Medical Record Keeping in South Africa:

A Medico-Legal Perspective

by

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OPSOMMING

Mediese rekords is die bron vir mediese inligting. Mediese rekordhouding is noodsaaklik om kwaliteit mediese sorg aan pasiënte te verskaf. Gebrekkige mediese rekords kan pasiëntbestuur en kontinuïteit van mediese sorg beïnvloed, wat tot onvoldoende gesondheidsorg kan lei (College of Physicians and Surgeons of British Columbia, 2014:1, Canadian Medical Association, 2012:3; Howarth & Gillespie, 2012:2; Pirkle *et al*., 2012:564; Wong & Bradley, 2009:4; Mann & Williams, 2003:329). Mediese rekords is ook medies-wetlike dokumente. Dit word gebruik om dokters teen regsaksie te verdedig, maar ook om medies-deskundige opinies in te lig in die geval van mediese litigasie prosesse. Goeie mediese rekordhouding is daarom van kardinale belang (Van den Heever & Lawrenson, 2015:3; Howarth & Gillespie, 2012:2; McQuoid-Mason & Dhai, 2011:85; Shamus & Stern, 2011:110).

Akkurate mediese rekordhouding is ook 'n vereiste in artikel 27A van die etiese en professionele reëls van die Raad vir Gesondheidsberoepe van Suid-Afrika, geregistreer ingevolge die Wet op Gesondheidsberoepe (Wet No. 56 van 1974) en afgekondig in Staatskoerant R717/2006. Volgens hierdie wet moet die Raad vir Gesondheidsberoepe van Suid-Afrika (die Raad) dokters van riglyne voorsien insake etiese en professionele gedrag. Die riglyne word verskaf in boekie-formaat. Boekie 9 bevat riglyne oor mediese rekordhouding. Die *Medical Protection Society* (MPS) is die voorste beskermingsorganisasie vir dokters. Die MPS beskerm en ondersteun dokters se professionele belange. Die MPS het ook riglyne gepubliseer oor mediese rekordhouding vir sy lede om te volg in Suid-Afrika.

Hierdie studie vergelyk die medies-etiese riglyndokumente en toepaslike wetgewing in Suid-Afrika om vas te stel tot watter mate die medies-etiese riglyndokumente Suid-Afrikaanse wetgewing in verband met mediese rekordhouding inkorporeer en herhaal. Die studie bepaal ook of die kwaliteit van mediese rekordhouding die uitkoms van mediese regsgedinge in Suid-Afrika beïnvloed. Laastens ondersoek dié studie, deur 'n kort vergelyking te tref tussen relevante Suid-Afrikaanse wetgewing en medies-etiese riglyndokumente met relevante Kanadese wetgewing, riglyne en

praktyke, of die verskillende medies-etiese riglyndokumente in Suid-Afrika ten opsigte van mediese rekordhouding van waarde is tot die verlangde mate.

Die studie kom tot die gevolgtrekking dat die howe in Suid-Afrika nie altyd die medies-etiese verantwoordelikheid oorweeg wat dokters in terme van die Wet op Gesondheidsberoepe het nie, naamlik om die Raad van Gesondheidsberoepe van Suid Afrika se medies-etiese riglynboekies te volg. Vir dié rede het die kwaliteit van mediese rekordhouding nie die uitkoms van die regsuitsprake wat in hierdie studie hersien is, beïnvloed nie. Daar is ook tot die gevolgtrekking gekom dat die Raad 'n stelsel moet implementeer om te verseker dat dokters opgelei word in die onderwerpe wat die riglynboekies aanspreek en die opleiding moet voldoende gemonitor word. Die Raad behoort ook oorsig te hê in die vorm van fisiese assessering van dokters se mediese rekordhoudingpraktyke en pasiëntpraktyke. Sodoende kan die Raad professionele en etiese gedrag reguleer soos vereis word deur die Wet op Gesondheidsberoepe. Die opleiding en assessering deur die Raad behoort deel te vorm van die lisensiëringsstandaarde vir dokters om in Suid-Afrika te praktiseer. Dit sal mediese foute as gevolg van onvoldoende rekordhouding tot 'n groot mate voorkom wat dan die veiligheid van die pasiënte en kwaliteit mediese sorg verbeter. Sodoende word litigasie ook verhoed. Daar is verder tot die gevolgtrekking gekom dat die verwysings na- en herhaling van relevante wetgewing en die Raad se riglyne vanuit die MPS-riglyne verwyder moet word. Die Raad se Riglynboekie 9 moet opgedateer word met die riglyne rakende mediese rekordhouding in Suid-Afrika wat slegs die MPS-riglyne vereis. Dit sal die riglyne konsolideer onder die Raad en sodoende kan daar dan met die huidige MPS-riglyne weggedoen word.

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ABSTRACT

Medical records are the source of medical information. The keeping of medical records is crucial to the provision of quality medical care to patients. Deficient medical records can influence patient management and the continuity of medical care, which may result in inadequate health care (College of Physicians and Surgeons of British Columbia, 2014:1; Canadian Medical Association, 2012:3; Howarth & Gillespie, 2012:2; Pirkle *et al*., 2012:564; Wong & Bradley, 2009:4; Mann & Williams, 2003:329). Medical records are also medico-legal documents. They are used to defend doctors against legal action and also to inform expert medical opinions in the case of medico-legal litigation. Therefore, good medical record keeping is of paramount importance (Van den Heever & Lawrenson, 2015:3; Howarth & Gillespie, 2012:2; McQuoid-Mason & Dhai, 2011:85; Shamus & Stern, 2011:110).

Accurate medical record keeping is also a requirement of section 27A of the ethical and professional rules of the Health Professions Council of South Africa (HPCSA), registered under the Health Professions Act (Act No. 56 of 1974) and promulgated in Government Gazette R717/2006. According to this act, the HPCSA has to provide doctors with guidance regarding ethical and professional conduct. The guidance is provided in the form of booklets. Booklet 9 provides guidance on medical record keeping. The Medical Protection Society (MPS) is the leading protection organisation for doctors. It protects and supports their professional interests. The MPS has also published guidelines regarding medical record keeping for its members to abide by in South Africa.

This study compares the medical ethical guidance documents and relevant legislation in South Africa to ascertain the extent that the medical ethical guidance documents incorporate and repeat South African legislation regarding medical record keeping. The study also determines if the quality of medical record keeping influences the outcome of medico-legal cases in South Africa. Lastly, it determines, by a brief comparison of relevant South African legislation and medical ethical guidance documents with relevant Canadian law, guidelines and practices, if the

different medical ethical guidance documents in South Africa regarding medical record keeping have value to the required extent.

The study concludes that the courts in South Africa do not always consider the medical ethical commitment that doctors have in terms of the Health Professions Act i.e. to abide by the HPCSA's medical ethical guidance booklets. Therefore the quality of medical record keeping did not influence the outcome of the cases reviewed in this study. It is also concluded that the HPCSA needs to implement a system to ensure that doctors are trained on the topics covered in the HPCSA guidance booklets, and that such training is adequately monitored. The HPCSA further ought to provide supervision in the form of physical assessments of doctors' medical record keeping practices and patient practices. This will ensure that the HPCSA regulates professional and ethical conduct, as required by the Health Professions Act. The training and assessments by the HPCSA should form part of the licensing standards to be met by doctors to practise medicine in South Africa. This will limit, to a great extent, medical errors due to inadequate record keeping in order to enhance patient safety and quality medical care. It is further concluded that the references to and repetition of relevant legislation and the HPCSA guidelines should be removed from the MPS guidelines. The HPCSA guidance Booklet 9 should be updated with the guidelines pertaining to medical record keeping in South Africa currently contained only in the MPS guidelines. This will create a consolidated guideline under the HPCSA and the current MPS guidelines can then be discontinued.

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Introduction and literature survey

1.1 Introduction

The keeping of health records is imperative, for various reasons. Two of the most common charges laid against health care professionals (HCPs) are inadequate record keeping and the altering of medical records (Health24, 2014:1). For the purpose of this work, the broad term HCPs will be narrowed down to doctors who are medically qualified and practising in South Africa. They will also be referred to simply as doctors.

Accurate medical record keeping is a requirement of section 27A of the ethical and professional rules of the Health Professional Council of South Africa (HPCSA), registered under the Health Professions Act (Act No. 56 of 1974) and promulgated in Government Gazette R717/2006. See section 1.4.1.1.2, p.9 of this chapter. Health records are medico-legal documents and are primarily important for providing critical medical information to support patient management and the continuity of medical care, which results in quality health care. Health records serve as a means of communication within a healthcare team regarding patients' health status and progress (College of Physicians and Surgeons of British Columbia, 2014:1; Canadian Medical Association, 2012:3; Howarth & Gillespie, 2012:2; Pirkle *et al*., 2012:564; Wong & Bradley, 2009:256; Mann & Williams, 2003:329). Shamus and Stern (2011:109) consider good medical record keeping to be as important as patient care itself. The secondary functions of the keeping of medical records include the provision of information for educational, epidemiological and research purposes, as well as various other purposes which fall outside the scope of this work (Pirkle *et al*., 2012:564; Pourasghar *et al*., 2008:143; Mann & Williams, 2003:329). Not only are medical records often the most important documents available to defend doctors against legal action, but good medical record keeping is of paramount importance to inform expert medical opinions in the case of medico-legal litigation (Van den

Heever & Lawrenson, 2015:3; Howarth & Gillespie, 2012:2; McQuoid-Mason & Dhai, 2011b:85; Shamus & Stern, 2011:110). Despite its importance, the management of medical records has been shown not to be a priority, particularly in developing countries, where medical records have been found to be generally inadequate and poorly managed (Wong & Bradley, 2009:253). According to Howarth and Gillespie (2012:1) and McQuoid-Mason and Dhai (2011b:85), accurate and good record keeping has an influence on the outcome of medico-legal claims as well as on the outcome of HPCSA investigations against doctors. See section 1.4.3, p.17 of this chapter regarding the quality of medical records. But is this true? This question will be answered as part of the discussion of the second research question to be addressed in this work.

The HPCSA defines a health record as any record which contains health information about an identifiable individual and which has been made by a doctor during or after a consultation with a patient and/or an examination of a patient (HPCSA, 2016e:1; Howarth & Gillespie, 2012:2). Health records, which are also known as medical records, are permanent records and are generated as a result of patient care. They include manual (hand-written), electronic and digital records. Examples include but are not limited to: doctor's notes; discharge summaries; letters between doctors; completed forms; templates and reports; imaging records; typed summaries; test results such as reports and print-outs from monitoring equipment; audio-visual records including clinical photographs; videos and tape-recordings; clinical research forms; data regarding assessments; and certificates (HPCSA, 2016e:1; Van den Heever & Lawrenson, 2015:3; Howarth & Gillespie, 2012:2; Logan *et al*., 2001:408). In many high-income countries, medical record keeping is supported by information technology (Wong & Bradley, 2009:253), which is per definition also acceptable for medical record keeping in South Africa. However, for the purpose of this work, medical records will be limited to the charting of medical information as hard copy only and will exclude electronic and digital records. According to Pourasghar *et al*. (2008:144) the same doctors who are responsible for charting medical information on paper will do so in electronic systems, and if they do not pay attention to certain documentation aspects (which form part of the scope of this study), then similar basic problems will occur in the electronic medical records. Further, the short-term

and long-term secure storage of medical records (archiving), including the retrievability of hard-copy medical records, do not fall within the scope of this study.

The HPCSA was established in terms of the South African Health Professions Act with the aim of ensuring the provision of the highest quality of healthcare to the public (Moodley, 2011b:147). It is a juristic body in South Africa (McQuoid-Mason & Dada, 2011:9). The HPCSA consists of 12 professional boards (for each branch of the health profession) and the Council. The function of the professional boards is basically to provide overall guidance to the branches of the profession concerned and also to protect the members of the public who make use of the services of the profession (McQuoid-Mason & Dada, 2011:333). One of the professional boards is the Medical and Dental (and medical science) Board, with which all practising medical doctors and dentists in South Africa have to register.

The HPCSA's website confirms that the functions of the Council and the professional boards include the training and education of doctors and providing guidance to the doctors to ensure their compliance with acceptable health care standards. The HPCSA therefore provides guidance booklets to be adhered to by doctors, which contain the ethical and professional rules and guidelines regarding various aspects in the profession. One such guidance booklet includes the topic of patient record keeping (guidance Booklet 9) (HPCSA, 2016e; McQuoid-Mason & Dada, 2011:210). The HPCSA's ethical and professional rules are currently reflected in guidance Booklet 2. Guidance Booklet 9 is basically the HPCSA document that defines medical records and provides guidance to doctors on what documents constitute medical records. Guidance Booklet 9 is of special interest for this work. See section 1.1, p.1 of this chapter.

The Medical Protection Society (MPS) is the world's leading protection organisation for doctors. It protects and supports the professional interests of more than 290,000 members globally (MPS, 2014:2). The MPS has also published guidelines regarding medical record keeping for its members to abide by in South Africa. It should be noted, however, that not all practising doctors in South Africa are members of the MPS. Some doctors may be members of another source of indemnity, and other doctors may not even have medical malpractice insurance or indemnity cover…

> as medical protection indemnity does not extend to matters arising where at the time of the incident, the doctor was employed or managed by the state/provincial healthcare system (M.P.S., s.a).

This is in line with section 1 of the State Liability Act (Act No. 20 of 1957). All practising doctors in South Africa are mandatory members of the HPCSA. In other words, all MPS members are HPCSA members.

Questions that arise are: which guidelines do non-MPS members abide by regarding medical record keeping, since other sources providing indemnity do not have guidelines for medical record keeping as the MPS does? How do the MPS guidelines regarding medical record keeping differ from those in the HPCSA guidance booklet regarding medical record keeping? To what extent does South African legislation prescribe how records pertaining to medical information are to be kept?

In order to seek answers to these questions, Carstens and Pearmain (2007:1) require that:

> legal questions are canvassed on an integrative level, with reference to a multi-layered approach. The multi-layered approach has the applicable supreme provisions of the Constitution of the Republic of South Africa, 1996 (further referred to as the Constitution) as its source as well as: the applicable principles of common law; relevant legislation (often articulated in terms of the Constitution); interpretative case law (as a source of the positive law) and considerations of medical ethics.

The multi-layered approach mentioned above will be applied in this work to find solutions to the research questions.

1.2 Research questions

1.2.1 To what extent do the different medical ethical guidance documents in South Africa for medical record keeping incorporate and repeat South African legal requirements?

1.2.2 Does the quality of medical record keeping influence the outcome of medico-legal cases in South Africa?

1.2.3 Do the different medical ethical guidance documents in South Africa regarding medical record keeping have value to the extent that it is required and needed?

1.3 Aim and methodology

As mentioned in section 1.1, p.1 of this chapter, good medical record keeping is imperative for various reasons, including providing a complete and accurate chronology of medical treatments, medical test results and future plans for medical care (Canadian Medical Association, 2012:3; Wong & Bradley, 2009:253). It is the responsibility of the doctor to ensure that medical records are accurate, valid and updated (Pourasghar *et al*., 2008:140). According to Moodley (2011b:155), all doctors have an ethical obligation to their own continuing professional development and they take responsibility for their own performance to ensure good patient care. This also implies that doctors in South Africa should be familiar with and adhere to the HPCSA guidance booklets to ensure compliance with health care standards, such as medical record keeping. See section 1.4.1.2, p.14 of this chapter. However, doctors can be familiar with the guidelines only if they are aware of them and trained on them. Training is one of the functions that the HPCSA is responsible for, as per the Health Professions Act, section 3(c), and as confirmed by the HPCSA website. See section 1.4.1.1.2, p.9 of this chapter.

