HPCSA Combined Ethical Guidelines

Health Professions Council of South Africa

Guidelines for Good Practice in the Health Care Professions

Combined Ethical Guidelines Document

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The Spirit of Professional Guidelines

High quality clinical outcomes are only achievable when patients and healthcare practitioners trust each other explicitly. Practice in the healthcare profession is therefore a moral enterprise and demands that health practitioners have a life-long commitment to sound, ethical professional practice and an unstinting dedication to the interests and wellbeing of society and their fellow human beings.

It is in this spirit that the HPCSA formulates these ethical guidelines, to guide and direct the practice of health practitioners. They apply to all persons registered with the HPCSA and are the standard against which professional conduct is evaluated.

> ***Note:*** *The terms "healthcare practitioner", "practitioner" and "healthcare professional" in these guidelines refer to persons registered with the HPCSA.*

BOOKLET 1: General Ethical Guidelines for the Healthcare Professions

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1. Introduction

1.1 Being registered as a healthcare professional with the Health Professions Council of South Africa (HPCSA) confers one the right and privilege to practise a profession. Correspondingly, practitioners have moral and ethical duties to others and society in general. These duties are, in part, in keeping with the principles of the South African Constitution (Act No. 108 of 1996) and the obligations imposed on healthcare professionals by law.

1.2 This first booklet on general ethical guidelines contains value-oriented principles and expresses the most honourable ideals to which members of the healthcare profession should subscribe in terms of their conduct.

1.3 Specific ethical guidelines and rules are derived from these general ethical guidelines. They offer more precise guidance and direction for action in concrete situations.

1.4 It is impossible, however, to develop a complete set of specific ethical prescriptions applicable to all conceivable real-life situations. In many specific or unique settings, healthcare professionals will have to work out for themselves what course of action is most appropriate from an ethical standpoint. This requires ethical reasoning.

1.5 This booklet lists core ethical values and standards that underpin professional and ethical practice in the healthcare professions and gives a concise explanation of how practical decisions should be made through ethical reasoning. It also explains what a duty is, and catalogues the general ethical duties of healthcare professionals.

> ***Note:*** *Environmental Health Practitioners do not see patients.*

2. Core Ethical Values and Standards for Good Practice

2.1 Maintenance of good professional practice is grounded in core ethical values and standards – the latter are the directives that follow the core values.

2.2 On occasion, the demands of these core values and standards may clash, thus placing competing demands on healthcare practitioners. The only way to address such clashes is through ethical reasoning.

2.3 The core ethical values and standards required of healthcare practitioners include:

2.3.1 Respect for persons: Healthcare practitioners must respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value.

2.3.2 Best interests or well-being of patients: - **Beneficence:** Healthcare practitioners must act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest. - **Non-maleficence:** Healthcare practitioners must not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.

2.3.3 Human rights: Healthcare practitioners must recognise and respect the human rights of all individuals.

2.3.4 Autonomy: Healthcare practitioners must honour the right of patients to self-determination, which allows them to make their own informed choices, and to live their lives by their own beliefs, values and preferences.

2.3.5 Integrity: Healthcare practitioners should incorporate these core ethical values and standards as the foundation for their character and practice.

2.3.6 Truthfulness: Healthcare practitioners must regard the truth and truthfulness as the basis of trust in their relationships with patients.

2.3.7 Confidentiality: Healthcare practitioners must treat personal or private information as confidential in professional relationships with patients - unless overriding reasons confer an ethical or legal obligation to disclosure.

2.3.8 Compassion: Healthcare practitioners should be sensitive to and empathise with the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.

2.3.9 Tolerance: Healthcare practitioners must respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions.

2.3.10 Justice: Healthcare practitioners must treat all individuals and groups in an impartial, fair and just manner.

2.3.11 Professional competence and self-improvement: Healthcare practitioners must continually endeavour to attain the highest level of knowledge and skills required within their area of practice.

2.3.12 Community: Healthcare practitioners should strive to contribute to the betterment of society in accordance with their professional abilities and standing in the community.

3. How to Resolve Ethical Dilemmas

3.1 The core values and standards referred to above are the foundation that grounds the general ethical guidelines in these booklets. Generally, the guidelines may be applied to many different settings. Questions may arise regarding healthcare practitioners' best use of these guidelines to make practical decisions or choices about the provision of healthcare.

3.2 This requires ethical reasoning that in general, proceeds using the following steps:

3.3.1 Formulate the problem: Determine whether the issue is an ethical one.

3.3.2 Gather information: All the relevant information should be collected - including clinical, personal and social data. Seek information from authoritative sources such as these guidelines, practitioner associations, respected colleagues and also incorporate the experience of practitioners generally when they deal with such matters.

3.3.3 Consider the available options: Consider the potential solutions and the principles and values that each of these uphold.

3.3.4 Make an ethical (and moral) assessment: The ethical content of each option must be determined by asking: - What are the likely consequences of each option? - What are the most important values, duties, and rights? Which weighs the heaviest? - What are the weaknesses of each option? - How would the healthcare practitioner himself or herself want to be treated or managed under similar circumstances? - How does the healthcare practitioner expect a patient would want to be treated?

3.3.5 Discuss your proposed solution: Discuss with those it may affect.

3.3.6 Act on your decision: Act with sensitivity to others who may be affected.

3.3.7 Regularly re-evaluate: Re-evaluate your decision and be prepared to act differently in future.

4. What It Means to Have a Duty

4.1 Ethical guidelines and legal prescripts express duties. A duty is an obligation to do or refrain from doing something in the personal, social, professional, or political spheres of people's lives.

4.2 Having a duty to another person means a practitioner is bound to that person in some respect and for some reason. The practitioner owes that person something, while he or she holds a corresponding right or claim against the practitioner.

4.3 An example of a right with a corresponding duty: Suppose a healthcare practitioner reaches an agreement with a colleague that the latter will do a locum for them while they are away: The colleague has a duty to do the locum and the healthcare practitioner has a right to the colleague's services. At the same time the colleague has a right to fair remuneration and the healthcare practitioner has a duty to compensate them.

4.6 Healthcare practitioners fulfil multiple roles and duties:

4.6.1 Natural duties: As human beings they have "natural duties", for example the natural duties to refrain from doing harm, to promote the good, or to be fair and just. As is the case with everyone, healthcare professionals owe these duties to all other people, whether they are patients or not, and quite independent of our professional qualifications.

4.6.2 Moral obligations: As qualified and licensed professionals they have "moral obligations", for example, to provide healthcare, relieve pain, gain informed consent, respect confidentiality, and to be truthful.

4.6.3 Institutional duties: Institutional duties are specific to the healthcare practitioner's particular institutionalised role, for example the duties of a practitioner employed by a company, a healthcare practitioner working in a governmental research agency, or a healthcare practitioner engaged in private practice. These duties are contained in employment contracts, job descriptions etc. Institutional duties must however also be consistent with the ethical and legal duties of healthcare practitioners.

4.6.4 Legal duties: Legal duties are imposed by the common law and by statutes (for example, the National Health Act No. 61 of 2003 or the Health Professions Act No. 56 of 1974) that require healthcare practitioners to follow certain procedures and to use particular skills and care when dealing with patients.

4.7 The duties listed in these general guidelines mostly fall into the second category – the general but acquired duties of a healthcare practitioner as a professional.

