Risks and exposures in professional practice today

During a recent webinar presented by Natasha Naidoo, senior associate in Norton Rose Fulbright's Insurance Litigation Team in Johannesburg, Naidoo gave examples of some of the claims for injuries which she has dealt with over the years – with a view to emphasising the importance of accurate recordkeeping, informed consent according to the guidelines and professional front-office support.

By Vanessa Rogers on behalf of Indwe Risk Services and MC De Villiers Brokers

"We deal with a number of cerebral palsy cases," she advised, "where the allegations are usually that there was a failure to monitor a patient's labour in accordance with the maternity care guidelines. Sometimes, there is a failure to perform a C-section on an urgent basis; the treating doctor did not consider the size of the baby's head in relation to the size of the patient's pelvis; and other factors were not taken into consideration, such as maternal age."

Additional examples from case law involved those of prematurity, where the allegation was that the premature baby was not monitored in terms of the South Africa guidelines for prevention of blindness; there was a failure to monitor, or inadequate monitoring of oxygen saturation levels; or there was a failure to monitor the baby for screening at an appropriate stage of his or her life, which resulted in permanent blindness.

Moving on from the high-risk speciality of obstetrics and gynaecology, Naidoo mentioned that during her consultations with hospital staff some aspects of care were not noted properly, or at all, in the clinical records. "Then there are cases," she added, "where patients are admitted to undergo a specific surgical procedure and complications arise, or the patient develops a hospital-acquired infection… Even in the most well-renowned hospitals in the world, it is not always possible to prevent a hospital-acquired infection. But, it wil only be evident from the clinical records of the patient that bloods were, in fact, taken at every possible interval to keep an eye out for possible infection – these being highly treatable via antibiotics."

Very common also, according to Naidoo, are claims against doctors not attending to hospitalised patients timeously when their condition takes a turn for the worst, and when he or she requires, e.g. mechanical ventilation. Sometimes a doctor may, in his defence, plead that he did in fact attend on the patient, she advises, but there is no record of this because the notes were not included in the clinical records. With the above in mind, the importance of accurate medical recordkeeping cannot be underestimated for its vital role in providing evidence in medical malpractice litigation. While healthcare professionals and facilities are required, by law, to keep contemporaneous medical records of their patients, it is worth examining exactly what good medical recordkeeping really involves.

The case for meticulous recordkeeping

“Personal particulars should be recorded accurately, and patients should be afforded the opportunity to update their details on a regular basis. As part of their training, reception staff should ensure that patients consider what basic information is held on file, and make changes if necessary to update the file,” suggested Naidoo.

“Then, the bio-psycho-social history of the patient, allergies and chronic medication should all be noted. The date, time and place of every consultation is vital and should be noted on the records. You should state precisely what your assessment of the patient entailed, details of routine examinations, the patient’s temperature, heart rate and blood pressure. The proposed clinical management of the patient, which would include diagnosis, treatment options going forward – all forms part of obtaining informed consent (see below*). Then, medication and dosage prescribed, of course, must be noted. Ensure that all information relating to the patient, including the blood test results, X-rays and results for any diagnostic tests, are all kept together in the patient’s file.

“Where you refer a patient to another practitioner, it is imperative that you note this and include a copy of the referral letter, stating why the referral is being made, what your views are, and what that particular practitioner should consider. Where a patient may raise a serious genetic issue, you should advise the patient to look further into it – even under circumstances where he or she does not present with any signs or symptoms of the inherited condition.

“Notes must be made legibly and be easily decipherable. Further, it is not only important to note what you told the patient, but also what the patient told you during the consultation. Then, where a patient is hospitalised, and you are placing the patient under another doctor’s care, a brief to the practitioner to whom you are handing the patient over should also appear in the records. Much of what I have said thus far in relation to good recordkeeping applies, also, to nursing staff. A nurse should bear in mind, at all times, that any notes or records taken while he or she is on duty constitutes a potential legal document which can be used in court.”

What exactly is informed consent?

Moving on to informed consent, Naidoo advised that it is a patient’s right, which flows from various legislations including the Constitution, to be placed in possession of all information necessary to make an informed decision on any medical issue. “Informed consent must be obtained when prescribing any form of treatment or undertaking any surgical procedures on behalf of a patient; an informed consent form should appear within the patient’s file, signed by both the patient and yourself,” according to Naidoo.

The requirements regarding informed consent, as per the webinar, are as follows:

an actual discussion must be held with the patient, during which he or she is informed of all conditions of which he or she has been diagnosed;

the patient must be informed precisely what options are available to him or her;

where there are different types of medication available, the patient should be informed of the full scope;

a recommendation should be made, as to his or her best options; and

where there is an alternative to surgery, the patient must be informed of exactly what this entails.

“So often a doctor will say, ‘I prescribed X and Y because I knew the patient couldn’t afford the most effective treatment, or had run out of medical funds,’ but the patient should be told irrespective,” enthused Naidoo. “Withholding this information is not helpful because the patient may be able to obtain the funds from a friend or relative, had they known about the most effective option.”

A last note on informed consent: the patient should be provided with the opportunity to ask questions. All the information provided to the patient would place him or her in a position to make an informed decision. And, of course, the informed consent form, signed by both parties, should form an integral part of their healthcare records.

So how exactly it is possible to mitigate the risks of medical recordkeeping, where practitioners are faced, on a daily basis, with saving lives under highly pressurised conditions within a frantic environment, asked Naidoo. Her answer was that it did not matter, for litigation purposes, whether notes were hand written or kept eletronically; all that was required was that they be stored safely so that the practitioner, or any other person – such as within the legal fraternity, or in court – was able to determine what, precisely, had transpired during the treatment.

Vital role of support staff

“Dictating notes, to be typed up by a secretary, may be helpful where the practitioner is doing ward rounds or even consulting with their patients in rooms. Brief handwritten notes may be made and, at the end of the consultation, the practitioner may take a few minutes to dictate these, using an app on their mobile device. A concern about accuracy, in the case of notes being typed up by another person, can be eliminated were the secretary, for example, cross references those dictated transcribed notes with the practitioner’s brief handwritten notes. Or, where the secretary highlights and later clarifies any queries with the practitioner directly,” advised Naidoo.

Of interest was a research study on medical recordkeeping, cited during the webinar, which revealed the following points as barriers to accuracy:

• 76 percent of practitioners said that it was too time-consuming to make comprehensive notes;

• 51 percent said they were too busy;

• 18 percent said they lacked computer skills;

• 41 percent said they kept records in a particular manner as a matter of habit and it worked for them;

• eight percent said they believed it unlikely that they would receive a complaint or claim against them; and

• 33 percent of said that they lacked the requisite training for accurate medical recordkeeping.

“While good recordkeeping is a tedious administrative task, it should be considered part of the treatment process of the patient. Training and workshops should be held on an ongoing basis so that practitioners, including nursing and reception staff, are alert to the requirements. From a legal perspective, attorneys are faced with various difficulties in medical malpractice claims. There are, at times, no medical records available; the file is lost; we are unable to defend the action; and the client must then consider conceding liability due to the lack of evidence in their defence… To avoid this unfortunate state of affairs, a plan of action should be implemented to ensure adequate recordkeeping is practised and implemented effectively within your practice,” Naidoo concluded.