Another function of the HPCSA under the Health Professions Act is to ensure the professional and ethical conduct of health care professionals. It is therefore assumed that doctors conduct themselves professionally and ethically if they abide by the published ethical guidelines of the HPCSA. Unprofessional conduct as defined by the Health Professions Act is:

> improper, disgraceful, dishonourable or unworthy conduct.

This study will compare the HPCSA guidance Booklet 9 and the MPS guidelines regarding medical record keeping in South Africa with the relevant legislation, from a medico-legal perspective. Because of the influence that the Canadian Charter of Rights and Freedoms (1982) has had on the South Africa Constitution (see section 1.4.1.1.1, p.8 of this chapter), relevant Canadian law, guidelines and practices will be used to provide clarity and guidance to this study as it attempts to answer the research questions.

The primary aims of the study can be summarised as follow:

1.3.1 A comparison of the medical ethical guidance documents (HPCSA guidance booklets and MPS guidelines) on medical record keeping;

1.3.2 A comparison of these medical ethical guidance documents with the relevant legislation in South Africa regarding medical record keeping in order to obtain a medico-legal perspective; and

1.3.3 A brief comparison of the relevant South African legislation and medical ethical guidance documents on medical record keeping with relevant Canadian law, guidelines and practices.

1.4 Literature survey

Medical record keeping is a medico-legal matter, but what role does the actual quality of medical record keeping play? Is the quality of medical record keeping assessed in South Africa? These are questions that will be answered in the literature survey in order to provide background information relating to the research questions and the analysis that will follow in the chapters of this work.

Ethics is how people ought to behave in a particular situation. It is a matter of knowing what the right thing to do is (Moodley, 2011a:3). How do doctors know what the right thing to do is when they keep or maintain medical records? Doctors ought to abide by the published guidance booklets of the HPCSA in order to be considered by this Council as acting professionally and ethically. The HPCSA is of the opinion, however, that professionalism should drive doctors to deliver high standards of patient care (including medical record keeping) since excellence in health care provision cannot be driven by a professional body (like the HPCSA or MPS) via guidelines, standards and rules alone (Moodley, 2011a:3). So what does the HPCSA do to guide doctors and thereby enhance professionalism besides providing guidance booklets? The HPCSA has previously been criticised for its inability to guide doctors (Oosthuizen & Carstens, 2015:269). This issue will also be addressed in this work.

1.4.1 Law and ethics in South Africa

Law and ethics are not the same thing, but they often overlap. Sometimes law calls for or forbids an action, but this is the opposite in ethics (Van Niekerk, 2011:11). Ethics is how things ought to be done for ethical reasons, regardless of legislation. Ethics is the study of morality, which involves a systematic reflection on the moral qualities of actions and behaviour (Dhai *et al*., 2011:3). Law is enforceable and results in legal accountability when breached. When the medical ethical guidance booklets of the HPCSA are not abided by, the HPCSA can take disciplinary action against doctors (Dhai *et al*., 2011:3; Singh, 2011:133). See section 1.4.1.2.1, p.14 of this chapter.

Giesen (1988b:669), however, is of the opinion that professional medical ethics and the law are not completely separate matters, as they are actually interwoven. He explains that law reflects society's standards, and medical ethics ought therefore to state the medical profession's standards (Giesen, 1988a:680). These two aspects then overlap, as there is a legal obligation that doctors must abide by the rules of medical ethics. Giesen (1988a:680) also indicates that medical ethics in professional education is not always taken seriously. and does not necessarily compel practical commitment. Medical ethics must however be considered by the law and society, since it is not just a set of moral obligations to be fulfilled by the doctors, but it is important for society and the courts to also understand the educational professional background and ethical commitment that doctors' work is based upon (Giesen, 1988b:669). This forms part of the integrative level that Carstens and Pearmain (2007:1) refer to, and is to be applied in this work. See section 1.1, p.4 of this chapter.

Section 15(A)(h) of the Health Professions Act calls for the professional boards to guide doctors and to protect the public. The guidance offered to doctors includes the guidance booklets published by the HPCSA, which doctors are required to follow. Therefore, the published HPCSA guidance booklets do not just have ethical standing as moral obligations have to be fulfilled, but can also be viewed as what is generally referred to as soft law. (The term "soft law" refers to official guidelines, regulations or other similar documents that are recognised or referred to in enacted legislation. The

guidance booklets have no legal force in themselves but attain a special status due to their association with the particular statue) (Dhai & Etheredge, 2011:33).

On the other hand, the MPS guidelines on medical records in South Africa do not attain the special status that the HPCSA guidance booklets hold, but form part of the statement of professional standards, as they are to guide and direct MPS members when keeping and maintaining medical records. The MPS guidelines are therefore to be acknowledged by those MPS members in the profession who are serious about their moral responsibility (Beauchamp & Childress, 2001:5).

1.4.1.1 Relevant South African Legislation

1.4.1.1.1 The Constitution

The content of the Constitution was influenced by international and foreign decisions as well as the Constitutions of other countries, so that the end result of the Constitution could benefit from lessons learned from other countries' decisions (Woolman, 1999:12-6; Sarkin, 1998:177). The text of the Constitution is largely based on the Canadian Charter of Rights and Freedoms (1982) because of the variance of diversity in race, culture and religion that South Africa and Canada have in common. It also entrenches the core values of freedom and equality in South Africa (Currie & De Waal, 2013:148; Schwartz, 2012:2). The Constitution contains a limitation clause (section 39(1)) that demands the consideration of applicable international law and allows for foreign law to be considered where South African law is inadequate during interpretation of the Bill of Rights (Currie & De Waal, 2013:147; Carstens & Pearmain, 2007:17; Davis, 2003:191,193). This is to ascertain that the limitation in question is justified regarding the values found in other open and democratic societies based on the principles of freedom and equality. Customary international law is binding on South Africa except if it is inconsistent with the Constitution or an act of Parliament. Therefore public international law can have a direct impact on the South African legal system (Currie & De Waal, 2013:148; Davis, 2003:191,193). However, references to international law seem not to be as persuasive to the Constitutional Court as comparative foreign law. In *S v Makwanyane* (1995), the Constitutional Court held that

> comparative human rights jurisprudence will be of great importance while an indigenous jurisprudence is developed however foreign case law will not necessarily provide a safe guide to the interpretation of the Bill of Rights (Currie & De Waal, 2013:147).

It is important to see how South African legislation and medical ethical guidelines in terms of medical record keeping compare internationally. Since the Constitution has been influenced by the Canadian Charter of Rights and Freedoms (1982), this study will briefly compare relevant Canadian legislation, guidelines and practices from specifically the Ontario province in Canada in so far as it is relevant to South African legislation, medical ethical guidelines and practices, in order to assist in the attempt to answer the research questions.

Patients' right to the privacy of their communications (including having their medical information kept confidential) is guaranteed in section 14(d) of the Constitution. Confidentiality in medical practices is vital so that patients might have a reasonable expectation that their sensitive information will not to be disclosed to others. It may encourage patients to share their sometimes-vital information with their doctors if they know that their sensitive information will be maintained confidential (McQuoid-Mason & Dhai, 2011a:86; Singh, 2011:130). The principle of the preservation of confidentiality for the sake of the confidence that patients must have in their doctors is an important principle of the World Medical Association Declaration of Geneva: International Code on Medical Ethics (Giesen, 1988b:672). In the context of health care, the patient's common law right to confidentiality is recognised in section 14 of the National Health Act (Act No. 61 of 2003). See section 1.4.1.1.3, p.12 of this chapter. Further, common law recognises the right that a doctor has to actually disclose the confidential information of a patient in certain circumstances, as allowed for by law (Singh, 2011:136). See section 1.4.1.1.3, p.12 of this chapter and section 2.3.1.2, p.26 of Chapter Two.

1.4.1.1.2 Health Professions Act

The Health Professions Act assigns various functions in section 3 to the HPCSA. The functions include but are not limited to:

- Section 3(c): Decision making regarding the professional boards and health profession matters including but not limited to education, training, ethics and professional conduct, disciplinary procedure and the maintenance of professional competence in terms of a strategic policy determined in accordance with the national health policy.
- Section 3(f): Controlling and making decisions regarding matters affecting the education and training of doctors and the manner in which doctors fulfil their duties regarding the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in patients. This is also a function of the professional boards, according to section 15A(c) of this act.
- Section 3(g): Promoting liaison in the field of education and training regarding the manner in which doctors fulfil their duties, and promoting the standards of such education and training. This is also a function of the professional boards, according to section 15A(d) of this act.
- Section 3(m): Maintaining professional and ethical standards in the health profession. The HPCSA provides standards in the form of the different guidance booklets which contain the ethical and professional rules and guidelines of the medical profession. These guidance booklets are updated from time to time by the HPCSA; i.e. the standards of professional and ethical conduct are being maintained by the HPCSA. But maintenance may not only require that the guidance booklets be periodically updated. The term “maintain” in this context may also require that the HPCSA assesses the actual professional and ethical conduct of doctors against the standards that are set and recorded in the guidance booklets.
- Section 3(n) allows for the HPCSA to investigate complaints concerning doctors and to take disciplinary action in accordance with the act to protect the public interest. The HPCSA can take disciplinary action in the case of the unprofessional behaviour of doctors. The professional boards can institute an inquiry into any complaint, charge or allegation of unprofessional conduct (section 41(1)) and the relevant professional board can impose a fine on the doctors who act unprofessionally (section 42(8)) (McQuoid-Mason & Dada, 2011:333). Section 49(1) calls for the HPCSA, in consultation with the

professional boards, to make rules, upon the infringement of which the professional boards may also take disciplinary action.

- Section 3(o) calls for doctors to respect the constitutional rights of patients, with particular reference to human dignity, bodily and psychological integrity, and equality. This section does not, however, explicitly require doctors to respect the right of privacy of communications (see section 14(d) of the Constitution).

Section 4(d) of the Health Professions Act assigns authority to the HPCSA to make rules (presented as guidance Booklet 2) on matters that the Council considers necessary so that the aims of the Act are achieved. Whether the Council is achieving its objectives as stipulated in terms of medical record keeping is an issue that will be assessed in this work.

Section 15(A) of this Act also assigns some other functions to the professional boards, which include:

- Section 15A(d): The promotion of liaison in the field of education and training in South Africa and elsewhere, and the promotion of the standards of such education and training;
- Section 15A(g): The maintenance and enhancement of the dignity of the relevant health professions, and the integrity of the doctors; and
- Section 15A(h): Guiding the relevant health professions and doctors and protecting the public.

Section 15B(1) of the Health Professions Act provides that when the HPCSA has determined that a matter falls entirely in the scope of the professional board, the decision of the professional board does not require ratification by the HPCSA (McQuoid-Mason & Dada, 2011:333).

The HPCSA guidance Booklet 2 stipulates in sections 13(1) and 13(2) the conditions under which a doctor can divulge confidential patient information. See section 2.3.1.2, p.26 of Chapter Two. In section 15 the HPCSA guidance Booklet 2 also calls for doctors to sign medical records, and for the doctors' initials and surname to be printed in block letters next to the medical notes recorded. See section 2.3.2.4, p.37

of Chapter Two. Section 27A of the HPCSA guidance Booklet 2 lists the main responsibilities of doctors, which include but are not limited to respecting patient's confidentiality and privacy and keeping accurate medical records. See section 2.3.1.1, p.25 of Chapter Two.

1.4.1.1.3 National Health Act

The National Health Act requires in section 13 that medical records must be created and maintained at the health establishment that the patient visits. The information (the patient's health status, treatment or length of stay at a health establishment) must be kept confidential according to section 14(1). Singh (2011:131) explains that the doctor-patient relationship is a relatively privileged relationship where the doctor has to maintain the confidence of his/her patients but can divulge confidential information in the cases allowed for by section 14(2) of the Act. See section 2.3.1.2, p.26 of Chapter Two.

Section 15(1) of this Act further allows for doctors to disclose confidential information regarding patients to other doctors, persons or health establishments if the reason for disclosure is the furtherance of the patient's best interest, and for legitimate reasons within the scope of the doctor's duty (McQuoid-Mason & Dada, 2011:8). See section 2.3.1.2, p.26 of Chapter Two.

Section 16(1) allows for a doctor to examine a patient's medical records under certain conditions, which are described in section 2.3.1.3, p.26 of Chapter Two.

Lastly, section 17(2) of the National Health Act regards it as an offence if:

(b) medical records are falsified by adding, deleting or altering information;
(c) medical records are created, altered or destroyed without permission;
(d) a person fails to create or alter medical records when required to do so;
(e) false information is provided to be included in medical records; or
(g) the personal identification elements of a medical record are linked with any element of the record that concerns the patient's condition, treatment or

history without the person who so links such information having the authority to do so.

1.4.1.1.4 Protection of Personal Information Act (Act No. 4 of 2013)

The Protection of Personal Information Act (further referred to as POPI Act) calls for the protection of personal information. The POPI Act aims to prevent the unlawful collection, storage, distribution and use of personal information. The term "personal information" according to section 1 of the POPI Act includes:

> information relating to an identifiable, living, natural person and where applicable to an identifiable, existing juristic person.

Further, the processing of information as defined in section 1 of the POPI Act, includes the recording and storage of information as well as updating or modifying it.

The POPI Act also describes the legal requirements for records management in section 19(1) and (2) of the Act.

The POPI Act was signed into law on 19 November 2013, but the president signed a Proclamation on 7 April 2014 declaring that only four parts of the POPI Act would become operational as of 11 April 2014. These include:

- Section 1: Definitions
- Part A of Chapter 5: Information Regulator
- Section 112: Regulations
- Section 113: Procedure for making regulations

Because the remainder of the POPI Act is not yet in effect, sections 19(1) and (2) that apply to this work will not be further discussed.

1.4.1.1.5 Promotion of Access to Information Act (Act No. 2 of 2000)

Personal information is defined in the Promotion of Access to Information Act, (further referred to as PAIA) as:

> information relating to an identifiable individual who is alive or dead for not more than 20 years, including but not limited to: the race; gender; pregnancy status; ethnic or social origin; colour; sexual orientation; age; physical or mental health; well-being; disability; birth of the individual; medical, criminal or employment history of the individual; identification number, symbol or particular; blood type and views or preferences of the individual.

The National Health Act section 15(2) accepts and refers to this definition of personal information.

The PAIA accommodates the constitutional right to access to any information held by the state or another person and which is required for the protection of any right (Van den Heever & Lawrenson, 2015:5). Sections 29 and 30 of the PAIA govern the right to access to medical records by patients and third parties (McQuoid-Mason & Dada, 2011:8). Before the PAIA was promulgated, patients were not entitled to see their own medical records until legal proceedings had successfully been instituted (Van den Heever & Lawrenson, 2015:5). Section 30(1) of the PAIA now allows for relevant persons to access medical records unless the disclosure of the information may cause serious harm to the person whose information is being disclosed (McQuoid-Mason & Dada, 2011:9). This provision becomes relevant in cases where patients, their family members or representatives and any other party/company/employer is seeking access to information from a doctor or hospital to protect any right guaranteed to them by the Constitution. It is also relevant in the case that information is required regarding adverse consequences related to a patient and when the doctor or hospital unjustifiably refuses to disclose such information. The PAIA does not apply to medical records being requested for criminal or civil proceedings after the commencement of the proceedings (section 7). This was confirmed in the case of *Unitas Hospital v Van Wyk* (2006).