4.8 No duty is absolute or can be held without exception irrespective of time, place, or circumstance. This is not surprising, since different duties may prescribe opposite decisions and actions in specific or real-life situations.

4.9 The catalogue of general duties below presents a fairly comprehensive picture of what it is that binds healthcare providers as professionals to their patients, as well as to others. They also are the basis on which, if these duties are not honoured without justification, that the HPCSA may impose sanctions on health professionals.

4.10 Any classification of duties is arbitrary, because specific duties may be owed to different parties simultaneously. Therefore, the classifications used below should be viewed only as a broad guide but informed by a set of core ethical values and standards of good practice that are regarded as basic ethical principles.

5. Duties to Patients

5.1 Patient's Best Interests or Well-being

Healthcare practitioners must:

5.1.1 Always regard concern for the best interests or well-being of their patients as their primary professional duty.

5.1.2 Honour the trust of their patients.

5.1.3 Be mindful that they are in a position of power over their patients and avoid abusing their position.

5.1.4 Within the normal constraints of their practice, be accessible to patients when they are on duty, and make arrangements for access when they are not on duty.

5.1.5 Make sure that their personal beliefs do not prejudice their patients' healthcare. Beliefs that might prejudice care include a patient's race, culture, ethnicity, social status, lifestyle, economic worth, age, gender, disability, disease status, sexual orientation, religious or spiritual beliefs, and any other perceived or real condition of vulnerability.

5.1.6 If they feel that their personal beliefs might affect the treatment they provide, they must explain this to their patients, and inform them of their right to seek care from other healthcare practitioners.

5.1.7 Not refuse or delay treatment because they believe that patients' actions have contributed to their condition, or because they – the healthcare practitioners - may be putting their own health at risk.

5.1.8 Apply their mind openly when making diagnoses and considering appropriate treatment.

5.1.9 Respond appropriately to protect patients from any risk or harm.

5.1.10 Respond to criticism and complaints promptly and constructively.

5.1.11 Not employ any intern, healthcare provider in community service, or healthcare practitioner who is not appropriately registered with the HPCSA, as locum tenens - or otherwise - in their own or any associated healthcare practice.

5.1.12 Inform their patients if they are in the employ of, in association with, linked to, or have an interest in any organisation or facility that could be interpreted as potentially creating a conflict of interest or dual loyalty in respect of their care of that patient.

5.1.13 In emergency situations, provide healthcare within the limits of their practice and according to their education and/or training, experience and competency under proper conditions and in appropriate surroundings. If unable to do so, refer the patient to a colleague or an institution where the required care can be provided.

5.1.14 **Provide emergency interventions when required:** In an emergency, where there is threat to life or limb (including a perceived threat) and where no appropriately trained healthcare professional is available, then the practitioner must intervene to the best of their ability.

5.1.15 **Be appropriately educated and trained:** To qualify as appropriately educated and trained, the individual practitioner must have successfully completed a training programme approved and accredited by the relevant Board for registration purposes with the following requirements also met: - The training entity/institution/hospital needs to be accredited by the board for training in that particular profession or discipline and for that particular competency. - The trainee must have completed a duration of under and/or postgraduate training as laid down by the Board. - The trainee must have been evaluated and certified as having met the requirements of the training programme by an entity accredited by the Board. - Short courses can only be recognised as enhancing or maintaining skills within the field of practice and category of registration in which the practitioner had already been credentialed and registered by the Board. - Practice should be within the scope of the practitioner's profession as laid down by the Board and is judged by the standards and norms considered reasonable for the circumstances under which the intervention took place.

5.1.16 **Be sufficiently experienced:** - Initial training under supervision as defined in clause 5.1.15 (b) above, by an entity accredited by the Board for such purposes. - Certification of successful completion of such training. - With any intervention, proficiency must be demonstrable, taking into account and judged by the standards and norms considered reasonable for the circumstances under which the intervention took place. - The introduction of new interventions within the practitioners' scope of profession is only permissible if the practitioner has undergone further appropriate training as approved by the Board.

5.1.17 **Work under proper conditions and surroundings:** All interventions must take place under appropriate conditions and surroundings. These are subject to judgement by the Board as to what is considered reasonable for the circumstances, surroundings and conditions, under which the intervention took place. No practitioner may embark upon an intervention unless he/she feels that it is in the patient's interest, and other than in a life or limb threatening emergency, that it is safe to do so.

5.2 Respect for Patients

Healthcare practitioners must:

5.2.1 Respect the privacy, confidentiality and dignity of patients.

5.2.2 Treat patients politely and with consideration (respect).

5.2.3 Listen to their patients and respect their opinions.

5.2.4 Not engage in improper relationships with their patients/clients and those who may be accompanying the patient.

5.2.5 Guard against human rights violations of patients, and not allow, participate in or condone any actions that lead to violations of the rights of patients.

5.2.6 Inform the patient of the choice of having a chaperone in the room during an examination.

5.2.7 Inform the patient if the practitioner will be having a chaperone in the room during an intimate examination.

5.3 Informed Consent

Healthcare practitioners must:

5.3.1 Always seek informed consent from patients ahead of providing any treatment or care, including taking of history and examination.

5.3.2 Fully inform their patients about their condition, its treatment and prognosis.

5.3.3 Give information to their patients in the way they can best understand it. The information must be given in a language that the patient understands and in a manner that takes into account the patient's level of literacy, understanding, values and belief systems.

5.3.4 Refrain from withholding from their patients any information, investigation, treatment, or procedure that the healthcare practitioner knows would be in the patient's best interests.

5.3.5 Apply the principle that informed consent is an on-going, iterative process.

5.3.6 Allow patients access to their medical records.

> *For detailed information consult the HPCSA Ethical Booklet 4 on Informed Consent*

5.4 Patient Confidentiality

Healthcare practitioners should:

5.4.1 Recognise the right of patients to be upheld by the healthcare practitioners to not disclose any personal and confidential information they acquire in the course of their professional duties, unless the disclosure thereof is: - made in accordance with the express patient's informed consent; - made in accordance with a court order to that effect; required by law; or - in the interest of the patient (See sections 14 and 15 of the NHA).

5.4.2 Not breach confidentiality without sound reason and without the knowledge of their patients.

5.4.3 When claiming from medical schemes, explain to patients the significance of ICD-10 coding and get the permission of patients to breach confidentiality when making a medical scheme claim.

> *For detailed information, consult the HPCSA Ethical Booklet 5 on Confidentiality: Protecting and Providing Information*

5.5 Patient Participation in Their Own Healthcare

Healthcare practitioners should:

5.5.1 Respect the right of patients to be fully involved in decisions about their treatment and care, even if they are not legally competent to give the necessary consent.

5.5.2 Respect the right of patients to refuse treatment or refuse to take part in teaching or research.

5.5.3 Inform their patients that they have a right to seek a second opinion without prejudicing their future treatment.

> *For detailed information, consult the HPCSA Ethical Booklet 3 on the National Patients' Rights Charter*

5.6 Impartiality and Justice

Healthcare practitioners should be aware of the rights and laws concerning unfair discrimination in the management of patients or their families on the basis of race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability.

