhere. Ordinarily POPIA restricts the collection of information about a person's health and sexual activity, however, health practitioners are exempt from these restrictions, provided that the information is being used for necessary purposes related to the provision of health care and related services.

POPIA REQUIREMENTS

The most important requirement for both POPIA and the HPCSA guidelines is that of consent. No information may be collected unless the patient has provided their consent to do so, through a written POPIA consent form. This is the general rule however there are a few instances in which health practitioners may be exempt from obtaining consent.

EXEMPTIONS FROM CONSENT

It is important to understand that the below mentioned instances are specifically in respect of POPIA and are different to the instances provided by the HPCSA Guidelines.

1. Consent is **not** required when the law requires the processing of information such as when the information is needed for Court hearings.
2. Consent is **not** required when processing the information needed in terms of a contract entered into by the patient.
3. Consent is **not** required where such processing is in the best interests of the patient and in doing so protects their rights.
4. Consent is **not** required where compliance is not reasonably practicable given the circumstances of a particular case.

COMPLIANCE

A private practice is supposed to be POPIA compliant since POPIA came into full effect on 1 July 2021. In a private practice, an information officer should be appointed. All patients from a practice, both new and existing patients, should sign onboarding consent forms that are POPIA compliant. If your onboarding consent forms do not mention POPIA, there is a very high chance that they are not compliant.

POPIA compliance means that the patient has been fully informed of the following:

1. Why the information needs to be collected;
2. What the information will be specifically used for;
3. How it will be stored;
4. The instances in which it may be transferred, if any.

WHAT ABOUT A LOCUM TENENS?

All patients should be signing an onboarding consent form when they join the practice. This consent should give a broader scope to the practice in order to provide for the instances when locums are providing service at the practice.

ACCESS TO INFORMATION

Patients have a right to view their records. When a patient submits a valid request in terms of your practices' Privacy Policy, you must allow your patient to see their records, unless there are valid and lawful reasons to refuse access.

Where you have provided a medical opinion, you may refuse to provide the information, however, you must then make a note of such on the patient's record.

SHARING DETAILS WITH OTHER MEDICAL PROFESSIONALS

It is common practice that, where necessary, a patient's medical records are shared with other medical professionals that are treating the same patient. However, it is important that this is done correctly and in line with POPIA. It is recommended that the initial consent signed by a patient should include a clause about the sharing of medical information with other health practitioners in respect of the provision of health care and related services.

BREACHES AND CYBER INSURANCE

Data breaches can occur in many different ways including through hacking, human error and social manipulation. Where a breach has occurred, POPIA may issue a severe fine for negligence or even jail time. There is also a serious risk of damage to the image of the practice.

With the ever evolving online world, there is a high risk of data breaches occurring. As a result, it would be wise to consider Cyber Insurance to cover the potential costs or damages related to a data breach.

If a data breach does occur, the following steps should be followed:

1. Your data breach team should be alerted to the breach and identify what data has been affected, how much damage has been done and who is directly affected;
2. Contain the breach quickly and secure the remaining data;
3. Notify Law Enforcement of the breach;
4. Notify the Information Regulator of South Africa, of the breach;
5. Those directly affected by the breach must be notified in writing;
6. The practice should develop a strategy to manage the public image properly and with transparency;
7. Assess whether any improvement can be made to the security of your data as well as the response plan for future breaches.

WHAT DOES THIS MEAN FOR MY MALPRACTICE INSURANCE?

Non-compliance with POPIA is not covered by your Medical Malpractice insurance when such a claim is made. This matter would be one dealt with by the Information Regulator together with the Courts. If you are looking for cover relating to data breaches, Cyber Insurance may be the way to go. Contact our Medrisk team for more information.

THE DOCTOR-PATIENT RELATIONSHIP

The doctor-patient relationship is based on trust. For health practitioners, it goes further than this. They also have a duty to their patients to always have concern for their best interests and well-being. The common question though is, how far does this duty extend and when can a health practitioner terminate the relationship with their patient.

The HPCSA Ethical Guidelines contained in Booklet 1 and Booklet 5, sets out the duties and obligations of health practitioners as well as recommended steps to follow in circumstances that require ethical reasoning.

ETHICAL CONSIDERATIONS

- Health practitioners are required to always act in the patients best interests, even if it contradicts their own personal interests.
- They must also make sure that their personal beliefs do not prejudice their patients' health care. These beliefs could be anything from a patient's ethnicity or lifestyle to their religious or spiritual beliefs.
- Furthermore, they may not refuse or delay treatment simply because they believe that the patient's condition is due to the patient's own actions.

INITIAL CONSIDERATIONS

- When considering whether to terminate a doctor-patient relationship, the health practitioner must consider the individual circumstances of each patient (i.e make the decision on a case by case basis).
- The termination must be justifiable and there must be reasonable grounds to do so.
- Before making the decision, the health practitioner must have considered all other reasonable alternatives.

POSSIBLE SITUATIONS

The following situations may provide grounds for termination of the doctor-patient relationship:

1. **Violent or aggressive behaviour** of patients towards their health practitioner. This could include patients acting in a repetitively rude or abusive manner to the health practitioner or their employees.
2. When patients are **non-compliant** by continually refusing or failing to comply with prescribed treatment and such refusal or failure to comply is placing the health practitioner at risk of patient complaint.
3. **Failure to pay fees** as this would often sour the relationship between patient and practitioner and result in a breakdown of the trust relationship. It may even get to a point where legal action is taken.
4. The HPCSA Guidelines advise against **improper relationships** between health practitioners and patients whether of a sexual nature or improper financial arrangements.
5. Where a patient requires treatment that is **contrary to the health practitioner's religious or deeply rooted moral belief** (e.g terminating a pregnancy or participation in end of life treatment). In this instance, the health practitioner must inform the patient of their objection and advise them that they may seek treatment from another health practitioner. The health practitioner has the constitutional right to conscience and religion but must be cautious not to judge a patient based on their choices.

SUGGESTED STEPS TO TAKE IN TERMINATING THE RELATIONSHIP

It is very important that a health practitioner does **NOT** abandon their patient during this time of terminating the relationship as the patient still has a right to their continued treatment.

- Record all discussions and decisions in the patient's records including the attempts to fix the broken relationship.
- Clearly inform the patient of the intention to terminate the relationship.
- Record the details and reasons for the termination in the patients' health record.
- Hand the patient over to another competent health practitioner in order for the patient's treatment to be continued (i.e. a report or referral letter).

AFTER TERMINATION

Although a health practitioner may have terminated the relationship with their patient, they are still bound by a constitutional obligation to treat the patient in an emergency.

REFERENCES

- Constitution of the Republic of South Africa, Act 108 of 1996.
- Health Practitioners Council of South Africa (HPCSA) Website: http://www.hpcsa.co.za.
- HPCSA Booklet 1: General ethical guidelines for healthcare professions.
- HPCSA Booklet 2: Ethical and professional rules of the health professions council of South Africa as promulgated in government gazette R717/2006.
- HPCSA Booklet 4: Seeking patients' informed consent: The ethical considerations.
- HPCSA Booklet 7: Guidelines withholding and withdrawing treatment.
- HPCSA Booklet 9: Guidelines on Patient Records.
- National Health Act, No. 61 of 2003.
- Protection of Personal Information Act, No. 4 of 2013.
- POPIA Website: https://popia.co.za.

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