1.4.1.2 Medical ethical guidance documents

1.4.1.2.1 HPCSA guidance booklets

For the documentation of patient care, doctors must abide by the guidance booklets published by the HPCSA. See section 1.4.1.1.2, p.9 of this chapter. According to the Health Professions Act, the function of the HPCSA includes the training and education of doctors. But Moodley (2011b:155) and Dhai and Etheredge (2011:33)

are of the opinion that doctors should take responsibility for their own performance, to ensure good patient care (which includes being familiar with and adhering to the guidance booklets on medical record keeping). Legally, though, it remains a function of the HPCSA. The HPCSA (and the MPS) do not perform formal training on the guidelines for doctors, and doctors have to keep themselves up to date with the latest versions of the guidance documents.

Guidance Booklet 9: *Guidelines on the keeping of patient records* of the HPCSA is of particular interest for this work due to the guidance provided on various aspects of medical record keeping, including but not limited to:

- The signing of official documents;
- The alteration of records;
- Access to records; and
- Providing guidelines in the form of a checklist for health record-keeping (HPCSA, 2016e:1).

The latest version of guidance Booklet 9 of the HPCSA is dated September 2016.

According to Health24 (2014:1), doctors found guilty by the HPCSA of charges such as a failure to keep proper records or altering medical records, for which guidance is provided in Booklet 9, can be issued with fines, can be suspended for different periods of time, or can be required to complete a course in medical ethics before being allowed to practise further. However, according to the information available from the HPCSA's website, doctors do not get formally assessed by the HPCSA (as The College of Physicians and Surgeons of Ontario (CPSO) does in Ontario – see section 1.4.2, p.16 below) on their performance in order for the HPCSA to determine their ongoing adherence to the HPCSA guidance documents. As the HPCSA does not assess doctors to determine their compliance with the guidance documents, the HPCSA has to rely on complaints received about doctors who have not abided by the requirements contained in the guidance booklets in the case of medical record keeping. The public, however, certainly does not know what guidance Booklet 9 for example requires, and therefore will not complain to the HPCSA in a case of non-compliance with guidance Booklet 9. See section 3.2.2, p.42 of Chapter Three.

1.4.1.2.2 MPS guidelines

The MPS guidelines on medical record keeping provide for:

> general guidance regarding clinical and medico-legal aspects of medical record keeping, confidentiality and security to facilitate the continuity of patient care (MPS, 2014:3).

The latest version of the MPS Guide on Medical Records in South Africa (further referred to as MPS guidelines) is dated 2014. These guidelines are to be adhered to by MPS members. MPS members also do not get formally assessed by the MPS regarding their compliance with the MPS guidelines. What is the purpose of the guidelines, then, if they are not enforced? The MPS guidelines seem to repeat enacted legislation and the HPCSA requirements. The question then arises as to whether the MPS guidelines regarding medical record keeping in South Africa have value? See Research question 1.2.3, p.4 of this chapter.

1.4.2 Canadian setting

Each province and territory in Canada has its own medical regulatory body as required by the Canadian Regulated Health Professions Act (RHPA) (1991). The medical regulatory body in each province presents as a College which is contracted by the provincial government to regulate the practice of medicine in order to protect the public interest. For example, in Ontario it is the CPSO which regulates the practice of medicine (Cirak, 2017). All doctors practising medicine in Ontario are mandatory members of the CPSO. The duties of the CPSO include (but are not limited to):

- Providing guidance via a practice guide and policies (which include the legal requirements found in legislation, regulations and by-laws) on professional conduct and on matters relevant to the practice of medicine and the certification of doctors to allow them to practise;
- Conducting annual peer assessments regarding the professional conduct of physicians and prescribing remediation as a quality assurance measure in all independent health facilities; and

- Conducting disciplinary hearings in cases of professional misconduct or if doctors are deemed incompetent (CPSO, 2014:1).

The functions of the HPCSA assigned by the South African Health Professions Act (see section 1.4.1.1.2, p.9 of this chapter) compare well with those of the CPSO, but there are duties that these two professional bodies differ on. The main duties of the CPSO will be briefly compared in Chapter Two (see section 2.2, p.21) with the duties of the HPCSA to determine the similarities in the scope of duties of these juristic bodies, as a background to the guidelines and practices regarding medical record keeping.

The CPSO provides an administrative Policy Statement #4-12, Medical Records (latest version dated May 2012), which sets out a physician's professional and legal obligations in terms of medical record keeping. The Policy Statement also provides a tool to assist doctors in implementing practical record-keeping practices. The Policy Statement also specifies additional requirements, which are based on the type of record kept (paper or electronic). On the other hand, the Canadian Medical Association has published a guidance module on Medical Records Management (Module 6) (latest version dated September 2012), which provides guidance on the regulatory standards for medical records and practical advice for using paper records (Canadian Medical Association, 2012:3).

The Policy Statement #4-12 as well as the Module 6: Medical records management guideline will be briefly compared in this work, with the HPCSA and MPS ethical guidance documents on medical record keeping, to determine similarities and differences in the guidance documents and practices in South Africa and Ontario (Canada) regarding medical record keeping.

1.4.3 Quality of medical records

Comprehensive and adequate medical records are the cornerstones of quality patient care, as they improve the coordination and continuity of patient care. It has been found in various research studies in different countries that the overall quality of medical records is poor (Bazzo, 2015:1; Mann & Williams, 2003:329). Good quality

medical records limit the risk to the quality of patient care, which can eventually undermine patient safety and lead to medical errors that can subsequently lead to lawsuits (Bazzo, 2015:1; Hong *et al*., 2015:48; Pirkle *et al*., 2012:564; Wong & Bradley, 2009:253). Good quality medical records are described as original recorded data which is legible, accurate, complete, has meaning, and preserves the confidentiality of patient information (Pirkle *et al*., 2012:564; Logan *et al*., 2001:408). Medical records should not only be comprehensive, legible and accurate (College of Physicians and Surgeons of British Columbia, 2014:2) but they should also be detailed, concise and objective, and the notes contained in them should be contemporaneously recorded (Howarth & Gillespie, 2012:1; Shamus & Stern, 2011:95). According to Howarth and Gillespie (2012:1) there is a misconception amongst doctors that little and limited medical records can make a case difficult to prosecute, but the authors confirm that this is not the case, and the MPS has in fact difficulty to defend such cases in South Africa. Mann and Williams (2003:330) add that structured information in medical records enhances the interpretation of the information and therefore limits clinical errors which may potentially lead to lawsuits. Structured records therefore seem to also benefit patients directly, as their outcomes will improve with better quality record keeping (Mann & Williams, 2003:329).

It is each doctor's responsibility to keep and maintain adequate medical records as per the established standard, which in South Africa is compliance with the HPCSA's and MPS's ethical guidance documents. Despite the existence of such established standards, several research studies which assessed medical records from various perspectives (including insurance, courts and forensic-legal medicine) have found medical records to be illegible, inadequate and incomplete (Hong *et al*., 2015:48; Pourasghar *et al*., 2008:140,144; Mann & Williams, 2003:330). Despite the consequences of poor record keeping, very few medical doctors receive formal training on this aspect during their extensive education (Bazzo, 2015:1; Pirkle *et al*., 2012:566; Pourasghar *et al*., 2008:143,144). It was found, however, that supervising and/or assessing medical records improves the quality of medical record keeping (Pirkle *et al*., 2012:566; Pourasghar *et al*., 2008:140). The improvement of medical record keeping therefore requires the training of doctors and some sort of supervision or assessment (Bazzo, 2015:1; Pirkle *et al*., 2012:566; Wong & Bradley,

2009:257). This may in the end lead to better patient safety, preventing medical errors to a large extent.

1.5 Chapter outline

The content of the various chapters in this work will include the following:

1.5.1 Chapter One: Introduction and literature survey

Chapter One, which is the introductory chapter, provides a background to the problem and presents the research questions and primary aims of the study. The literature survey provides further information pertaining to the research questions and the analysis that will follow in the chapters of this work.

1.5.2 Chapter Two: Medical record keeping in terms of the different medical ethical guidance documents and relevant legislation: A comparison

In Chapter Two the current guidance documents of the HPCSA and MPS respectively, with specific reference to medical record keeping, will be considered. These ethical guidance documents will be compared to South African legislation and relevant Canadian law, guidelines and practices to determine the similarities and differences in these ethical guidance documents and legislation.

1.5.3 Chapter Three: Discussion of differences in the relevant legislation and medical ethical guidance documents regarding medical record keeping in South Africa

Chapter Three will evaluate and discuss from a medico-legal perspective the differences in the ethical guidance documents and relevant legislation regarding medical record keeping in South Africa. In this chapter, case law will also be considered to determine if the outcome of medico-legal cases in South Africa is influenced by the quality of medical record keeping.

1.5.4 Chapter Four: Conclusion and recommendations

Chapter Four will conclude with making recommendations as to whether or not the South African ethical guidance documents regarding medical record keeping have value to the extent that it is required and needed.

1.6 Conclusion

Medical record keeping is imperative. In South Africa this practice is guided by legislation which is enforceable, the HPCSA's guidance documents, which are considered to be soft law, as well as the MPS's guidelines, which have no legal force. The similarities and differences amongst these guidance documents and the relevant legislation will be determined in the next chapter and briefly compared with the most pertinent, relevant Canadian law, guidelines and practices.

CHAPTER 2

Medical record keeping in terms of the different medical ethical guidance documents and relevant legislation: A comparison

2.1 Introduction

It is clear from the Introduction in Chapter One that adequate and accurate medical record keeping is required and imperative for various reasons. This practice is guided in South Africa by legislation, the HPCSA's ethical and professional rules and guidance booklets to be followed by all practising doctors, and the MPS guidelines for MPS members. The similarities and differences in South African legislation and the medical ethical guidance documents will be considered in this chapter. The South African requirements and practices will be briefly compared with the most pertinent relevant Canadian law, guidelines and practices. The Ontarian guidance documents that will be considered in this chapter include the CPSO Policy Statement #4-12 and the Module 6: Medical records management guidelines published by the Canadian Medical Association. Relevant case law will be considered only in Chapter Three, when it will be determined if the outcome of medico-legal cases in South Africa is influenced by the quality of medical record keeping.

2.2 The duties of the HPCSA vs the duties of CPSO

Just as doctors in South Africa are mandatory members of the HPCSA, doctors in Ontario are mandatory members of the CPSO. The main overall duty of the HPCSA as per section 3 of the South African Health Professions Act and as listed in detail in Chapter One (see section 1.4.1.1.2, p.9) is to protect the citizens of South Africa, who have a right to have access to health care services, which is guaranteed in section 27(1)(a) of the Constitution. The main duty of the HPCSA – the protection of South African citizens - finds application in various smaller duties such as:

- Making decisions regarding and improving the standards of the education and training of doctors;
- Making decisions on the ethical and professional conduct of doctors so that the dignity of the health profession is maintained and enhanced, and also the integrity of South African doctors; and
- Investigating complaints received against doctors and taking disciplinary action in cases where unprofessional conduct is confirmed.

In addition to duties like those of the HPCSA, article 2.1 of the Canadian RHPA also assigns one ultimate duty to Colleges (such as the CPSO). This ultimate duty is to ensure that the citizens in the province have access to an adequate number of qualified doctors regulated by CPSO. The purpose of this provision amounts to public protection. According to the legislation, the HPCSA and CPSO have similar main objectives: the protection of the public by ensuring the provision of quality health care services.

The Canadian RHPA requires that the CPSO regulates doctors' medical practices and governs doctors in accordance with the Canadian RHPA, regulations and by-laws, by means of developing, establishing and maintaining standards of qualification, knowledge, skill, practices and professional ethics. Further, the CPSO has to develop, establish and maintain programmes to encourage continuous evaluation, competence and improvement among doctors.

The Canadian RHPA further requires that the CPSO develop standards in collaboration and consultation with other Colleges for the common duties that health professionals perform. Lastly, the CPSO is required to promote and enhance relations between the College and its members (the doctors), other health profession colleges, key stakeholders and the public.

The Policy Statement #4-12 (further referred to as Policy Statement) published by the CPSO as a guidance document elaborates on the duties of the CPSO that the Canadian RHPA calls for. See section 1.4.2 in Chapter One, p.16.

Both the CPSO and the HPCSA provide guidelines to be adhered to by doctors, and both bodies have the authority to conduct disciplinary hearings in cases of suspected professional misconduct. The main explicit difference between the duties of the HPCSA and the CPSO as assigned by the respective Health Profession Acts is that the CPSO has to establish and maintain programmes so that doctors are assessed for competence and improvement in terms of the quality of their medical records and the quality of the medical care that they provide to patients. Medical records in Ontario have to meet provincial licensing standards in order for doctors to be authorised to practise medicine (Canadian Medical Association, 2012:3). The Ontarian Module 6: Medical records management guideline requires in the introductory section that medical records be easily understandable, comprehensive and compliant with the guidelines. Adherence to these standards is reviewed during CPSO peer assessments. The Module 6: Medical records management guideline warns that if an assessor finds that the record-keeping at a medical practice is sub-standard, then a more formal review will be initiated by CPSO and disciplinary action may follow (Canadian Medical Association, 2012:3). This practice is different in South Africa, as the HPCSA does not assess doctors for competence and compliance with the standards (as recorded in the guidance booklets) set by the Medical and Dental (and medical science) Board (which is an affiliate of the HPCSA).

2.3 Ontarian guidance documents vs South African guidance documents

As said in section 1.4.2, p.16 Chapter One, the CPSO has published an administrative Policy Statement based on the legislative requirements and which provides the professional expectations of the College that are mandatory for doctors to adhere to regarding medical record keeping (CPSO, 2012:3). The Canadian Medical Association provides guidance in the Module 6: Medical records management guideline on medical record keeping. In South Africa, the South African Medical Association (the equivalent of the Canadian Medical Association) does not have a guidance document for doctors that addresses issues regarding medical record keeping, as in Canada. On the other hand, the Canadian Medical Protective Association (the equivalent of the MPS in

South Africa) does not have guidelines on medical record keeping, which the MPS has.

The Module 6: Medical records management guidelines, is based on the Policy Statement, just as the MPS guidelines in South Africa are based on the HPCSA guidance booklets and elaborate/clarify aspects addressed in the guidance document that they are based upon. The Module 6: Medical records management guidelines address principles and policies and provide practical guidance for medical record keeping in Ontario that apply to both hard-copy and electronic records. This work focusses only on the aspects regarding hard-copy medical records.

The Module 6: Medical records management guidelines and the Policy Statement specifically provide guidance on the structure of medical notes and the contents thereof. Both the South African guidance documents include a provision stipulating the minimum information required i.e. the contents to be included in medical records. In the section *Accessibility* the MPS guidelines provide guidance on how the MPS suggests the medical notes should be structured, although the guidance is not as detailed as that in the Ontarian Policy Statement and Module 6: Medical records management guidelines, which includes examples. The HPCSA guidance Booklet 9 suggests a specific chronology for the filing of medical records. This is also not an aspect that is addressed by legislation.