5.7 Access to Care

Healthcare practitioners should:

5.7.1 Promote access to healthcare. If they are unable to provide a service, they should refer the patient to another healthcare practitioner or to a healthcare facility where the required service can be obtained, provided that in an emergency situation, practitioners shall be obliged to provide care in order to stabilize the patient and then to arrange for an appropriate referral to another practitioner or facility.

5.8 Allocation of Critical Scarce Healthcare Resources: Ethical Considerations

The following principles should be considered when deciding allocation of scarce healthcare resources. The process to allocate the resources shall be transparent, inclusive, accountable, and consistent throughout the period:

5.8.1 **Fairness:** Each person's interest should count equally, irrespective of race, ethnicity, creed or gender.

5.8.2 **Equity:** Allocation of resources shall be impartial regardless of patient's social circumstances and ability. Notwithstanding, resources allocation should prioritise those in society with the greatest need.

5.8.3 **Application:** It is most appropriate to guide the allocation of scarce resources among individuals or populations who can be expected to derive the same benefit from the resource.

5.8.4 **Best outcome:** This principle can be used to justify the allocation of resources according to their capacity to do the best or minimize the most harm, for example, using available resources to save the most lives possible.

5.8.5 **Prioritise the worst off:** This principle can be used to justify the allocation of resources to those in greatest medical need or those most at risk.

5.8.6 **Prioritise those tasked with helping others:** This principle can be used to justify the allocation of resources to those who have certain skills or talents that can save many other people.

5.9 Potential Conflicts of Interest

Healthcare practitioners should:

5.9.1 Always seek to give priority to the investigation and treatment of patients solely based on clinical need.

5.9.2 Avoid over-servicing and only recommend or refer patients for necessary investigations and treatment, and should only prescribe treatment, drugs or appliances that serve the needs of their patients.

5.9.3 Declare to their patients – verbally and by a displayed notice – any pecuniary interest they have in institutions, diagnostic equipment, or the like to which they make referrals.

5.9.4 Refrain from coercing patients or their family members.

6. Duties to Colleagues and Other Healthcare Practitioners

6.1 Referrals to Colleagues and Potential Conflicts of Interest

Healthcare practitioners should:

6.1.1 Act in their patients' best interests when making referrals and providing or arranging treatment or care. They should not ask for, or accept, any inducement or incentive, from colleagues to whom they refer patients as it may affect or be seen to affect the healthcare practitioners' judgement.

6.1.2 Treat patients referred to them in the same manner in which they would treat their own patients.

6.1.3 Not service a patient in more than one capacity or charge fees based on more than one consultation where health practitioners are registered with more than one statutory council or professional board or in one or more categories within the same professional board.

> *Adhere to the guideline on self-referral and other referrals mentioned in Booklet 11 on Guideline on Over-servicing, Perverse incentives and Related Matters.*

6.2 Working with Colleagues

Healthcare practitioners should:

6.2.1 Work with and respect other health professionals in pursuit of the best healthcare possible for all patients.

6.2.2 Not discriminate against colleagues, including but not limited to healthcare practitioners applying for posts, because of their views of their race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability.

6.2.3 Refrain from speaking ill of colleagues or other healthcare practitioners (See Rule 12 of the ethical Rules of conduct).

6.2.4 Not make a patient doubt the knowledge or skills of colleagues by making comments about them that cannot be justified.

6.2.5 Support colleagues who uphold the core values and standards embodied in these guidelines.

6.2.6 Advise colleagues who are impaired to seek professional assistance or report them to the HPCSA for assistance.

7. Duties to Patients of Other Health Care Practitioners

Healthcare practitioners must:

7.1 Act expediently to protect patients from risk due to any reason.

7.2 Report violations and seek redress in circumstances where they have a good or persuasive reason to believe that the rights of patients are being violated.

7.3 Report impaired colleagues who are a danger to the health of their patients in order that such colleagues may be provided with the necessary support to overcome their impairment and prevented from harming patients (See HPCSA Booklet 2 on Ethical and Professional Rules of the HPCSA Rule 25).

> *For detailed information, consult the HPCSA Ethical Booklet 11 on Guideline on Over-Servicing, Perverse incentives, and Related Matters.*

8. Duties to Themselves

8.1 Knowledge and Skills

Healthcare practitioners must:

8.1.1 Maintain and improve the standard of their performance by keeping their professional knowledge and skills, including their knowledge and skills related to ethics, human rights and health law, up to date throughout their working life. In particular, they should regularly take part in educational activities that would enhance their provision of health services.

8.1.2 Acknowledge the limits of their professional knowledge and competence.

8.1.3 Observe and keep up to date with the laws that affect professional healthcare practice in general and their practice, in particular (for example, the provisions of the National Health Act No. 61 of 2003).

8.1.4 For detailed information, consult the HPCSA guidelines for Continuing Professional Development.

8.2 Maintaining a Professional Practice

Healthcare practitioners should:

8.2.1 Keep their equipment and analysers in good working order.

8.2.2 Maintain proper hygiene in their working environment.

8.2.3 Keep accurate, detailed and up-to-date patient records.

8.2.4 Refrain from engaging in activities that may affect their health and lead to impairment.

8.2.5 Ensure that staff members employed by them are trained to respect patients' rights; in particular the right to confidentiality.

9. Duties to Society

9.1 Access to Scarce Resources

Healthcare practitioners should:

9.1.1 Deal responsibly with scarce healthcare resources.

9.1.2 Refrain from providing a service that is not needed.

9.1.3 Refrain from unnecessary wastage, and from participating in improper financial arrangements, especially those that escalate costs and disadvantage individuals or institutions unfairly.

9.2 Healthcare Policy Development

9.2.1 Healthcare practitioners should include, amongst other health-related and clinical foci, ethical considerations, legal requirements and human rights in the development of healthcare policies.

10. Duties to the Health Care Profession

10.1 Reporting Misconduct

Healthcare practitioners must:

10.1.1 Report violations and seek redress in circumstances where they have good or persuasive reason to believe that the rights of patients are being violated and/or where the conduct of the practitioner is unethical.

10.1.2 Where it is in their power, protect people who report misconduct from victimisation or intimidation.

11. Duties to the Environment

11.1 Conservation of Natural Resources

Healthcare practitioners should recognise that they have a responsibility to ensure that in the conduct of their affairs they do not in any way contribute to environmental degradation.

11.2 Disposal of Healthcare Waste

Healthcare practitioners should protect the environment and the public by ensuring that healthcare waste is disposed of legally and in an environmentally friendly manner.

BOOKLET 3: National Patients' Rights Charter

September 2016

Preamble

The Department of Health, in consultation with various other bodies, developed a National Patients' Rights Charter. The document contained herein was launched by the Minister of Health and agreed to by the HPCSA.

1. Introduction

1.1 For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services.

1.2 To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa, 1996 (Act No. 109 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and, therefore, proclaims this PATIENTS' RIGHTS CHARTER as a common standard for achieving the realisation of this right.

1.3 Equally, Practitioners should adhere to the stipulations of this charter as it relates to them.

2. Patients' Rights

2.1 Healthy and Safe Environment

Everyone has a right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal, as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

2.2 Participation in Decision-Making

Every citizen has the right to participate in the development of health policies, whereas everyone has the right to participate in decision-making on matters affecting one's own health.