The Ontarian Policy Statement and Module 6: Medical records management guidelines provide guidance regarding the disclosure and security of confidential patient information and the quality of medical records, just as the MPS and HPCSA guidance documents do. The South African guidance documents include requirements that should be met when doctors write medical notes, including but not limited to comprehensiveness, the alteration of records, the attributability of notes, and the identification of medical records.

2.3.1 Disclosure of confidential patient information

It should be noted that the disclosure of Human Immunodeficiency Virus (HIV) status information falls outside the scope of this work. So does the disclosure of information

to protect vulnerable patients who lack legal capacity and proxy consent as allowed for by the Mental Health Care Act (Act No. 17 of 2002). Further, the HPCSA guidance Booklet 5, which addresses mainly *Confidentiality: Protecting and providing information,* is not the focus of this work. Booklet 9: *Guidelines on the keeping of patient records* is the main focus. The protection of health records and the unauthorised access to medical records will also not be considered.

2.3.1.1 Respecting patient confidentiality

The patient's right to the confidentiality of his/her medical information is guaranteed in section 14(d) of the Constitution. This is a common law right which is also recognised in section 14(1) of the National Health Act. See section 1.4.1.1.1, p.8 of Chapter One. The HPCSA rule 27(A) and guidance Booklet 1: *General Ethical Guidelines for the Healthcare Professional*, section 5.2.1, acknowledges the Constitutional right that patients have for doctors not to disclose their medical information and to respect their privacy and confidentiality. Sections 5.2.5 and 8.2.5 of the HPCSA guidance Booklet 1 respectively call on doctors not to violate this right and for doctors to ensure that their staff is trained to respect patient rights and to keep patient information confidential. Part 2 of the MPS guidelines (Disclosure and security under the sub-header *Confidentiality)* confirm and repeat the common law duty of doctors to preserve professional confidence. According to the MPS guidelines this includes but is not limited to the training of staff on confidentiality, implementing confidentiality agreements for staff, and using a confidential cover when medical records need to be transferred. Further, the MPS guidelines require that medical information may be disclosed to the patient if the patient is older than 12 years, consents to the disclosure, and has the maturity to understand the implications of the disclosure.

Section 16(1) of the National Health Act allows for a doctor to examine a patient's medical records for the purpose of:

(a) Treatment when the patient consents to it

(b) Study, teaching or research with the consent of the patient or approval from the head of the health establishment and the relevant research ethics committee.

Section 16(2) of the National Health Act allows for medical records which do not reflect any confidential patient identifiers to be used without the patient's consent for reasons

mentioned in sections 16(1)(a) and (b) of the National Health Act. The HPCSA guidance booklet does not stipulate any requirement in terms of confidentiality regarding the examination of medical records for treatment, studying, teaching or research purposes. On the other hand, the MPS guidelines refer in two sections to section 16 of the National Health Act, and repeat these statutory requirements.

2.3.1.2 Disclosure to the patient

The HPCSA guidance Booklet 1 allows in section 5.3.5 for patients to have access to their own medical records.

The Ontarian Module 6: Medical records management guidelines as well as the Policy Statement, section *Overview and organization of medical records* allow the same, unless an exception applies as stipulated in section 52(1) of the Canadian Personal Health Information Protection Act (2004). The Module 6: Medical records management guidelines, however, indicate that medical records cannot be disclosed to a patient if the disclosure poses a serious risk to the patient or others. This is in line with the South African PAIA section 30(1), which allows for medical records to be accessed by the patient unless the disclosure of the information in the records can cause serious harm to the physical and mental health or well-being of the patient. This requirement is repeated in the MPS guidelines.

Section 11.1.1 of the HPCSA guidance Booklet 9 requires that copies of medical records or an abstract or direct access to medical information can be provided to patients from the age of 12 years old, upon request for access to the information.

2.3.1.3 Disclosure to third parties with patient consent

In section 14(2) the National Health Act allows for doctors to disclose confidential patient information to third parties in certain cases. These include:

(a) When a patient grants written consent for the disclosure of information
(b) A court order or law demands the disclosure
(c) When there is a serious threat posed to public health and the public will benefit from disclosure of the information

The HPCSA guidance Booklet 9, section 11.1.4 and the MPS guidelines repeat the permission granted by section 14(2) of the National Health Act, to disclose medical information to third parties, which includes disclosure with the patient's written consent. In section 13(2)(a) the HPCSA guidance Booklet 2 allows for a doctor to disclose patient information to a third party if the patient provides express consent for it. This is in line with the National Health Act section 14(2)(a) mentioned above. Under the respective sections *Statutory obligations* and *Disclosure in the public interest*, the MPS guidelines repeat the circumstances under which medical information may be disclosed according to the National Health Act, as long as the reason for the disclosure of patient information is documented.

The HPCSA guidance Booklet 3: *National Patient Right's Charter* section 2.7 and the HPCSA guidance Booklet 1, section 5.4.1 also allow for medical information to be disclosed but with consent from the patient, or when required by law or a court order. This is in line with the National Health Act sections 14(2)(a) and (b) (see above). The HPCSA guidance Booklet 1 further refers in section 5.4.1 to sections 14 and 15 of the National Health Act. In section 5.4.2 it requires that no breach of confidential patient information is allowed without sound reason and without the knowledge of the patient. It is assumed that "the sound reason" that the HPCSA guidance booklet refers to is as per local legislation and all the HPCSA requirements in this regard. Section 5.4.3 of the HPCSA guidance Booklet 1 is a practical requirement that requires doctors to explain the ICD-10 coding system to their patients and obtain consent from the patients to breach confidentiality when claims are submitted to medical schemes.

The MPS guidelines, Part 2: Disclosure and security under the sub-header *Confidentiality* refers to section 14(d) of the Constitution regarding the right to privacy. The MPS guidelines require in two sections (*Confidentiality* and the section *Research and audit*) that when a doctor is intent on using a patient's information for purposes other than immediate care such as sharing the information with non-medical persons or for research purposes, then the doctor must obtain the patient's consent to keep, process and use the information. The MPS guidelines refer twice to section 15 of the National Health Act regarding access to patient records, and they repeat the statutory requirements regarding a doctor's being allowed to disclose confidential patient information if it is in the patient's best interest (as required by the HPCSA guidance

Booklet 1 section 5.4.1) and is in the scope of the doctor's obligation. The MPS guidelines stipulate that any permission granted by a patient does not constitute a general waiver of confidentiality. It repeats the requirement that the patient/party granting written consent for the disclosure of the information should specify various points in this regard including: the purpose of the disclosure, who may disclose the information, how the information will be shared, and to whom the disclosure may be made. The MPS guidelines further require that if patient information is shared, that the records being shared are accompanied by a cover page stating "private and confidential" and that measures have to be implemented to ensure that the information arrives at the recipient it is intended for.

The HPCSA guidance Booklet 1 requires in section 5.4.1 for patient information to be disclosed if it is in the interest of the patient. This is in line with section 15(1) of the National Health Act that requires it to be in the scope of the doctor's obligation to disclose information that is in the patient's best interest (see section 1.4.1.1.3, p.12 of Chapter One), for example when one doctor refers the patient to another doctor. The MPS guidelines allow for patient information to be disclosed on a need-to-know basis within a health care team depending on the role that the team member plays in the patient's care, but it should mainly be for the purpose of safety and continuity. The HPCSA guidance booklet does, however, allow for the disclosure of patient information to take place within a health care team as long as the patient consents to it, even if it is implied consent. Further, the MPS guidelines acknowledge that patients may not be aware that they have a right to request for certain information to be withheld from the doctor referred to, but the guidelines require that patients are informed of this right, upon which their decision should be respected.

Section 30(3)(a) of the PAIA allows for a doctor to grant a third-party access to patient information only when the third party can prove that counselling has been arranged before, during and after the disclosure of the information. This is to prevent or limit harm to the patient. The HPCSA's Rule 13(1)(a) requires that when a doctor discloses patient information verbally or in writing to a third party, that it is done in terms of statutory provision. Therefore, the HPCSA's rule 13(1) repeats the PAIA requirements as mentioned above. The HPCSA guidance Booklet 9 section 11.1.2 refers to the name of the act incorrectly as the "Access to Information Act" instead of the Promotion

of Access to Information Act. Section 11.1.2 of the HPCSA guidance Booklet 9 and the MPS guidelines section *Request for access* repeats the PAIA section 30(2)(a) requirements, which permit, for the parent or legal guardian of a patient younger than 16 years, to apply for access to the medical records of the minor patient if the patient is incapable of managing his or her own affairs. The MPS guidelines also clarify in the section *Relatives* that relatives of legally competent patients have no automatic right to access an adult patient's records.

The HPCSA guidance Booklet 2 calls for the parents or guardian of a patient younger than 12 years of age to provide written consent before the patient's information can be disclosed to third parties. This is different from the provisions of the PAIA but in line with section 129 of the Children's Act (Act No. 38 of 2005), which provides for a child at the age of 12 years to consent to medical treatment for him/herself or his/her child. Therefore from the age of 12 years a patient has to give consent for his/her own medical information to be disclosed to a third party. The Children's Act is supreme over the PAIA regarding the minimum age when a patient can grant consent for the disclosure of the child's medical information to a third party. The MPS guidelines require (in the sub-section *Parents and guardians*) the same as the current HPCSA guidance Booklet 2.

In section 63(1) the PAIA requires that the superintendent of a hospital refuses a request for access to medical records kept at the hospital if the disclosure of the confidential information involves the unreasonable disclosure of the personal information of the patient or a deceased individual. The PAIA section 63(2) stipulates that a request for access to medical records cannot be refused in the following circumstances:

(a) If the patient has consented to the disclosure of the information

(b) If the information is already publicly available

(c) If the patient is informed before s/he provides any information to the hospital/doctor, that the information may or will be made available to the public

(d) When the medical information concerns information regarding a patient's mental or physical health and well-being and the patient is under the care of the requester when:

   i. The patient is younger than 18 years of age

   ii. The patient is incapable of understanding the request for access to his/her medical records.

(e) An individual who is deceased and the requester for access to the medical information is:

i. The deceased individual's next of kin

ii. Making the request with the written consent of the individual's next of kin

The MPS guidelines repeat these sections 63(1) and (2) of the PAIA when they provide guidance regarding the circumstances when legal practitioners in cases of claims should be provided with a copy of a patient's medical records.

The HPCSA guidance Booklet 2 section 13(2)(c) requires that the information of a deceased patient may be disclosed only with the written consent of a next-of-kin or the executor of the deceased patient's estate. This is in line with the PAIA section 63(1)(e)(i) and (ii) as stated above. The MPS guidelines add to this in the section *Deceased patients* when they state that there are exceptions to this HPCSA rule, as when, for example, an inquest magistrate requires that medical information is disclosed. The MPS guidelines further refer to the obsolete 2008 HPCSA guidance Booklet 5 regarding the consideration of the circumstances before a doctor agrees to a request for the disclosure of information, taking into consideration the effect of the disclosure on the deceased patient's partner or family.

The MPS guidelines indicate in the section *ICD-10 Coding* that, when medical schemes require confidential patient information, a patient should be fully informed who will have access to his/her medical information. The patient should also be informed of the purpose of granting the access and the implications of disclosing the information, as against refusing its disclosure. This section also requires that doctors who do not have direct contact with patients, such as pathologists, must confirm with the primary doctor that the patient consented to the disclosure of his/her medical information and that the medical information was also disclosed to the medical scheme of the patient.

In the section *Publishing case reports, photographs or other images* the MPS guidelines refer to the HPCSA guidance Booklet 5, section 9.1.4 regarding the need to obtain the express consent of patients before case reports, photographs and images of a patient can be published in the media, regardless of whether the patient can be identified or not.

2.3.1.4 Disclosure to third parties without patient consent

Section 11.2 of the HPCSA guidance Booklet 9 provides the circumstances under which a doctor may disclose the medical records of a patient without the written consent of the patient. The circumstances include court orders to make the records available and when the non-disclosure of the medical information about the patient would present a serious threat to public health. This is a repetition of the National Health Act sections 14(2)(b) and (c) respectively. The other circumstances as per section 11.2 of the HPCSA guidance Booklet 9 include when the third party is a doctor and:

- being sued by the patient and the third party requires the medical records for his/her defence;
- has a case of disciplinary proceedings against him/her; or
- is under statutory obligation to disclose the medical information.

An example of such statutory obligations to disclose medical information as allowed for by the HPCSA guidance Booklet 9 would be as required by section 116(1)(a) of the Children's Act, which allows for information to be disclosed:

> for the purpose of protecting the interests, safety or well-being of a child

as in a case of suspected child abuse.

In the respective sections *Professional ethics* and *Disclosure in the public interest*, the MPS guidelines refer to and repeat the HPCSA requirements regarding the above-mentioned circumstances when patient information can be disclosed to third parties without the patient's consent. However, the MPS guidelines acknowledge several times that confidentiality is not an absolute obligation and that there are:

> exceptional circumstances under which a doctor can disclose information after careful and due consideration.

The MPS guidelines also repeat the requirement from the HPCSA guidance booklet that a doctor must always first attempt to obtain the patient's consent before patient information is disclosed, even in a case when the disclosure of information is in the

public's best interest. If the patient does not then consent to the disclosure of information, then the doctor can continue with the disclosure of information without the patient's consent.

The HPCSA guidance booklets dated 2008, referred to by the MPS guidelines, are obsolete, as the latest versions of the HPCSA guidance booklets were published in September 2016.

In the section *Court orders* the MPS guidelines confirm, elaborate and clarify that a definitive court order should be adhered to (and not threats of court orders) when the court demands the disclosure of medical information, even if the doctor has concerns about the disclosure of the records. In such cases the guidelines require the doctor to attach a cover letter directed to the judge expressing the concerns that the doctor has, and to seek advice from the MPS. These practical aspects are not addressed by the South African legislation or the HPCSA guidance booklets relevant to this work.

In the section *Practical tips for paper-based medical records* the Ontarian Module 6: Medical records management guideline calls for doctors to keep individual/per patient medical records and not to keep "family files" due to the right to confidentiality that individuals have. The Policy Statement requires the same. Family or individual patient files are neither addressed by South African legislation nor by the local medical ethical guidance documents.

The Module 6: Medical records management guidelines also allows that no consent is required if the disclosure of information is mandated by law (see section 2.3.1.3, p.26 of this chapter for a similar requirement by the South African National Health Act), unless the information is shared with third parties for reasons other than care and treatment, in which case consent is then required. The Ontarian Policy Statement requires the same in the section C*hronological and systematic.* It always requires patient consent when patient information is collected, used or disclosed, unless no consent is required by the Canadian Personal Health Information Protection Act (2004). The implied consent of a patient to the disclosure of medical information can be assumed in certain situations which are stipulated in the Policy Statement.

The MPS guidelines (section *Where allowing access might be permissible*) require that in order to determine if the disclosure of patient information is required, the circumstances have to be assessed individually and the reasons for the decision to disclose patient information to a third party have to be documented comprehensively.

The MPS guidelines are the only guidance document that attaches a timeline to disclosure. In the sub-section *Requests for access* to medical information it provides that the information should be provided upon request for access – that is, within 30 calendar days - regardless of whether it is the patient or a legal representative requesting the access. A timeline is also not provided by South African legislation.

2.3.2 Quality of medical records

2.3.2.1 General quality of medical records

The legislation does not address the quality aspects of medical record keeping. Rule 27A(h) of the HPCSA requires that doctors keep accurate patient records at all times. The MPS guidelines repeat this request in Part 1: *Quality and accessibility*, under the sub-header *Comprehensible and accurate*, when it calls for medical records to be accurate and understandable. This is also a requirement in the Ontarian Module 6: Medical records management guideline. See section 2.2, p.21 of this chapter. Sections 13.1 and 13.2 of the HPCSA guidance Booklet 9 and the MPS guidelines further require that medical notes are complete, concise and consistent with factual, objective findings.

According to the MPS guidelines, Part 1, section *Quality,* good quality medical record keeping includes notes that are comprehensive, contemporaneous, understandable, accurate and attributable to the person who makes the notes. Part 1, section *Records management* of the MPS guidelines refers doctors to the POPI Act sections 19(1) and 19(2) regarding an acceptable records management policy. However, these sections in the POPI Act are not yet effective. See section 1.4.1.1.4, p.13 of Chapter One.

The Module 6: Medical records management guidelines expects medical records to be accurate, legible, contemporaneously completed, comprehensive (see section 2.3.2.2, p.35 of this chapter), complete, self-explanatory, accessible and retrievable.

The Policy Statement require medical notes to be made contemporaneously when the doctor consults the patient.

2.3.2.1.1 Structured medical records

The HPCSA guidance Booklet 9 requires in section 13.4 that medical notes are filed in a certain order. The MPS guidelines call for the same in Part 1, sections *Standards* and *Accessibility*. The section *Accessibility* in the MPS guidelines further requires information to be organised systematically under headings so that relevant information is highlighted to make referencing easier. The *Standards* section of the MPS guidelines also refers doctors in private practice to the guidance provided by the relevant professional bodies and associations in South Africa, which include the HPCSA. The section *Chronological and Systematic* in the Ontarian Policy Statement also calls for the chronological and systematic filing of patient records, but interestingly enough it does not require the filing of medical records in date order. The Module 6: Medical records management guidelines require well-organised medical records.

2.3.2.1.2 Use of abbreviations

The MPS guidelines and Policy Statement (section *Overview and organization of medical records*) warn against the use of abbreviations that are not understandable. The MPS guidelines advise in Part 1, *Abbreviations* that when the author of the information is in doubt, abbreviations should rather not be used. The Ontarian Module 6: Medical records management guidelines suggest a practical solution i.e. a glossary to be filed with medical records which lists and explains all the abbreviations to ensure their correct interpretation. Also, the Policy Statement calls for the meaning of the abbreviations to be available so that confusion may be avoided. The HPCSA guidance booklets do not address this aspect at all.

2.3.2.1.3 Inappropriate entries

The HPCSA guidance Booklet 9 guards in section 13.3 against unsolicited, self-serving and disapproving comments in medical records, whilst the section *Abbreviations* of the MPS guidelines warns that sarcastic and derogatory abbreviations should not be recorded in medical records. The Ontarian guidance documents do not address this aspect.

2.3.2.1.4 Legible records

The MPS guidelines call in Part 1, section *Accessibility* for hand-written medical notes to be legible. See section 2.3.2.1, p.33 of this chapter. The guidelines also call for crucial information to be extracted and highlighted on a summary sheet and/or the cover of the records for easy reference. The HPCSA guidance booklets do not explicitly require records to be legible, whereas the Ontarian Module 6: Medical records management guidelines recommends dictating, voice-to-print technology, or typing to save time and to ensure the legibility of notes. In the section *Overview and organization of medical records* the Policy Statement refers to Regulations that call for legible medical records and then it provides examples to enhance the understanding of the concept “legibility”.

2.3.2.2 Comprehensive records

The minimum, compulsory elements of information to appear in patients’ medical records are presented in section 4.1 of the HPCSA guidance Booklet 9. The MPS guidelines repeat these compulsory elements in the section *Comprehensive* and add a few additional elements which the HPCSA guidance booklets do not require. Therefore, the MPS guidelines are more stringent regarding the minimum compulsory information that medical records should contain. It should be noted that the MPS guidelines reference again the obsolete HPCSA guidance Booklet 9 (2008 version) instead of the current Booklet 9 dated September 2016.

The Ontarian Module 6: Medical records management guidelines require that each set of medical records contains cumulative profile summary sheets which contain

cumulative patient-, medical- and medication profiles. The guidelines provide in the section *The daily diary of appointments* further guidance regarding the content or essential elements that these cumulative profiles should contain as well as the essential components of progress notes.

Both the Module 6: Medical records management guideline (section *The Cumulative Patient Profile*) and the Policy Statement encourage doctors in Ontario to use stamps with prompts for required information and/or worksheet templates to facilitate note keeping and assist in ensuring that essential information is not omitted. This is not something that the South African medical ethical guidance documents suggest or acknowledge in guidelines. However, the Policy Statement reminds doctors that even when templates and checklists are used, free-text writing remains important.

The Policy Statement further recommends the Subjective Objective Assessment (assessment and management of the patient) Plan (management/follow-up plan) (*SOAP*) format to document patient consultations. The guideline provides detailed information on the four different elements contained in *SOAP* by providing examples for each, which guide doctors in terms of the type of information required in the medical records. The *SOAP* format is also suggested by the MPS guidelines, but they do not provide as comprehensive and detailed guidance on each of the four elements as the Ontarian Policy Statement does. The HPCSA guidance booklets and Module 6: Medical records management do not require the *SOAP* format for record keeping.

2.3.2.3 Alterations of records

The HPCSA requires in section 4.2 of guidance Booklet 9 that non-erasable ink should be used to record medical notes and states that no correction fluid may be used in making corrections. Sections 8 and 13.5 of the same guidance booklet as well as Part 1, section *Comprehensible and accurate* of the MPS guidelines provide guidance in terms of changes/corrections to be made in medical records. Both the HPCSA and MPS guidance documents require that initial entries are not removed from records and that errors or incorrect entries are corrected with non-erasable ink by striking a single line through the incorrect entry which the corrector should sign and date. These guidelines require that original entries remain legible.

The HPCSA guidance Booklet 9 requires in section 8.3 that late entries in records are signed and dated whereas the MPS guidelines require (Part 1, section *Contemporaneous*) information to be recorded in patient medical records as it becomes available, i.e. contemporaneous recording. The MPS guidelines require that retrospective entries in the records are accompanied by a statement indicating the late entry or addendum with a reason for it and the date and the time of the late entry. The Policy Statement and HPCSA guidance Booklet 9 section 8.4 require the same. See section 2.3.2.1, p.33 of this chapter. The MPS guidelines explicitly advise against the retrospective dating of information.

On the other hand, the Policy Statement requires that additions or changes in medical notes are only initialled and dated. Signature in full is not required, as against the South African medical ethical guidance documents, which require signature in full.

The Policy Statement also allow for patients to request changes to their medical records if the patients can prove that the information in their medical records is inaccurate. Such a request also has to be documented in the medical records. This is in line with the Canadian Personal Health Information Protection Act (2004), section 55(8). The South African medical ethical guidance documents and the Ontarian Policy Statement do not address this aspect.

2.3.2.4 Attributable medical notes

The Ontarian Policy Statement indicates that every doctor is “accountable for his/her own entries” made in medical records.

Rule 15 of the HPCSA requires that doctors sign medical records and record their initials and surname in block letters with the signature. Section 5 of the HPCSA guidance Booklet 9 requires the same when it refers to rule 15. Part 1 of the MPS guidelines refers in the section *Attributable* to the HPCSA requirement regarding attributable records. Both the Ontarian Module 6: Medical records management guidelines and the Policy Statement, section *Overview and organization of medical records* call for attributable entries i.e. signed and dated entries. The MPS guidelines are more stringent when they require, in addition to names and signatures, also the

designation of the author of medical notes to be recorded with a date and time in order to identify the most senior clinician present at the time of making the notes. The MPS guidelines further require that a contact/bleep number of the doctor is recorded in hospital notes.

2.3.2.5 Identification of records

The HPCSA guidance Booklet 9 requires in section 4.1.1 that the identifying particulars of a patient be reflected on their medical records. Section 13.8 of the same guidance booklet requires that every page of medical records and attachments is clearly labelled. It is not specified, however, what kind of information should be used for the labelling of the medical records, whereas the MPS guidelines require that:

> each page of the medical records has to be labelled with the patient's name and another identifier.

The Ontarian Module 6: Medical records management guideline and the Policy Statement just call for the "labelling" of medical records, as the HPCSA guidance booklet does, without specifying what detail of the patient has to be recorded to identify the medical records.

The MPS guidelines advise in the section *Checking the patient's identity* that the identity of the patient is first confirmed with the patient before a consultation or procedure to ensure that the correct patient is being addressed/treated. Further, the MPS guidelines require that the identification on a patient's test results or reports is confirmed with the patient it is intended for, before disclosure of the results to patients. This issue is not addressed in the HPCSA guidance booklets or in the Ontarian guidance document.

2.4 Conclusion

In Chapter Two the similarities and differences amongst the relevant South African pieces of legislation and medical ethical guidance documents were determined and briefly compared with the most pertinent, relevant Canadian law, guidelines and practices regarding medical record keeping. Chapter Three will evaluate and discuss

from a medico-legal perspective the differences in the medical ethical guidance documents and legislation regarding medical record keeping in South Africa. Relevant case law will also be considered to determine if the outcome of medico-legal cases in South Africa is influenced by the quality of medical record keeping.

CHAPTER 3

Discussion of differences in the relevant legislation and medical ethical guidance documents regarding medical record keeping in South Africa

3.1 Introduction

In Chapter Two the current medical ethical guidance documents of the HPCSA and the MPS were considered with specific reference to medical record keeping. The guidance documents were also compared to relevant South African legislation and relevant Canadian law pertaining to medical record keeping and practices, to determine whether there are any differences. The extent to which the HPCSA guidance Booklet 9 and MPS guidelines incorporate and repeat South African legislation regarding medical record keeping aspects has also been determined. Chapter Three will evaluate and discuss, from a medico-legal perspective, differences in the medical ethical guidance documents and legislation regarding medical record keeping in South Africa. In this chapter relevant case law will also be considered to determine if the outcome of medico-legal cases in South Africa is influenced by the quality of medical record keeping.

3.2 HPCSA guidance booklets

3.2.1 Availability of the booklets

As seen in Chapter One (section 1.4.1.1.2, p.9), via the professional boards the HPCSA is legislatively responsible for promoting the standards of and facilitate the education and training of doctors regarding the manner in which doctors fulfil their duties. The HPCSA is also responsible for ensuring the professional and ethical conduct of doctors, and the Health Professions Act calls for the HPCSA to make rules and provide guidance booklets on the matters necessary to achieve the aim of the Act. Therefore, the HPCSA ought to ensure that doctors are equipped with the

most up-to-date guidance booklets to fulfil their duties in compliance with the objective that the Act assigns to the HPCSA: to ensure the provision of the highest quality of health care to the public. The HPCSA's guidance booklets are made available via the HPCSA's website. See Chapter One, section 1.1, p.1. However, the availability of the guidance booklets via the HPCSA website is no proof that the doctors have received the guidance booklets or even more importantly familiarised themselves with their content. Because the HPCSA is of the opinion that guidelines and rules alone cannot drive excellence in health care provision (Moodley, 2011a:3) it would be expected that the HPCSA will at least notify all practising doctors when updated versions of the guidance booklets become available. Since training is a duty of the HPCSA assigned to it by the Health Professions Act, one would also expect that the HPCSA will offer mandatory training on the guidance booklets. This is however not the case. If doctors are not aware of the latest guidance booklets and trained on these, compliance with the rules and medical ethical guidelines cannot be expected. The HPCSA is of the opinion that professionalism should drive doctors to deliver a high quality of care to their patients (Moodley, 2011a:3), but professionalism should be enhanced by training and education.

It is clear from Chapter Two that not even the MPS is aware of the most recent HPCSA guidance booklets, as the most recent version of the MPS guidelines on medical records in South Africa still refers doctors on various places to obsolete versions of the HPCSA guidance booklets. See Chapter Two, section 2.3.1.3, p.26, section 2.3.1.4, p.31 and section 2.3.2.2, p.35. If an indemnity insurance provider's most recent guideline, which their members have to follow, does not reference the most recent HPCSA guidance booklets, then surely the HPCSA's responsibility does not stop with only publishing its latest guidance booklets on its website and assuming that doctors and interested parties will become aware of the updated versions. A solution for the MPS in this regard may be to exclude references to the HPCSA requirements and stop incorporating the repetition of HPCSA requirements, but instead to provide only practical guidance on aspects which the HPCSA Booklet 9 does not address. This would prevent MPS members from following outdated guidelines based on obsolete HPCSA guidance booklets. Non-MPS

members are not susceptible to this risk as they should follow only the latest versions of the HPCSA guidance booklets, which they should be trained on.

3.2.2 Enforcement of the guidance booklets

Giesen (1988b;a:669;680) correctly expresses the opinion that it is important for the courts to understand the educational professional background of doctors and the medical ethical commitment that doctors' work is based upon. See Chapter One, section 1.4.1, p.7. These are not always taken seriously by the courts. The courts ought always also to consider the HPCSA guidance booklets (which are soft law - see Chapter One, section 1.4.1, p.7). A case where the court understood and considered the ethical commitment that doctors' work is based upon was that of *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal* (2016), where the judge stated that:

> especially the rule relating to the keeping of the records are [sic] non-discretionary requiring strict compliance.

This is a compelling reason for the HPCSA to ensure that doctors are familiar with its guidance booklets and to enforce compliance to them. Only then can the HPCSA enforce the professional and ethical conduct of doctors and ensure the provision of the highest quality of health care to the public, both of which duties are assigned to the HPCSA by the Health Professions Act.

The ideal is correctly stated by Moodley (see Chapter One, section 1.4, p.6) that doctors ought to take responsibility for their own performance to ensure good quality care, but that is the ideal – how it ought to be. The HPCSA still has the legislative duty to promote the standards of and facilitate the education and training of doctors and ensure that professional and ethical conduct occurs. Therefore the HPCSA has to control the training of doctors. There are various ways to do this, but they are not within the scope of this work therefore they will not be discussed and elaborated on further. Not only should training be controlled, but the implementation of the guidance documents needs to be ensured. The only way in which the HPCSA can confirm that doctors are actually complying with the requirements of the guidance booklets is the physical performance of assessments in this regard. Such

assessments are already performed by the CPSO in Ontario as part of the licensing requirements of doctors. See section 2.2, p.21 of Chapter Two.

In Canada the RHPA calls for the CPSO to regulate doctors' medical practices and to govern doctors by means of developing, establishing and maintaining standards of qualification, knowledge, skill, practice and professional ethics. The CPSO therefore established and maintains programmes to assess doctors for competence and improvement in terms of the quality of their keeping of medical records as well as the quality of the medical care that they provide to patients. See Chapter Two, section 2.1, p.21. If the HPCSA could adopt such supervisory practice in conjunction with moderating the training of doctors it would improve medical record keeping in South Africa (Bazzo, 2015:1; Pirkle *et al*., 2012:566; Wong & Bradley, 2009:257). See Chapter One, section 1.4.3, p.17.