2.3 Access to Health Care

Everyone has the right to access to health care services that include: - Receiving timely emergency care at any health care facility that is open, regardless of one's ability to pay; - Treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof; - Provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV or AIDS patients; - Counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS; - Palliative care that is affordable and effective in cases of incurable or terminal illness; - A positive disposition displayed by health care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance; - Health information that includes information on the availability of health services and how best to use such services, and such information shall be in the language understood by the patient.

2.4 Knowledge of One's Health Insurance/Medical Aid Scheme

A member of a health insurance or medical aid scheme is entitled to information about that health insurance or medical aid scheme and to challenge, where necessary, the decision of such health insurance or medical aid scheme relating to the member.

2.5 Choice of Health Services

Everyone has a right to choose a particular health care provider for services or a particular health facility for treatment, provided that such choice shall not be contrary to the ethical standards applicable to such health care provider or facility.

2.6 Treated by a Named Health Care Provider

Everyone has a right to know the person that is providing health care and, therefore, must be attended to by only clearly identified health care providers.

2.7 Confidentiality and Privacy

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or any order of court.

2.8 Informed Consent

Everyone has a right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and risks associated therewith and the costs involved.

2.9 Refusal of Treatment

A person may refuse treatment and such refusal shall be verbal or in writing, provided that such refusal does not endanger the health of others.

2.10 A Second Opinion

Everyone has the right on request to be referred for a second opinion to a health provider of one's choice.

2.11 Continuity of Care

No one shall be abandoned by a health care professional who or a health facility which initially took responsibility for one's health without appropriate referral or hand-over.

2.12 Complaints About Health Services

Everyone has the right to complain about health care services, to have such complaints investigated and to receive a full response on such investigation.

3. Responsibilities of the Patient

Every patient or client has the following responsibilities:

3.1 To take care of his or her own health.

3.2 To care for and protect the environment.

3.3 To respect the rights of other patients and health care providers.

3.4 To utilise the health care system properly and not to abuse it.

3.5 To know his or her local health services and what they offer.

3.6 To provide health care providers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.

3.7 To advise health care providers of his or her wishes with regard to his or her death.

3.8 To comply with the prescribed treatment or rehabilitation procedures.

3.9 To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.

3.10 To take care of the health records in his or her possession.

BOOKLET 4: Seeking Patients' Informed Consent - The Ethical Considerations

Revised: December 2021

1. Introduction

Successful professional relationships between healthcare practitioners and patients depend upon mutual trust. To establish that trust, practitioners must respect patients' autonomy - their right to decide whether or not to undergo any medical intervention - even where a refusal may result in harm to themselves or in their own death.

Patients must be given sufficient information in a manner that they can understand, to enable them to exercise their right to make informed decisions about their care. This is what is meant by informed consent.

The right to informed consent flows from the South African Constitution, the National Health Act, various other statutes, the common law and the HPCSA's ethical rules and guidelines.

2. Consent to Investigation and Treatment

2.1 Providing Sufficient Information

Patients are entitled to information about their condition and treatment options. The amount of information will vary according to: - The nature of the condition - The complexity of the treatment - The risks associated with the treatment or procedure - The patient's own wishes

The National Health Act requires patients to be given information about: - Their health status (except where disclosure would be contrary to best interests) - The range of diagnostic procedures and treatment options available - The benefits, risks, costs and consequences associated with each option - The patient's right to refuse health services and the implications of such refusal

Information patients want or ought to know includes: - Details of the diagnosis and prognosis - Uncertainties about the diagnosis - Options for treatment or management, including the option not to treat - Purpose of proposed investigation or treatment - Details of procedures or therapies involved - Likely benefits and probabilities of success for each option - Serious or frequently occurring risks - Lifestyle changes which may be caused or necessitated - Whether proposed treatment is experimental - How and when condition and side effects will be monitored - Name of practitioner with overall responsibility - Whether students will be involved - Reminder that patients can change their mind at any time - Reminder of right to seek a second opinion - Details of costs or charges

Healthcare practitioners must not exceed the scope of authority given by a patient, except in an emergency.

2.2 Responding to Questions

Healthcare practitioners must respond honestly to any questions and answer as fully as the patient wishes. If there are limitations in competence/experience, practitioners should seek additional information from credible sources.

2.3 Withholding Information

Healthcare practitioners should not withhold information necessary for decision making unless disclosure could cause the patient serious harm. Serious harm does not mean the patient would become upset or decide to refuse treatment.

A risk is "material" if: - A reasonable person in the position of the patient would attach significance to it - The healthcare practitioner should reasonably be aware that the patient would attach significance to it

No-one may make decisions on behalf of a mentally competent adult.

2.4 Presenting Information to Patients

Obtaining informed consent involves a continuing dialogue. Healthcare practitioners should: - Use up-to-date written material, visual and other aids - Meet particular language and communication needs - Discuss possibility of patient being accompanied by relative or friend - Explain probabilities of success using accurate data - Give distressing information in a considerate way - Provide information about counselling services and support groups - Allow sufficient time to reflect - Involve nursing or other healthcare team members where appropriate - Ensure obtaining of informed consent is not delegated inappropriately - Give clear instructions on how to review decisions

Consent will not be informed if given as a result of: - Duress - Coercion - Manipulation - Misrepresentation - Mental impairment (including under influence of alcohol, drugs, or premedication)

3. Who Obtains Consent?

The healthcare practitioner providing treatment or undertaking an investigation has responsibility to discuss it with the patient and obtain informed consent. Where delegation is necessary, the delegate must: - Be suitably educated, trained and qualified - Have sufficient knowledge of the proposed investigation or treatment - Understand the risks involved - Act in accordance with these guidelines

The healthcare practitioner remains responsible for ensuring the patient has been given sufficient time and information before starting any treatment.

4. Ensuring Voluntary Decision Making

It is for the patient, not the healthcare practitioner, to determine what is in the patient's own best interests. Practitioners should: - Give a balanced view of options - Explain the need for informed consent - Declare any potential conflicts of interest

Healthcare practitioners should ensure patients have considered options and reached their own decision, taking appropriate action if patients are being offered inappropriate or unlawful financial or other rewards.

5. Emergencies

In an emergency where consent cannot be obtained, healthcare practitioners may provide medical treatment to anyone who needs it, provided treatment is limited to what is immediately necessary to save life or avoid significant deterioration.

Healthcare practitioners must respect terms of any valid advance refusal they know about.

6. Establishing Capacity to Make Decisions

6.1 Assessing Mental Capacity

Healthcare practitioners must work on the presumption that every adult has capacity to decide whether to consent to, or refuse, proposed medical intervention, unless shown they cannot understand information presented clearly.

If a patient's choice appears irrational, this is not evidence in itself that the patient lacks competence.

6.2 Fluctuating Capacity

Where patients have difficulty retaining information or are only intermittently competent: - Provide assistance needed to reach an informed decision - Record any decision made while competent - Review decisions at appropriate intervals before treatment starts

6.3 Mentally Incapacitated Patients

The National Health Act provides for certain persons to consent on behalf of mentally incompetent patients: 1. A person authorized by the court (e.g., a curator) 2. In order of priority: spouse, partner, parent, grandparent, major child, or brother or sister

6.4 Third Party Nominations

The National Health Act allows patients (while still mentally competent) to mandate another person in writing to give consent on their behalf.