Holding disciplinary hearings (by the Professional Conduct Committee of the professional board) for unprofessional conduct is not adequate to ensuring the professional and ethical conduct of doctors. Fewer than 0,25% of medical professionals (including doctors) were found to be guilty of unprofessional conduct annually between 2007 and 2013 (Hoffmann & Nortjé, 2016:108). Further, Hoffmann and Nortjé (2016:108) report that 29% of the guilty decisions between 2007 and 2013 were for the reason of negligence or incompetence in evaluating, treating or caring for patients (which was the second most frequent reason for findings of unprofessional conduct). Of the reported unprofessional conduct decisions between 2007 and 2013, there were 39 cases of negligence regarding patient documents or records, which included making misleading, inaccurate or false medical statements, and eight cases of the disclosure of confidential patient information without the permission of the patient (Hoffmann & Nortjé, 2016:113). Disciplinary hearings result mainly from public complaints (Hoffmann & Nortjé, 2016:108). It should be kept in mind that many unprofessional conduct cases may remain unreported by patients for various reasons (Hoffmann & Nortjé, 2016:112). Therefore, disciplinary hearings cannot be used as a yardstick to determine if doctors are compliant with the HPCSA guidance booklets. Patients cannot complain to the HPCSA regarding the general quality of the medical records as per the guidance Booklet 9 requirements, since the

general public is not aware of and familiar with all the requirements that doctors have to abide by. Neither is it the public's obligation to ensure the application of the guidance documents. But compliance with the tenets of the guidance booklets is something that should be determined when physical onsite assessments are being performed by the HPCSA, as it is the HPCSA's duty to ensure that compliance takes place. But because patients do not complain regarding medical record keeping deficiencies or non-compliances and because the HPCSA does not assess doctors' medical records, the actual quality of the medical records in South Africa is unknown. From the literature survey in Chapter One it is clear, however, that medical record keeping is inadequate in many countries. See Chapter One, section 1.1, p.2. It is futile to produce medical ethical guidelines in compliance with the legislative requirements but not to enforce compliance with them. The enforcement of compliance with the medical ethical guidelines would ensure the provision of the highest quality of health care to the public. This is, after all, the main objective of the Health Professions Act.

The Health Professions Act requires the HPCSA to maintain professional and ethical standards in the health profession, and to make decisions regarding professional conduct and the maintenance of professional competence, which includes the HPCSA assessment of the actual professional and ethical conduct of doctors against the standards recorded in the guidance booklets, which standards may be construed as soft law. Continuous evaluation, the promotion of competence, and the improvement of practice among doctors (as per the current situation in Ontario), would be fitting exemplifications of the performance of the HPCSA's current legislative duty to make decisions regarding professional conduct and the maintenance of professional competence. The performance of routine physical assessments could also pro-actively determine if medical record-keeping is sub-standard, upon which disciplinary action could be taken (which is also a legislative duty of the HPCSA and the professional boards). The performance of such physical assessments would enhance the dignity of the health profession and enhance the integrity of doctors, both of which are legislative duties of the HPCSA.

3.3 The courts' perspective on quality aspects regarding medical record keeping

As seen in Chapter One (section 1.1, p.1), accurate and good record keeping is said to have an influence on the outcome of medico-legal claims as well as the outcome of the investigations of the HPCSA against doctors (Howarth & Gillespie, 2012:1; McQuoid-Mason & Dhai, 2011b:85). This ought to have been an outcome of the judgment of *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal* (2016) (see section 3.2.2, p.42 of this chapter). In this case the court understood the importance of the legislative requirement that doctors adhere to the HPCSA's guidance Booklet 9 regarding medical record keeping. The judge acknowledged that the HPCSA's guidance Booklet 9:

> prohibits alteration of records and requires reasons for any amendments to be specific on the record. Errors may be corrected but the date of the change must be entered and the correction signed in full. The original record must remain intact and fully legible. Additional entries at a later date must be dated and signed in full. I have detailed the National Health Act and Guidelines to emphasise their importance and the rationale and seriousness with which the health professions view the keeping of patient's records.

According to Health24 (2014:1), doctors who are found guilty by the HPCSA of charges such as a failure to keep proper records or altering medical records may be issued fines, may be suspended for different periods of time, or may be required to complete a course in medical ethics before being allowed to practise further (Health24, 2014:1). See Chapter One, section 1.4.1.2.1, p.14.

This judgment would seem to have been contradicted in the recent case of *M obo M vs MEC for Health, Eastern Cape* (2017). In this case medical notes were found to be inadequate and incomplete. Some information had been falsified, information in the records had been altered, some information had been obscured when corrections were made, and some information had been overwritten in the records. Despite section 17(2) of the National Health Act's regarding it as an offence if medical records are falsified by adding, deleting or altering information and if false information is provided, these non-compliances did not have any influence on the outcome of this case. They were also not referred to or addressed by the HPCSA,

and no inquiry or disciplinary hearing was instituted by the Professional Conduct Committee of the relevant board/s.

In another case, that of *VRM v Health Professions Council of SA & Others* (2003), it was pointed out that**:**

> the court accepted a submission that the guidelines were not cast in stone.

This also contradicts the court's perspective in *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal* (2016). See section 3.2.2, p.42 of this chapter. Soft law and the ethical commitment that doctor's work is based upon (as Giesen (1988b:669) opined), seems not always to be considered by the courts. Therefore, the HPCSA also has to educate the medical expert witnesses regarding the legislative requirement relating to HPCSA guidance documents. See section 1.1, p.1 of Chapter One. The HPCSA has to implement physical assessments of medical records and patient practices to ensure application and oversight of adherence to the medical ethical guidelines. The practice of performing physical assessments would also bring awareness to medical expert witnesses regarding the importance of the HPCSA guidance documents and importance of medical ethics, which would enhance not only the dignity of the health profession but also the integrity of doctors, fulfilling the aim of the Health Professions Act. A change in the systems of the HPCSA leading to the enforcement of compliance with the guidance booklets would also raise awareness with the courts regarding the ethical commitments that doctors have.

The MPS guidelines are not enforceable since they are not considered soft law, so the courts correctly do not take these guidelines into consideration. They are applicable to MPS members only.

3.4 Enhancement of the integrity of medical records

For many years the overall quality of medical record keeping has been poor, as has been found in various research studies in different countries. The keeping of comprehensive and adequate medical records is a cornerstone of quality patient

care, for various reasons (Bazzo, 2015:1; Hong *et al*., 2015:48; Pirkle *et al*., 2012:564; Wong & Bradley, 2009:253; Mann & Williams, 2003:329;). See Chapter One, section 1.4.3, p.17. According to the HPCSA guidance Booklet 9, the MPS guidelines and the literature survey, good quality medical records will identify the patient while preserving the patient's confidentiality. Further, good quality medical records are original, legible, accurate, complete, concise, consistent, comprehensive, attributable, contemporaneously made and understandable (Pirkle *et al*., 2012:564; Logan *et al*., 2001:408). It should be noted that the use of the term "contemporaneous" means that there should be no retrospective back-dating of records. If the medical records are not signed (i.e. attributable), then they do not have legal force (Thomas, 2009:387). Bazzo (2015:1), Pirkle *et al*. (2012:566) and Pourasghar *et al*. (2008:143,144) point out that despite the importance of medical records and the integrity that keeping them requires, very few doctors receive formal training on the quality aspects of medical record keeping. It is confirmed from the HPCSA's website that the HPCSA currently does not regard medical record keeping as a topic for training (HPCSA, s.a). How can doctors improve their medical record keeping skills and documentation practices without training? Even when they are trained on the documentation practices required as per the HPCSA guidance Booklet 9 they may be reluctant to implement the requirements unless they are forced to and/or have been faced with disciplinary hearings or lawsuits where inadequate record keeping or a lack of adherence to the quality aspects of medical record keeping influenced the outcomes of their cases. As seen in section 3.3, p.44 of this chapter, the courts are not always considerate of the medical ethical commitment that doctors have in terms of the Health Professions Act. Therefore, training and findings of guilt will not in themselves be adequate to ensuring the enforcement of the requirements stipulated in the guidance booklet.

Since the HPCSA is legislatively responsible for making decisions regarding and promoting the standards of the education and training of doctors (see Chapter Two, section 2.2, p.21) it is obliged to enforce adherence to the tenets of the guidance booklets. It had also been found in studies conducted that the supervision and/or the assessment of medical records improve the quality of medical record keeping (Pirkle *et al*., 2012:566; Pourasghar *et al*., 2008:143,144). See Chapter One, section 1.4.3,

p.17. Therefore, medical record keeping in South Africa will improve when a juristic body (as in Ontario) starts enforcing good documentation practices. Patient practices will improve as a result of supervision as well as improved medical record-keeping.

No legislative changes are required to the Health Professions Act to change the current system of the HPCSA to incorporate physical assessments at medical practices. Such assessments are already allowed for by sections 3(f), 3(g) and 3(m) of the Health Professions Act. See Chapter One, section 1.4.1.1.2, p.9. These sections respectively allow for education and training regarding the manner in which doctors fulfil their duties and for the standards of education and training to be promoted. They also require the HPCSA to maintain professional and ethical standards in the health profession. The duty assigned to the HPCSA of the maintenance of professional and ethical standards could include the assessment of the actual professional and ethical conduct of doctors against the standards that are set by the guidance booklets i.e. physical assessments of medical records and patient practices. Physical assessments would result in the improved integrity of medical records as well as the enhancement of the integrity of doctors and the medical profession as a whole.

3.5 Deficiencies regarding good documentation practices for medical records

The quality aspects of documentation practices for medical records are not addressed by legislation. As seen in section 3.2.1, p.40 and section 3.4, p.46 of this chapter, the keeping of good quality medical records is a requirement of the HPCSA guidance Booklet 9 and of the MPS guidelines as well. As seen in Chapter Two, guidelines provided in the HPCSA guidance booklets are referred to and repeated in the MPS guidelines. Also, the MPS guidelines repeat and often refer to the legislative requirements regarding medical record keeping. Some practical guidance on good documentation practices which is not given in the current HPCSA guidance Booklet 9 is provided in the MPS guidelines. These deficiencies might influence the quality of patient care negatively, could negatively affect patient safety, and could

lead to medical errors that could subsequently result in lawsuits (Bazzo, 2015:1; Hong *et al*., 2015:48; Pirkle *et al*., 2012:564; Wong & Bradley, 2009:253).

As per the MPS guidelines, the common deficiencies which the MPS finds in medical record keeping include: negative findings from tests performed; information regarding discussions about the risks and benefits of proposed treatments, including the option of no treatment; and medication allergies, adverse reactions that patients experience and the results of investigations and tests. Further problems commonly found by the MPS include that doctors do not review previous medical records during consultations with patients; derogatory comments regarding patients being recorded in the records; and factually incorrect medical notes (MPS, 2014:5). Addressing these issues, which are not addressed in the HPCSA guidance Booklet 9, would also be beneficial to non-MPS members and could enhance the integrity of the medical records and the doctors. Therefore, these deficiencies could be addressed in the HPCSA guidance Booklet 9.

The MPS guidelines call for patient consultations to be recorded in the *SOAP* format, to impose an easy-to-follow structure on medical records, while the HPCSA guidance booklet does not require medical notes to be recorded in a specific format (MPS, 2014:9). See Chapter Two, section 2.3.2.2, p.35. The *SOAP* format for structuring medical records is also required by the Ontarian Policy Statement and the Module 6: Medical records management guidelines. Therefore, it is a guideline that could add value to and improve medical record keeping in South Africa if added to the HPCSA guidance Booklet 9, so that all practising doctors (instead of MPS members only) implemented this format to document patient consultations.

If the HPCSA guidance Booklet 9 incorporates detailed requirements regarding a format in which patient consultations are to be recorded, then this aspect does not have to be addressed in the MPS guidelines, as medical record keeping by all practising doctors in South Africa will benefit from this practice, and not only record keeping by MPS members.

The Ontarian Module 6: Medical records management guideline requires a cumulative profile summary for each patient medical file and provides guidance

regarding the content and essential elements that such a profile should contain. Such a summary would enhance the follow-up care of patients. This is another Canadian practice that ought to be considered for inclusion in the HPCSA guidance Booklet 9.

3.6 Disclosure of confidential patient information

It is clear that confidential patient information is sensitive and should be handled with care at all times. The Constitution guarantees a patient the right to privacy. This includes the stipulation that medical information must be kept confidential. Confidentiality is also a common law right for patients, a fact which is acknowledged by the National Health Act. However, for certain strictly legitimate reasons, the National Health Act and the PAIA allow for confidential patient information to be disclosed. See Chapter Two, section 2.3.1.2, p.26, section 2.3.1.3, p.26 and section 2.3.1.4, p.31.

One additional requirement that is acknowledged by the MPS guidelines but which applies to all doctors, not just to MPS members, is that patients should be informed that they can request certain information to be withheld from a doctor to whom they are referred. It is important that all practising doctors explain this right to patients. Therefore it should be included in the HPCSA guidance booklets. Once it is so included there would be no additional need for the MPS guidelines to remind their members of this aspect, as doctors have to abide to the soft law.

As mentioned in section 3.2.1, p.40 of this chapter, there were eight unprofessional conduct decisions between 2007 and 2013 which related to the disclosure of confidential patient information without permission from the patient (Hoffmann & Nortjé, 2016:113). It was made clear in the judgement of *Simaan v South African Pharmacy Board* (1980) that when there is a disciplinary hearing before the court case takes place, then:

> The court cannot interfere with the finding of fact by the board if it had evidence before it upon which it could reasonably and honestly have arrived at the conclusion at which it did.

Therefore, the outcome of a disciplinary hearing by the Professional Conduct Committee of a professional board is final and cannot be taken further, to litigation. Despite the paucity of disciplinary hearings regarding the unauthorised disclosure of confidential patient information, keeping the medical information of a patient confidential is not only a HPCSA requirement but also a Constitutional right for patients and a legal requirement of the National Health Act. It is not a requirement of the Health Professions Act, (see Chapter Two, section 2.4, p.38) that patient health information be kept confidential, but adherence to such a requirement would also enhance the health profession's dignity.

3.7 Conclusion

In Chapter Three the differences in the medical ethical guidance documents and relevant legislation regarding medical record keeping in South Africa have been evaluated and discussed from a medico-legal perspective. It has been found that the MPS guidelines provide practical guidance to MPS members regarding the quality of medical records, which the HPCSA doesn't do. It has been suggested that guidelines pertaining to deficiencies regarding good documentation practices should be included in the HPCSA guidance booklets so that all practising doctors can abide by established practice when keeping medical records.

Case law was also considered in Chapter Three to determine if the outcome of medico-legal cases in South Africa had been influenced by the quality of medical record keeping.

In the final chapter of this study, Chapter Four, the main research findings of this comparative analysis will be considered, in order to be able to conclude whether the ethical guidance documents in South Africa regarding medical record keeping have value to the extent that is required and needed. Recommendations will be made in this regard.

CHAPTER 4

Conclusion and recommendations

4.1 Introduction

A comparative analysis was conducted in Chapter Three on the main differences found in the medical ethical guidance documents (HPCSA guidance booklets and MPS guidelines) regarding medical record keeping, the relevant South African legislation and the relevant Canadian law, guidelines and practices.