Healthcare practitioners must respect any refusal of treatment given when the patient was competent, provided the decision is clearly applicable to current circumstances.

6.5 Children

Per the Children's Act, 2005: - A person over 18 years is an adult and legally competent - A child of 12 years can consent to medical treatment if of sufficient maturity and mental capacity - A child of 12 years can consent to surgical operation if of sufficient maturity, with mental capacity, and duly assisted by parent or guardian - For children under 12 or lacking sufficient maturity, parent, guardian or care-giver may consent - Hospital superintendent may consent in emergencies to preserve life - Minister of Health may consent if parent/guardian unreasonably refuses - High Court or children's court may consent in instances where others refuse or are unable

Per the Choice on Termination of Pregnancy Act: - A female of any age is legally competent to consent to termination of pregnancy if she has necessary mental capacity

No parent, guardian or care-giver may refuse to assist or withhold consent by reason only of religious or other beliefs, unless there is a medically accepted alternative.

7. The "Best Interests" Principle

When deciding what options are in the best interests of a patient who lacks capacity, consider: - Options for investigation or treatment which are clinically indicated - Evidence of patient's previously expressed

preferences - Knowledge of patient's background (cultural, religious, employment) - Views about patient's preferences given by third parties - Which option least restricts the patient's future choices

The South African Constitution provides that "a child's best interests are paramount in every matter concerning a child."

8. Applying to the Court

Healthcare practitioners should seek court rulings where: - Patient's capacity to consent is in doubt - Differences of opinion about best interests cannot be resolved - Third party is not nominated - Situation is contentious (e.g., parent withholding consent to life-saving treatment)

9. Forms of Consent

9.1 Express Consent

Patients can indicate informed consent either recorded or in writing.

Written consent should be obtained when: - Treatment or procedure is complex or involves significant risks - Providing clinical care is not the primary purpose - There may be significant consequences for patient's employment, social or personal life - Treatment is part of a research programme

9.2 Statutory Requirements

Some statutes require particular forms of consent for specific procedures (sterilizations, terminations of pregnancy, removal of organs from deceased persons).

9.3 Implied Consent

Submission in itself may not necessarily indicate consent. Consent must at all times be expressed and not implied.

10. Reviewing Consent

A signed consent form is not sufficient evidence of ongoing consent. Review patient's decision close to treatment time, especially where: - Significant time has elapsed since consent was obtained - Material changes have occurred in patient's condition - New potentially relevant information has become available

11. Consent to Screening and Testing

Healthcare practitioners must ensure anyone considering screening or testing can make a properly informed decision, explaining clearly: - Purpose of the screening or test - Likelihood of positive or negative findings - Possibility of false positive or negative results - Uncertainties and risks attached to the process - Significant medical, social or financial implications - Follow up plans including availability of counselling and support services

12. ICD-10 Coding and Informed Consent

For ICD-10 coding purposes, patients should be given information about: - Who will access their information - For what purpose - Implications of utilization of such information

Provider responsibilities: - Provide information about legislative requirements for supplying ICD-10 codes - Procure patient's consent to release ICD-10 coding to medical scheme - Advise patient of choice not to have ICD-10 coding divulged - Indicate that practitioner does not control management of information once divulged

Written consent is strongly suggested. Consent may be once-off for treatment of similar conditions with verbal reminder. Fresh consent should be obtained for new or different conditions.

BOOKLET 5: Confidentiality - Protecting

and Providing Information

Revised: December 2021

1. Preamble

Healthcare practitioners hold information about patients that is private and sensitive. The National Health Act provides that this information must not be given to others unless the patient consents or the healthcare practitioner can justify the disclosure.

Practitioners are responsible for ensuring that clerks, receptionists and other staff respect confidentiality in their performance of duties.

2. Definitions

Anonymised data: Data from which the patient cannot be identified by the recipient. Name, address, and full postal code must be removed, together with any other identifying information.

Consent: Consent for provision of a specified health service given by a person with legal and mental capacity. A person older than 12 years may consent to medical and surgical treatment subject to being sufficiently mature.

Express consent: Consent expressed orally or in writing.

Healthcare personnel: Includes both healthcare providers and health workers (clinical services and administrative staff).

Patients/Users: A person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service.

Personal information: Information about people that healthcare practitioners extract in a professional capacity from which individuals can be identified.

Public interest: The interests of the community as a whole or individuals or a group within the community.

3. Patients' Right to Confidentiality

The National Health Act states that all patients have a right to confidentiality, consistent with the right to privacy in the South African Constitution.

Rule 13 of the HPCSA Ethical and Professional Rules states that a practitioner may divulge information regarding a patient only if: - In terms of a statutory provision - At the instruction of a court - In the public interest - With the express consent of the patient - With written consent of parent or guardian of minor under 12 years - For deceased patient, with written consent of next of kin or executor

Disclosures in the public interest include situations where patient or other persons would be prone to harm.

4. Maintaining and Retaining Confidentiality

Patients have a right to expect information about them will be held in confidence. Confidentiality is central to trust between healthcare practitioner and patient.

When asked to provide information, healthcare practitioners should: - Seek consent of patient wherever possible - Provide comprehensive information about potential for breach of confidentiality with ICD-10 coding - Anonymise data where unidentifiable data will serve the purpose - Keep disclosures to the minimum necessary

Healthcare practitioners must always be prepared to justify their decisions.

5. Protecting Information

Healthcare practitioners and health establishments must effectively protect personal information against improper disclosure at all times. Employees such as clerks and receptionists must be trained to respect

confidentiality.

Healthcare practitioners should: - Not discuss patient information where they can be overheard - Not leave patient records where they can be seen by unauthorized persons - Endeavour to ensure consultations are private

6. The Right of Patients to Information

Patients have a right to information about healthcare services available to them.

The National Health Act requires healthcare providers to inform patients of: - Their health status (except where contrary to best interests) - Range of diagnostic procedures and treatment options - Benefits, risks, costs and consequences associated with each option - Patient's right to refuse health services and implications of refusal

Information should include diagnosis, prognosis, treatment options, outcomes, common and serious side-effects, likely time-frames, and expected costs.

7. Disclosure of Information to Others Providing Care

Healthcare practitioners cannot treat patients safely without having relevant information about condition and medical history.

Practitioners should ensure patients are aware that personal information will be shared within the healthcare team and explain the reasons. Express consent is not usually needed for sharing information to enable treatment (e.g., GP disclosing to secretary for referral letter).

Any recipient of personal information must understand it is given in confidence.

8. Disclosure of Information Other Than for Treatment

8.1 Principles

Information about patients is requested for education, research, monitoring, epidemiology, public health surveillance, clinical audit, administration, planning, insurance and employment.

Healthcare practitioners must: - Seek consent for disclosure - Anonymise data where possible - Keep disclosures to minimum necessary

8.2 Obtaining Consent for Disclosure

Where disclosures will have personal consequences: - Obtain express consent especially where patient may be personally affected - Provide enough information for the patient to base their decision - Explain how much information will be disclosed and to whom - If patient withholds consent, explain consequences of disclosure and non-disclosure

For research, education, training, administration or clinical audit: - Identifiable data can only be used with informed consent - Use of identifiable data is permitted for efficient administration and clinical audits - De-identify data as soon as possible when anonymised data would serve the purpose

8.3 Disclosures in the Public Interest

Personal information may be disclosed in the public interest where benefits outweigh patient's interest in keeping information confidential. Examples include: - Access to prophylactic treatment for infectious disease contact - Employee with health condition rendering them unable to work safely - Driver requiring medication that might impair driving ability

9. Putting the Principles into Practice

9.1 Disclosures Which Benefit Patients Indirectly

Monitoring public health and safety: - Healthcare practitioners must co-operate with regulatory bodies by providing relevant information - Seek express consent whenever practicable - If patients have not expressed objection, assess likely benefit of disclosure

Administration and financial audit: - Record financial/administrative data separately from clinical information - Provide in anonymised form wherever possible

Medical research: - Where identifiable information is needed and consent cannot be obtained, data should be anonymised - Matters should be drawn to attention of research ethics committee

Publication of case-histories and photographs: - Express consent required before publishing personal information in media - For deceased patients, follow appropriate guidelines

9.2 Disclosures Where Practitioners Have Dual Responsibilities

Situations arise where practitioners have contractual obligations to third parties (employers, insurance companies, benefits agencies, etc.).

When asked to write reports or disclose information, practitioners must: - Ensure patient has been told about purpose of examination/disclosure - Obtain or have seen written consent - Disclose only relevant information - Include only factual information that can be substantiated - Check if patient wishes to see report before disclosure

Disclosures without patient consent can only be justified in exceptional circumstances (e.g., protecting others from risk of death or serious harm).

9.3 Disclosures to Protect Patient or Others

Disclosure without consent may be justified where failure to do so exposes patient or others to risk of death or serious harm.

Such circumstances may arise with: - Colleague placing patients at risk due to illness - Patient who continues to drive against medical advice when unfit - Disclosure that may assist in prevention or detection of serious crime

9.4 Children and Patients Who May Lack Competence

If practitioners consider a patient incapable of giving consent due to immaturity, illness or mental incapacity: - Try to persuade them to allow appropriate person to be involved - If essential in patient's interests, may disclose relevant information to appropriate person - Seek consent from legally designated person - Document steps taken and reasons for deciding to disclose

If practitioner believes child or legally incompetent patient is victim of neglect or abuse: - Give information promptly to appropriate responsible person or statutory authority - Inform patient before disclosing - Inform those with parental responsibility where appropriate

9.5 Disclosure After Patient's Death

Healthcare practitioners have obligation to keep personal information confidential after death.

Circumstances where disclosure may be appropriate: - To assist in connection with an inquest - As part of clinical audit or for education/research with ethics committee approval - On death certificates (required by law) - For public health surveillance approved by research ethics committee

For conflicts of interest between parties affected by death (e.g., insurance companies), only release information with consent from next-of-kin, executor, or if deceased consented before death.

10. Disclosure in Connection with Judicial or Statutory Proceedings

Healthcare practitioners: - May be required to disclose information for statutory requirements (notifiable disease, suspected child abuse) - Must disclose information if ordered by judge or presiding officer - Should not

disclose personal information to third parties without patient's express consent (except as outlined above) - May disclose to statutory regulatory body for healthcare professions where necessary for justice and patient safety

11. Electronic Processing of Information

Healthcare practitioners must: - Ensure appropriate arrangements for security of personal information - Take professional advice on keeping information secure before connecting to networks - Ensure fax machines and computer terminals are secure - Satisfy themselves that data transmitted electronically cannot be intercepted - Note that information sent through the internet may be intercepted

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BOOKLET 9: Guidelines on the Keeping of Patient Health Records

Revised: September 2022

Section 13 of the National Health Act states that the person in charge of a health establishment must ensure that a health record is created and maintained for every user of health services.

1. Definition of a Patient Health Record

A patient health record is the longitudinal collection of an individual's personal and health information, recorded by a healthcare practitioner or at their directive, regardless of the form or medium used.

2. Purpose of Patient Health Records

Primary purpose: - To be a reminder of what has been found, decided on or done - To promote and ensure continuity of care - To provide evidence of the standard of care

Also used for: - Promoting good clinical practice - Conducting clinical audits - Teaching and research - Administrative purposes - Evidence for occupational disease and injury compensation - Evidence during litigation

3. Content of Patient Health Records

3.1 Clinical Findings

Should include (but not limited to): - Who is making the notation - Times of consultation and clinical interactions - Full clinical history - Clinical examination - Differential diagnosis - Information and advice given to patient - Clinical decisions made, when and by whom - Decisions and actions agreed to - Written affirmation of agreements (consent forms) - Treatment administered (including detailed operation notes) - Drugs and doses given - Investigations ordered, results, and dates - Future appointments and referrals - Any other documentation relevant to patient's health

3.2 Interactions to be Recorded

- Face-to-face discussions between patient and practitioner
- Progress notes for specific episodes of care
- Virtual, telephonic or similar discussions/consultations with patient and relatives
- Discussions with colleagues related to the patient
- All correspondence related to care

3.3 Compulsory Elements

- Personal (identifying) particulars of patient
- Full biopsychosocial history, including allergies and idiosyncrasies
- Time, date and place of consultation
- Assessment of the patient

- Proposed management
- Medication and dosage prescribed
- Details of referrals
- Patient’s response to treatment, including adverse effects
- Investigations ordered and results
- Details of times booked off work and relevant reasons
- Written proof of informed consent when relevant

4. Rules Related to Patient Health Records

Rule 27A requires practitioners to: - Act in best interests of patients - Respect patient confidentiality, privacy, choices and dignity - Maintain highest standards of personal conduct and integrity - Provide adequate information about diagnosis, treatment options, alternatives, costs - Keep professional knowledge and skills up to date - Maintain proper communication with patients and other professionals - Obtain informed consent (except in emergency) - Keep accurate patient records

4.1 Contemporaneous

- Must be made at time of patient interaction or as soon as possible thereafter
- Late entries and addenda must be noted as such with reasons given

4.2 Integrity

- Must be accurate, complete and comprehensive
- Must be clear and legible
- Must be unambiguous (especially regarding abbreviations)
- May not be tampered with
- May not contain derogatory or similar language
- Must be regularly checked
- Must be in order with all pages identifying the patient

4.3 Attributable

- Any person making an entry must be identifiable
- Each entry must be dated and timed
- Written entries must be signed in full
- Name must be recorded in block letters with contact details

4.4 Accessible

- Must be readily available whenever patient is seen
- Information must be stored for easy access
- Critical information (allergies, idiosyncrasies, special needs) should be prominently recorded

4.5 Securely Stored

- Control measures must prevent unauthorised access
- Applies to all records regardless of format (electronic or hard copy)

5. Alteration of Patient Health Records

- Late and additional entries must be dated and signed in full
- Reason for amendment or error must be specified

6. Privacy and Security of Patient Health Records

- Control measures must prevent unauthorised access to records and storage facilities
- All records must be protected against improper access and disclosure
- Storage facilities must have secure restricted access control
- Electronic data must be managed, stored and backed up using internationally accepted standards (e.g., ISO 27799:2016)
- Protect patient confidentiality during electronic data transmission and document transfer

7. Retention of Patient Health Records

General rule: Store for at least six (6) years from date record became dormant (when patient was last treated). Ideally store indefinitely, especially electronically.