Case law was also considered in Chapter Three to determine if the outcome of medico-legal cases in South Africa is influenced by the quality of medical record keeping.

Chapter Four will now conclude with the main findings of the research done for this work. Recommendations will be made as to how the differences found in the medical ethical guidance documents and legislation can be addressed.

4.2 Aim of the research

Quality medical care of patients relies to a great extent on quality medical record keeping. Therefore, the comprehensiveness and adequacy of medical records are crucial. Quality medical record keeping enhances patient safety and prevents medical errors that could subsequently lead to lawsuits. However, it was found in research studies conducted in different countries that the overall quality of medical records is poor (Bazzo, 2015:1; Hong *et al*., 2015:48; Pirkle *et al*., 2012:564; Wong & Bradley, 2009:253; Mann & Williams, 2003:329). Despite their general awareness of the consequences of poor record keeping, very few medical doctors receive formal training on good documentation practices during their extensive education (Bazzo, 2015:1; Pirkle *et al*., 2012:566; Pourasghar *et al*., 2008:143,144). It was also found that supervision over and/or assessments of medical records improve the quality of medical record keeping (Pirkle *et al*., 2012:566; Pourasghar *et al*., 2008:140).

Improvement in medical record keeping, therefore, requires training and some sort of supervision or assessment (Bazzo, 2015:1; Pirkle *et al*., 2012:566; Wong & Bradley, 2009:257).

Section 3(m) of the Health Professions Act requires that the HPCSA (which is a juristic body that all practising doctors in South Africa belong to mandatorily (McQuoid-Mason & Dada, 2011:9)) maintains professional and ethical standards in the health profession. The HPCSA provides standards for doctors to abide by, in the form of different guidance booklets. Accurate medical record keeping is a requirement of section 27A of the ethical and professional rules of the HPCSA, which is registered under the Health Professions Act and promulgated in Government Gazette R717/2006, and which became the HPCSA guidance Booklet 2. The HPCSA also has a guidance booklet (Booklet 9) on medical record keeping. These guidance booklets do not only have ethical standing, but also have to be abided to due to their association with the Health Professions Act (Dhai & Etheredge, 2011:33).

On the other hand, the MPS, which is the world's leading protection organisation for the professional interests of doctors, also published guidelines regarding medical record-keeping for its members in South Africa. The MPS guidelines do not attain any special status, as the HPCSA guidance booklets do. It only describes some of the professional standards which should guide and direct MPS members when keeping and maintaining medical records. However, not all practising doctors in South Africa are members of the MPS. Some doctors may be members of another source of indemnity.

Questions arose such as: How do the MPS guidelines regarding medical records differ from those given in the HPCSA guidance Booklet 9? Which guidelines do non-MPS members abide by? To what extent does South African legislation cover aspects of medical record keeping to be followed when charting medical information, and how does it differ from what the medical ethical guidance documents cover? Who trains doctors on the legislation and guidelines regarding medical record keeping and how are these medical ethical guidelines enforced?

This study has compared the different medical ethical guidance documents and relevant legislation in South Africa to ascertain the extent to which the medical ethical guidance documents incorporate and repeat South African legislation regarding medical record keeping. The study has also determined if the quality of medical records influences the outcome of medico-legal cases in South Africa. Lastly, it has determined by a brief comparison of relevant South African legislation and medical ethical guidance documents with relevant Canadian law, guidelines and practices, if the different medical ethical guidance documents in South Africa regarding medical record keeping have value to the extent that it is required and needed.

4.3 Summary and conclusion

Legislation is enforceable and has to be adhered to under all circumstances. A breach of a legislative requirement results in legal accountability (Dhai *et al*., 2011:3; Singh, 2011:133). The relevant guidance documents focus on aspects such as good documentation practices and medical record keeping. Currently, neither the HPCSA nor the MPS trains doctors on the guidance booklets or enforces compliance with its guidelines. Not all practising doctors in South Africa are MPS members that have to abide by the MPS guidelines, and the MPS guidelines do not attain any special status. This is different from the HPCSA guidance booklets, which attain a special status as soft law. The Health Professions Act expects doctors to adhere to the HPCSA guidance booklets. In order to adhere to the guidance booklets, doctors need to be familiar with their content. They need to be trained on the guidelines provided. However, the HPCSA is of the opinion that professionalism should drive high standards of patient care and doctors should not be driven by guidelines, rules and standards alone (Moodley 2011a:3). But the HPCSA has been criticised in the past for its guidance of doctors (Oosthuizen & Carstens, 2015:269). The HPCSA also processed only a few guilty disciplinary cases between 2007 and 2013 in which doctors were found guilty and ordered to receive more training or to attend medical ethics courses (Hoffmann & Nortjé, 2016:111). This may be a reflection of the ignorance that the HPCSA has of the value of training. But the HPCSA still has a legislative duty according to the Health Professions Act to facilitate the education and training of doctors and to ensure the professional and ethical conduct of doctors.

The HPCSA also has a legislative duty to make decisions on the training and professional conduct of doctors as well as the maintenance of doctors' professional competence. Therefore the duty assigned to the HPCSA regarding decision making and the facilitation of training on the guidance booklets cannot be passed on to the doctors themselves under the cover of a belief that professionalism should drive the highest quality of healthcare to the public.

The courts ought to always consider the HPCSA guidance booklets in medico-legal cases, due to the special status that the guidance booklets have and also due to the ethical commitment that the work of all practising doctors is based on (Giesen, 1988b:669). However, it has been found in this study that the courts do not always consider the medical ethical commitment that doctors have in terms of the Health Professions Act; i.e. to abide to the medical ethical guidance booklets. Therefore the quality of medical record keeping has not influenced and could not influence the outcomes of the cases reviewed.

It was also found that no disciplinary hearings between 2007 and 2013 resulted from poor record keeping practices as such. The reason for this may be because disciplinary hearings result mainly from public complaints, while many potential unprofessional conduct cases are not reported by patients for various reasons (Hoffmann & Nortjé, 2016:108,112). Also, it is typically not a patient that will complain about poor record keeping. That is why it is important for the courts and the HPCSA to consider the guidance booklets in terms of medical record keeping when determining professional conduct.

In Canada the RHPA calls for the CPSO to regulate doctors' medical practices and to govern doctors by means of developing, establishing and maintaining standards of qualification, knowledge, skill, practice and professional ethics. Hence the CPSO mounts programmes to assess doctors for competence and improvement in terms of the quality of their medical records as well as the quality of the medical care that doctors provide to their patients (Cirak, 2017). The HPCSA's basic legislative duties do not differ from those of the CPSO. However, the practices differ. No legislative changes are required to the Health Professions Act to lead to the performance of assessments for medical record keeping and patient practices in South Africa, as the

HPCSA has been assigned the legislative duty to make decisions on the professional conduct of doctors as well as the maintenance of professional competence regarding doctors. The enforcement and oversight of adherence to the guidance booklets are facets of this duty of the HPCSA. The assessors could confirm competence in terms of the quality of medical care provided to patients. In a case of non-compliance then a more formal review could be initiated by the HPCSA and disciplinary action might follow, as is the practice in Ontario (Canadian Medical Association, 2012:3). Quality medical record keeping and quality patient care will then become a focal point for improvement - not only for the HPCSA but also for doctors and the courts in medico-legal cases. This practice would also assist in educating medical expert witnesses regarding the importance of the HPCSA guidance documents and medical ethics, which would enhance the dignity of the health profession as well as the integrity of doctors, and thus fulfil the aims of the Health Professions Act.

In addition to the fact that the MPS guidelines do not attain any special status, it was confirmed in this study that the MPS guidelines on the topic of medical record keeping to a large extent incorporate repeats from the HPCSA guidance Booklet 9 and relevant legislation. The HPCSA guidance Booklet 9 contains useful practical guidance on good documentation practises and reference relevant legislation but do not incorporate repetitions of the legislation. Quality aspects regarding medical record keeping are not addressed by relevant legislation in South Africa. It is specifically for this reason that the HPCSA guidance Booklet 9 is very useful in providing guidance to doctors on practical aspects. The MPS guidelines refer in various places to obsolete versions of the HPCSA guidance booklets and to sections in the POPI Act which are not effective yet. There are, however, differences regarding quality aspects of medical record keeping between the MPS guidelines and Ontarian guidance documents, on matters which the HPCSA guidance Booklet 9 does not address. These include issues which relate to patient care and issues that could constitute risks to patient safety, as well as: the requirement to review previous medical records during consultations with patients; derogatory comments not to be recorded in medical records; and confirmation that these are the medical records of the correct patient before proceeding with treatment or recording further medical notes. The HPCSA guidance Booklet 9 also lacks the requirement for patient

consultations to be recorded in the *SOAP* format so that the flow of the medical records can be followed easily and a cumulative profile summary for each patient's medical file can be produced.

The Constitution guarantees a patient the right to privacy, which guarantee includes the stipulation that medical information is to be kept confidential. Confidentiality is also a common law right for patients, a fact which is acknowledged by the National Health Act. However, for certain strictly legitimate reasons, the National Health Act and the PAIA allow for confidential patient information to be disclosed. Both sets of medical ethical guidance documents accord with the relevant South African law in this regard except for the requirement from the MPS that patients should be informed that they can request certain information to be withheld from a doctor that they are referred to. This requirement is not reflected in the HPCSA guidance Booklet 9. However, it should be noted that the HPCSA guidance Booklet 5, which mainly address *Confidentiality: Protecting and providing information,* may address this requirement, but guidance Booklet 5 does not fall within the scope of this work.

4.4 Recommendations

The extent to which the different medical ethical guidance documents incorporate repetitions of relevant South African legislation regarding medical record keeping has been discussed. Further, this study has also determined if the quality of medical records influences the outcome of medico-legal cases in South Africa. It has also been asked whether the different medical ethical guidance documents in South Africa regarding medical record keeping have value to the extent that it is required and needed. Based on these discussions, the following recommendations are made.

If the references to and repetition of HPCSA guidance booklets and legislation are removed from the MPS guidelines and the HPCSA guidance Booklet 9 is updated with the aspects regarding medical record keeping in South Africa which the guidance booklet currently lacks but the MPS guidelines require, then the current MPS guidelines would become obsolete. The HPCSA guidance booklets have to be mandatorily adhered to by all practising doctors; therefore the updated HPCSA guidance booklet will target all practising doctors and not just a certain group of

doctors, which the MPS does. It would be logistically easier if all the practical guidelines regarding medical record keeping were located in one booklet. Having one user-friendly guidance booklet to abide by instead of two guidance documents might also improve adherence amongst MPS members. It would also be valuable, however, if the MPS could have input into the HPCSA guidance booklets when it is updated from time to time, so that the MPS could have confidence that the HPCSA guidance Booklet 9 addressed their concerns from a medico-legal perspective. Other deficiencies of the HPCSA guidance booklet in comparison with the Ontarian guidance documents could be made good when the HPCSA guidance Booklet 9 is updated, which could be valuable regarding the improvement of medical record keeping in South Africa.

When the HPCSA guidance Booklet 9 is updated, it should not reference versions of other guidance documents (as the MPS guidelines currently do) or incorporate other guidance documents. Since the HPCSA guidance Booklet 9 is a “living” document and will be revised from time to time, it is best that no reference be made to the version numbers or dates of other guidance documents. This would ensure that the booklet does not become outdated when the other guidance document is updated.

To ensure the professional and ethical conduct of doctors by improving their medical record-keeping practices, the HPCSA should implement a system to ensure that doctors are trained on the contents of the HPCSA guidance booklets and the updates of these booklets when they are published and should monitor the training. It is mandatory that the guidelines be adhered to, because they are considered to be soft law. The completion of such training should form part of the licensing standards for doctors to practise medicine in South Africa, so that the number of medical errors arising from poor record keeping that could lead to lawsuits can be limited. This would enhance patient safety and improve the quality of the medical care provided.

Since no legislative changes are required to authorize the HPSCA’s supervision of medical record keeping practices and patient practices, and it is allowed for by the Health Professions Act, the HPCSA ought to provide such supervision in order to maintain professional competence. This should also form part of licensing standards for doctors to practise medicine in South Africa. Therefore, physical assessments

ought to be performed from time to time at every medical practice in South Africa to determine adherence to the relevant legislation and the medical ethical guidance Booklet 9 of the HPCSA. The highest quality of healthcare to the public will be ensured when good quality medical records are kept. In cases of non-compliance, more formal reviews should be initiated by the HPCSA and disciplinary action should follow (as in Ontario).

Although the quality of medical record keeping does not currently influence the outcome of medico-legal cases in South Africa, the courts should always consider medical ethics and understand the ethical commitment that doctor's work is based upon, so that medico-legal questions can be canvassed on an integrative level which includes medical ethics (Carstens & Pearmain, 2007:1; Giesen, 1988b;a:669;680).

LIST OF ABBREVIATIONS

CPSO	The College of Physicians and Surgeons of Ontario
HCP	Health Care Professional
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
MPS	Medical Protection Society
PAIA	Promotion of Access to Information Act
POPI	Protection of Personal Information Act
RHPA	Regulated Health Professions Act
SOAP	Subjective Objective Assessment Plan

METHODOLOGY OF REFERENCING

The Harvard referencing style to cite information sources is used in this work. This work includes two types of citations: in-text citations (in the body of the work) and the Bibliography located at the end of the work.

In-text citations are used when sources are directly quoted or paraphrased. For in-text citations, the following information from sources will reflect: the name of the author, year of publication of the information and the page number where the information can be located in the source. Multiple sources for a quotation or paraphrased in-text are listed in chronological order by year starting with the most recent source of information. Where there are multiple sources from the same year, sources are listed alphabetically by surname of the first author (Ultimate guide to Harvard Referencing, 2018:1).

In text examples:

> Despite its importance, the management of medical records has been shown not to be a priority, particularly in developing countries, where medical records have been found to be generally inadequate and poorly managed (Wong & Bradley, 2009:253).

> Health records serve as a means of communication within a healthcare team regarding patients' health status and progress (College of Physicians and Surgeons of British Columbia, 2014:1; Canadian Medical Association, 2012:3; Howarth & Gillespie, 2012:2; Pirkle *et al*., 2012:564; Wong & Bradley, 2009:256; Mann & Williams, 2003:329).

In the Bibliography, citations are listed in full so that the original sources can be located. Each citation in the Bibliography includes but is not limited to: the name of the author(s), the year that the information was published, the title of the publication and page numbers where the information can be located in the source.

Citations for books, journals, legislation and case law appear in one list in alphabetical order by the surname of the first author or organisational name, or by the first word of the title of the publication if there is no author. Therefore, in the Harvard referencing style, books, journals, legislation and case law used are not listed under sub-headers of such. If there are multiple sources by the same author, then citations are listed in order of the year of publication (Ultimate guide to Harvard Referencing, 2018:1).

Examples in Bibliography:

Beauchamp, T.L. & Childress, J.F. 2001. Principles of biomedical ethics. 5th ed. New York: Oxford University Press.

Canadian Medical Association. 2012. Module 6: Medical Records Management. https://www.cma.ca/Assets/assets-library/document/en/practice-management-and-wellness/MEDED-12-00307-PMC-Module-6-e.pdf Date of access: 14 June 2017.

Currie, I. & De Waal, J. 2013. Interpretation of the Bill of Rights. (*In* Currie, I. & De Waal, J., *eds*. The Bill of Rights handbook. Cape Town: Juta. p. 147-148.)