Exceptions: - **Patients under 18 years:** Keep until patient's 21st birthday - **Mentally incapacitated patients:** Keep for duration of patient's lifetime - **Occupational Health and Safety Act records:** Keep for 20 years after treatment - **Conditions taking long to manifest (e.g., asbestosis):** Keep not less than 25 years - **State hospital or clinic records:** Only destroy with authorization from Deputy Director-General

8. Ownership of Patient Health Records

- Patient health record is owned by the practitioner or entity generating it
- Patient is entitled to access and obtain information contained in record
- Patients who pay for records and images must be allowed to retain them
- In multi-disciplinary practices, the governing body should ensure guidelines are followed

When practitioner in private practice passes away: - Estate (including records) will be administered by executor - If practice is taken over, executor shall carry over records to new practitioner - New practitioner must inform all patients of change in ownership - If practice not taken over, executor should inform patients and transfer records as requested - Remaining records should be kept in safe keeping for at least 12 months

When practitioner closes practice: - Within three months of closure, inform all patients in writing - Accept requests to transfer records to other practitioners - Records must be kept in safe keeping for at least 12 months

9. Access to Health Information and Patient Health Records

Section 10 of the National Health Act states that a healthcare practitioner must provide a patient with a discharge report at time of discharge (in writing for inpatients, verbal acceptable for outpatients).

Principles regarding access: - Provide any person 12 years and older with copy or access to their own records on request - For patients under 16 years, parent or legal guardian may apply for access with written authorization from patient - Information about termination of pregnancy may not be divulged to any party except patient herself - No information to third party without written authorization, court order, or where non-disclosure represents serious threat to public health

Disclosure without authorization permitted when: - Court orders records to be handed to third party - Third party is healthcare practitioner being sued who needs records for defence - Practitioner has disciplinary proceedings and requires records for defence - Statutory obligation to disclose (e.g., suspected child abuse) - Non-disclosure would represent serious threat to public health

Protection of Personal Information Act (POPIA): - Special personal information (religious beliefs, race, health, sex life, biometrics) may be processed by healthcare professionals if necessary for proper treatment and care - Personal information should be kept confidential - POPIA should be read in conjunction with Booklet 4 and Booklet 5

10. Checklist for Patient Health Record Keeping

- Records should be complete, but concise
- Records should be consistent
- Avoid self-serving or disapproving comments
- Use standardised format (history, physical findings, investigations, diagnosis, treatment, outcome)
- If alteration needed, put line in ink through original entry (keeping it

legible), sign and date
- Release copies only after receiving proper authorization
- Keep billing records separate from patient care records
- Always label attached documents (each individual sheet)

11. Signing of Official Documents

Rule 15: Any student, intern or practitioner who signs official documents relating to patient care shall do so by signing next to his or her initials and surname in block letters.

12. Certificates and Reports

Rule 16: A certificate of illness must contain: - Name, address and qualification of practitioner - Name of patient - Employment number (if applicable) - Date and time of examination - Whether based on personal observations or information from patient - Description of illness in layman's terminology (with informed consent) - Whether patient is totally indisposed or able to perform less strenuous duties - Exact period of recommended sick leave - Date of issuing the certificate - Clear indication of identity of practitioner who issued certificate, personally signed

If preprinted stationery is used, delete irrelevant words.

Practitioner shall issue brief factual report to patient requiring information about themselves.

13. Issuing of Prescriptions

Rule 17: - Typewritten, computer-generated, pre-typed, preprinted, or standardised prescriptions permitted for Schedules I, II, III and IV medicines, under personal and original signature - Handwritten prescriptions required for Schedules 5, 6, 7 and 8 medicines, under personal and original signature

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BOOKLET 11: Guidelines on Overservicing, Perverse Incentives and Related Matters

March 2025

1. Introduction

The HPCSA requires that a health practitioner shall at all times act in the best interests of their patient and regard clinical needs as paramount. Health practitioners shall: - Always try to avoid potential conflicts of interest - Maintain professional autonomy and independence - Maintain commitment to relevant professional and ethical rules and policies

Any conflicts of interest, incentives or forms of inducement that threaten such autonomy, independence or commitment are unacceptable.

A conflict of interest occurs when a health practitioner's private interests compete with their professional and ethical responsibilities towards patients and the profession, with risk that the practitioner will prioritise these interests above patient care.

These guidelines apply to health practitioners in both public and private sectors. It is an offence either to offer a perverse incentive or to accept one.

The HPCSA may lay a charge against any person, corporate body or legal entity in terms of the Prevention and Combating of Corrupt Activities Act, 2004.

2. Definitions

Advertise: Any written, pictorial, visual or other descriptive material or verbal statement intended to promote the sale of medicine, medical device, scheduled substance, health related product, or attract patients

to any health establishment or health related service.

Complementary medicine: Any substance from plant, mineral or animal origin used for complementing the healing power of a human or animal body (includes herbal, homeopathic, ayurvedic, nutritional).

Dual Practice: A health practitioner who holds registration with more than one statutory council, professional board or professional category and practices on multiple professional designations.

Endorse: Any action whereby a person attaches approval to or sanctions any health establishment or medicine, medical device, scheduled substance or health related product with a view to encouraging preferential use for financial gain.

Health practitioner: Any person registered in terms of applicable Acts governing statutory health councils, including persons registered with HPCSA and registered student health practitioners.

Health establishment: Whole or part of an institution, facility, building or place operated for inpatient or outpatient treatment (includes clinics, hospitals, community health centres, consulting rooms, pharmacies, laboratories, ambulances, etc.).

Health related product: Any commodity other than medicine, medical device or scheduled substance produced for medicinal or other preventive, curative, therapeutic, diagnostic or assessment purposes.

Improper financial gain or other valuable consideration / Perverse incentive: Money or any other form of compensation, payment, reward or material benefit which is not legally due, or given with understanding that recipient will engage or refrain from engaging in certain behaviour that is: - Illegal; and/or - Contrary to ethical or professional rules; and/or - May adversely affect patient interests

Medical device: Any instrument, appliance, material, machine, apparatus, implant or diagnostic reagent used for diagnosis, prevention, monitoring, treatment or alleviation of disease, injury or handicap; investigation, replacement or modification of anatomy or physiological process; or control of conception.

Overservicing: Supply, provision, administration, use or prescription of any treatment or care (including diagnostic and other testing, medicines and medical devices) which is: - Medically and clinically not indicated - Unnecessary or inappropriate under the circumstances - Not in accordance with recognised treatment protocols and procedures - Without due regard to both financial and health interests of the patient

Promote: Any action to further or encourage preferential use of any health establishment, medical device, health related service, or prescribe medicine for financial gain or other valuable consideration.

Family Member: Spouse and spouse’s grandparents, parents, siblings, children, nieces, nephews, aunts, uncles, first cousins, any other person sharing same household, including person one habitually cohabits with.

3. Overservicing, Perverse Incentives and Related Matters

The following acts or omissions are not permissible for any health practitioner:

3.1 Overservicing

A health practitioner shall not: - Provide service or perform procedures that are neither indicated nor scientific or shown to be ineffective, harmful or inappropriate through evidence-based review - Refer a patient to another health practitioner for services or procedures that are neither indicated nor scientific or shown to be ineffective, harmful or inappropriate

3.2 Manufacturing

A health practitioner shall not manufacture or participate in manufacture for commercial purposes or trade of medicine, medical device or scheduled substance, except where it forms an integral part of normal scope of practice.