Hong, C.J., Kaur, M.N., Farrokhyar, F. & Thoma, A. 2015. Accuracy and completeness of electronic medical records obtained from referring physicians in a Hamilton, Ontario, plastic surgery practice: a prospective feasibility study. *Plastic surgery*, 23(1):48-50.

If there are multiple sources by the same year and the same author then an alphabetical letter, starting with *a* onwards, is added behind the year. This additional alphabetical letter will reflect in both the in-text citation as well as the Bibliography.

In text examples:

Giesen (1988b:669), however, is of the opinion that professional medical ethics and the law are not completely separate matters, as they are actually interwoven. He explains that law reflects society's standards, and medical ethics ought therefore to state the medical profession's standards (Giesen, 1988a:680).

Examples in Bibliography:

Giesen, D. 1988a. Legal perceptions of medical progress, role conflicts and change in patient attitudes. (*In* Giesen, D., *ed*. International malpractice law: a comparative law study of civil liability arising from medical care. Tübingen: JCB Mohr. p. 674-693.)

Giesen, D. 1988b. The traditional doctor-patient relationship and medical ethics. (*In* Giesen, D., *ed*. International malpractice law: a comparative law study of civil liability arising from medical care. Tübingen: JCB Mohr. p. 669-673.)

BIBLIOGRAPHY

Acts ***see*** South Africa

Anon. 2012. HPCSA and Docs - a relationship on the rocks? *Medical Chronical*, 3 Sep. http://www.medicalchronicle.co.za/hpcsa-and-docs-a-relationship-on-the rocks/ Date of access: 30 April 2014.

Anon. 2013. Health Professions Council tried to stop exposure of Eastern Cape health crisis. *Daily Maverick*, 5 Nov. http://www.dailymaverick.co.za/article/2013-11-05 Date of access: 30 April 2014.

Bazzo, D.E.J., Sieber, W.J. & William, A. 2015. Competency in medical record-keeping: development of a scale and assessing CME (CPD) impact. (*In* The world book of family medicine. European edition. Wonca Europe.)

Beauchamp, T.L. & Childress, J.F. 2001. Principles of biomedical ethics. 5th ed. New York: Oxford University Press.

Canada. 1982. Canadian Charter of Rights and Freedoms. Constitution Act, 1982. http://laws-lois.justice.gc.ca/eng/Const/page-15.html Date of access: 9 April 2018.

Canada. 1991. Regulated Health Professions Act, 1991. https://www.ontario.ca/laws/statute/91r18 Date of access: 9 April 2018.

Canada. 2004. Personal Health Information Protection Act, 2004. https://www.ontario.ca/laws/statute/04p03 Date of access: 9 April 2018.

Canadian Charter of Rights and Freedoms ***see*** Canada

Canadian Medical Association. 2012. Module 6: Medical Records Management. https://www.cma.ca/Assets/assets-library/document/en/practice-management-and-wellness/MEDED-12-00307-PMC-Module-6-e.pdf Date of access: 14 June 2017.

Canadian Medical Protective Association. s.a. Good practices guide. https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/index/index-faculty-e.html Date of access: 24 February 2018.

Canadian Personal Health Information Protection Act ***see*** Canada. 2004.

Canadian Regulated Health Professions Act ***see*** Canada. 1991.

Carstens, P.A. & Pearmain, D. 2007. Foundational principles of South African medical law. Durban: LexisNexis.

Cirak, M. 2017. The College of Physicians and Surgeons of Ontario. [e-mail]. 4 August 2017.

Claydon, J. & Hatfield, J. 1986. The use of International Human Rights Law to interpret Canada's Charter of Rights and Freedom. 2 *Connecticut journal of international law*, 2(349):349-359.

College of Physicians and Surgeons of British Columbia. 2014. Professional Standards and Guidelines - Medical Records. https://cpsbc.ca/for-physicians/standards-guidelines Date of access: 11 August 2017.

College of Physicians and Surgeons of Ontario. 2012. Policy statement #4-12 - Medical records. http://www.cpso.on.ca/Policies-Publications/Policy/Medical-Records Date of access: 4 August 2017.

Court cases ***see*** South Africa.

Currie, I. & De Waal, J. 2013. Interpretation of the Bill of Rights. (*In* Currie, I. & De Waal, J., *eds*. The Bill of Rights handbook. Cape Town: Juta. p. 147-148.)

Davis, D.M. 2003. Constitutional borrowing: the influence of legal culture and local history in the reconstitution of comparative influence: the South African experience. *International journal of constitutional law*, 1(2):181-195.

Dhai, A. & Etheredge, H. 2011. Codes of healthcare ethics. (*In* Dhai, A. & McQuoid-Mason, D., *eds*. Bioethics, human rights and health law: principles and practice. Cape Town: Juta. p. 16-34.)

Dhai, A., McQuoid-Mason, D. & Knapp van Bogaert, D. 2011. Ethical concepts, theories and principles and their application to healthcare. (*In* Dhai, A. & McQuoid-Mason, D., *eds*. Bioethics, human rights and health law: principles and practice. Cape Town: Juta. p. 3-15.)

Dick, R.S., Steen, E.B. & Detmer, D.E., *eds*. 1997. The computer-based patient record: an essential technology for health care. Rev. ed. Washington, D.C.: National Academy Press.

Giesen, D. 1988a. Legal perceptions of medical progress, role conflicts and change in patient attitudes. (*In* Giesen, D., *ed*. International malpractice law: a comparative law study of civil liability arising from medical care. Tübingen: JCB Mohr. p. 674-693.)

Giesen, D. 1988b. The traditional doctor-patient relationship and medical ethics. (*In* Giesen, D., *ed*. International malpractice law: a comparative law study of civil liability arising from medical care. Tübingen: JCB Mohr. p. 669-673.)

Health Professions Council of South Africa (HPCSA). 2016a. Confidentiality: protecting and providing information. Booklet 5. http://www.hpcsa.co.za/Conduct/ Ethics Date of access: 17 March 2018.

Health Professions Council of South Africa (HPCSA). 2016b. General ethical guidelines for the Healthcare Professions. Booklet 1. http://www.hpcsa.co.za/ Conduct/Ethics Date of access: 20 May 2017.

Health Professions Council of South Africa (HPCSA). 2016c. Ethical and professional rules of the Health Professions Council of South Africa. Booklet 2. http://www.hpcsa.co.za/ Conduct/Ethics Date of access: 28 October 2017.

Health Professions Council of South Africa (HPCSA). 2016d. National Patients' Rights Charter. Booklet 3. http://www.hpcsa.co.za/Conduct/Ethics Date of access: 20 May 2017.

Health Professions Council of South Africa (HPCSA). 2016e. Guidelines on the keeping of patient records. Booklet 9. http://www.hpcsa.co.za/Conduct/Ethics Date of access: 20 May 2017.

Health Professions Council of South Africa (HPCSA). s.a. Website. http://www.hpcsa.co.za/RecentConvitions/Historical Date of access: 17 March 2018.

Health24. 2014. Suing doctors in South Africa. http://www.health24.com/lifestyle/woman/yourlife/suing-doctors-in-sa-20120721 Date of access: 24 March 2017.

Hershey, N. & Holt, C. 2005. Hospital law manual. New York, NY: Aspen.

Hoffmann, W.A. & Nortjé, N. 2016. Patterns of unprofessional conduct by medical practitioners in South Africa (2007-2013). *South African family practice*, 58(3):108-113.

Hong, C.J., Kaur, M.N., Farrokhyar, F. & Thoma, A. 2015. Accuracy and completeness of electronic medical records obtained from referring physicians in a Hamilton, Ontario, plastic surgery practice: a prospective feasibility study. *Plastic surgery*, 23(1):48-50.

Howarth, G. & Gillespie, G. 2012. Medical records: which path will you take? https://www.medicalprotection.org/southafrica/casebook/casebook-may-2012/medical-records-which-path-will-you-take Date of access: 26 March 2017.

Huffman, E.K., Finnegan, R. & Price, E. 1985. Medical record management. 8th ed. Berwyn, Ill.: Physicians' Record Company.

Hyat, E., Lillian, R.H. & August, H.G. 1972. Law of the hospital, physician and patient. 3rd ed. Berwyn, Ill.: Physicians' Record Company.

Logan, J.R., Gorman, P.N. & Middleton, B. 2001. Measuring the quality of medical records: a method for comparing completeness and correctness of clinical encounter data. (AMIA Annual Symposium Proceedings. American Medical Informatics Association. p. 408-412.) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2243504/ Date of access: 14 June 2017.

Mann, R. & Williams, J. 2003. Standards in medical recordkeeping. *Clinical medicine,* 3(4):329-332.

McQuoid-Mason, D. & Dada, M. 2011. A-Z of medical law. Cape Town: Juta.

McQuoid-Mason, D. & Dhai, M. 2011a. Confidentiality. (*In* Dhai, A. & McQuoid-Mason, D., *eds*. Bioethics, human rights and health law: principles and practice. Cape Town: Juta. p. 86-91.)

McQuoid-Mason, D. & Dhai, M. 2011b. Consent. (*In* Dhai, A. & McQuoid-Mason, D., *eds*. Bioethics, human rights and health law: principles and practice. Cape Town: Juta. p. 69-85.)

Medical Protection Society (MPS). 2014. Medical Records in South Africa: an MPS Guide. http://www.medicalprotection.org/southafrica/advice-booklets/medical-records-in-south-africa-an-mps-guide Date of access: 13 March 2017.

Medical Protection Society. s.a. Web site. http://www.medicalprotection.org/southafrica/for-members/frequently-asked-questions Date of access: 30 August 2017.

Moodley, K. 2011a. A place for ethics, law and human rights in healthcare. (*In* Moodley, K., *ed*. Medical ethics, law and human rights: a South African perspective. Pretoria: Van Schaik. p. 3-6.)

Moodley, K. 2011b. Professionalism. (*In* Moodley, K., *ed*. Medical ethics, law and human rights: a South African perspective. Pretoria: Van Schaik. p. 143-155.)

Oosthuizen, W.T. & Carstens, P. 2015. Medical malpractice: the extent, consequences and causes of the problem. *Journal of Contemporary Roman-Dutch Law*, 78:269-284.

Physicians' office medical records. CPSA Web site. http://www.cpsa.ab.ca/publicationresources/policies.asp Date of access: June 2003.

Pirkle, C.M., Dumont, A. & Zunzunegui, M.V. 2012. Medical recordkeeping, essential but overlooked aspect of quality of care in resource-limited settings. *International journal for quality in health care,* 24(6):564-567.

Pourasghar, F., Malekafzali, H., Kazemi, A., Ellenius, J. & Fors, U. 2008. What they fill in today, may not be useful tomorrow: lessons learned from studying medical records at the Womens Hospital in Tabriz, Iran. *BMC public health*, 8(1):139-145.

Sarkin, J. 1998. The effect of constitutional borrowings on the drafting of South Africa's Bill of Rights and interpretation of human rights provisions. *Journal of constitutional law*, 1(2):176-204.

Schwartz, D. 2012. Charter of Rights turns Canada into a 'constitutional' trendsetter: The Charter of Rights and Freedoms turns 30 on April 17. *CBC News*, 7(16):1-3.

Shamus, E. & Stern, D. 2011. Legal issues in the medical record. (*In* Shamus, E. & Stern, D., *eds*. Effective documentation for physical therapy professionals. New York: McGraw-Hill. p. 95-120.)

Singh, J.A. 2011. Law and the health professional in South Africa. (*In* Moodley, K., *ed*. Medical ethics, law and human rights: a South African perspective. Pretoria: Van Schaik. p. 109-141.)

Snell, P. 1984. Writing it down. *British medical journal*, 289(6459):1674-1678.

South Africa. 1957. State Liability Act 20 of 1957.

South Africa. 1974. Health Professions Act 56 of 1974.

South Africa. 1980. *Simaan v South African Pharmacy Board* 1980 (1) SA 764 (T).

South Africa. 1992. Protection of Information Act 84 of 1992.

South Africa. 1995. *S v Makwanyane* 1995 (3) SA 391 (CC).

South Africa. 2000. Promotion of Access to Information Act 2 of 2000.

South Africa. 2000a. *Korf v Health Professions Council of South Africa* 2000 (1) 1171 (T).

South Africa. 2002. Mental Health Care Act 17 of 2002.

South Africa. 2003. Constitution of the Republic of South Africa 108 of 1996. Chapter 2: Bill of Rights. http://www.info.gov.za/documents/constitution/ 1996/a108-96.pdf Date of access: 21 May 2010.

South Africa. 2003. *VRM v Health Professions Council of SA & Others* [2003] JOL 11944 (T).

South Africa. 2005a. Children's Act 38 of 2005. (Regulation gazette no. 28944). *Government gazette*, 492:38, 19 Jun. 2006.

South Africa. 2005b. National Health Act 61 of 2003. (Regulation gazette no. 26595). *Government gazette*, 469:1-94, 23 Jul. 2004.

South Africa. 2006. *Unitas Hospital v Van Wyk* 2006 (4) SA 436 (SCA).

South Africa. 2007. Health Professions Council of South Africa: guideline for good practice in the health care professions (Booklet 2). 2nd ed. Ethical and Professional Rules of the Health Professions Council of South Africa as promulgated in *Government Gazette*, R717/2006.

South Africa. 2013. Protection of Personal Information Act 4 of 2013.

South Africa. 2016. *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal* (14275/2014) [2016] ZAKZPHC 27 (14 March 2016).

South Africa. 2017. *M obo M v MEC for Health, Eastern Cape* (726/14) [2017] ZAECMHC 6 (30 March 2017).

Thomas, J. 2009. Medical records and issues in negligence. *Indian journal of urology*, 25(3):384-388.

Ultimate guide to Harvard Referencing: cite this for me. http://www.citethisforme.com/harvard-referencing Date of access: 28 March 2018.

Van den Heever, P. & Carstens, P. 2011. Res Ipsa Loquitur and medical negligence: a comparative survey. Cape Town: Juta.

Van den Heever, P. & Lawrenson, N. 2015. Health records. (*In* Van den Heever, P. & Lawrenson, N., *eds*. Expert evidence in clinical negligence: a practitioner's guide. Cape Town: Juta. p. 3-10.)

Van Niekerk, A. 2011. Ethics and philosophy. (*In* Moodley, K., *ed*. Medical ethics, law and human rights: a South African perspective. Pretoria: Van Schaik. p. 7-17.)

Williams, F. & Boren, S.A. 2008. The role of the electronic medical record (EMR) in care delivery development in developing countries: a systematic review. *Inform prim care*, 16(2):139-145.

Wong, R. & Bradley, E.H. 2009. Developing patient registration and medical records management system in Ethiopia. *International journal quality health care*, 21(4):253-258.

Woolman, S. 1999. Limitations. (*In* Woolman, S. & Bishop, M., *eds.* Constitutional law in South Africa. Cape Town: Juta. Chapter 12:12-1-12-66.) http://www.chr.up.ac.za/chr-dd/centre-publications_constitlaw/pdf/12-Limitation.pdf Date of access: 8 October 2017.

Wright, P., Jansen, C. & Wyatt, J.C. 1998. How to limit clinical errors in interpretation of data. *Lancet*, 352(9139):1539-1543.