3.3 Advertising

Not allowed to advertise or endorse or encourage use of any health establishment, medicine, medical device, scheduled substance, health related product or service if any financial gain or other valuable consideration is derived.

3.4 Preferential Usage or Prescriptions

Shall not engage in or advocate preferential use of any health establishment, medical device, health related service or prescribe any medicine if any financial gain or other valuable consideration is derived.

3.5 Referrals

Self-referrals: - Self-referral to own health establishment in which practitioner or close family member/business associate has financial interest or potential conflict of interest is permitted on condition that interest is discussed, and agreement reached with patient prior to referral for consent.

Other referrals: - Shall not refer clients or patients to any health establishment or other health practitioners if referral would constitute overservicing - Prohibited to consult with one patient in more than one capacity

3.6 Technological Equipment and Platforms

- Shall only own and use technological equipment or platforms if it forms integral part of scope of profession and practice
- Must have received appropriate training in using and managing such equipment
- Over-use of medical equipment for procedures, tests and applications that are not indicated, scientific or evidence-based is prohibited (constitutes overservicing)
- Usage for profiteering and charging fees not market related is prohibited

3.7 Financial Interest in Health Establishments

A health practitioner may have direct or indirect financial interest or shares in a hospital or healthcare institution provided that: - Interests or shares are purchased at market-related prices in arm’s length transactions - Purchase transaction or ownership does not impose conditions that detract from good, ethical and safe practice - Returns on investment or dividends are not based on patient admissions or meeting particular targets - Practitioner does not over-service patients and establishes appropriate peer review and clinical governance procedures - Practitioner does not participate in advertising or promotion of the facility - Practitioner does not engage in or advocate preferential use of the facility - Purchase agreement is approved by council based on listed criteria - Practitioner annually submits report to council indicating number of patients referred to such facility and other facilities

3.8 Rentals as Perverse Incentives

A health practitioner shall not: - Pay rentals in lease agreements that are not market related, not in arm’s length transaction or at preferential rates - Enter into lease agreements conditional on achieving certain turnover or admission targets - Rent consulting rooms under financial arrangements not openly available to other similarly qualified practitioners

3.9 Commission

Accepting commission: - Shall not accept commission or any financial gain from any person or body in return for purchase, sale or supply of any goods, substances or materials used in practice

Paying commission: - Payment of or receipt of commission to or from any person recommending patients is prohibited

3.10 Charging or Receiving Fees

For referring patients: - Shall not charge a fee or receive any financial gain for referring patients to other health professionals or for participation in drug trials or research trials

For seeing representatives: - Shall not charge a fee or receive any financial gain for seeing medical representatives

For services not personally rendered: - Charging or receiving fees for services not personally rendered is prohibited, except for services rendered by another health practitioner associated as partner, shareholder or locum tenens

3.11 Sharing of Fees

Shall not share fees with any person or health professional who has not taken a commensurate part in the service for which fees are charged.

3.12 Contracts

Shall not enter into a contract to work in a particular health establishment on the understanding that the practitioner generates a particular amount of revenue.

Note: A health establishment may equip a facility for a specific practitioner according to specifications and enter into contractual agreement, but practitioner may not agree if establishment stipulates turnover targets.

3.13 Dual Practice

A health practitioner who holds registration with more than one professional board, professional category or statutory council or practices in alternative healing methods shall ensure: - Patients are clearly informed at start of consultation of the profession in which practitioner is acting - Patients are not consulted in dual capacity or charged fees based on dual consultation

3.14 Managing Potential Conflicts of Interest

- Avoid conflicts of interest where possible and be open about financial interest with patients
- Declare all financial or commercial arrangements relating to products, services, companies, or devices communicated about in public domain
- Consider potential impact of responsibilities before investing in or undertaking any financial interests that may affect clinical decisions
- Declare conflicts of interest to patient and not abuse position for financial gain
- When interests compete, prioritisation of patient care is critical

3.15 Alternative Options and Respecting the Right of Patients to Choose

- Be transparent about any interests that could influence treatment recommendations
- Ensure patients are fully informed about all available options, including choice to refuse treatment
- Disclose any knowledge of alternative treatments that could be more beneficial
- Do not mislead patients about accessibility of alternatives
- If treatment option involves personal interest, disclose it and explain rationale
- Present information on other suitable options
- Ensure patient understands their right to make decisions and seek second opinion
- Do not attempt to sway patients’ choices for personal, employer, or related party gain
- Do not recommend unnecessary treatments to meet targets or for financial advantage
- Document discussions about conflicts of interest in patient’s medical record
- Shall not entice patients with discounted services in return for

advertisement of services

BOOKLET 16: Ethical Guidelines on Social Media

March 2025

1. About These Guidelines

These guidelines are developed to support health practitioners with regard to understanding their obligations when using social media. The guidelines apply to all health practitioners registered with the Health Professions Council of South Africa (HPCSA).

2. Introduction

2.1 The usage of social media is expanding rapidly as individuals and organisations are embracing user-generated content through social networks, internet forums and personal blogs.

2.2 Irrespective of whether online content is accessible to the public at large or is limited to a specific health practitioner, there is a need to maintain the highest professional and ethical standards in using social media.

2.3 Awareness to potential risks involved in engaging and sharing of information via social media, even if the consequences may be unintended, is critical for a health practitioner.

2.4 These guidelines shall be read in line with the Ethical Rules of Conduct for Health Practitioners Registered under the Health Professions Act, 1974 (Rules), as amended, and any other applicable regulatory tools.

3. Definition of Social Media

3.1 Social media describes any online tools and electronic communication platforms that are used for private messaging, social networking, sharing content such as opinions, information, photos, videos and audio.

3.2 Social media includes social networks, content-sharing platforms, personal and professional blogs, internet discussion forums and the comment sections of websites.

4. Context in Relation to HPCSA

4.1 A key mandate, amongst others, of the HPCSA is to guide the professions and to protect the public.

4.2 Social media is beneficial as it allows instant updates on the latest developments, including healthcare issues, through reputable user-generated content, builds a professional support network; as well as to communicate and share information with the public and amongst health practitioners.

5. Obligations in Relation to Social Media

5.1 Just as with all aspects of ethical and professional conduct, a health practitioner shall be aware of their obligations on the Rules and other pieces of relevant legislations, such as the Promotion of Access to Information Act, 2000, the Protection of Personal Information Act, 2013, and other applicable laws.

5.2 There are ethical obligations and responsibilities imposed on a health practitioner regarding their relationships with their patients and each other, such as those set out in the General Ethical Guidelines for Health Care Professionals (Booklet 1) and Confidentiality: Protecting and Providing Information (Booklet 5).

5.3 Obligations relating to the electronic storage and transmission of health records for professional purposes are found in General Ethical Guidelines for Management of Health Records (Booklet 9) and Ethical Guidelines for Good Practice in Telehealth Practice (Booklet 10).

6. Patient Confidentiality and Privacy

6.1 Patients and clients are entitled to privacy and confidentiality, which is enshrined, first and foremost, in the Constitution of the Republic of South Africa, 1996, as well as in other legislations.

6.2 Disclosure of a patient's information may only be done in accordance with a court order, the patient's consent and/or in terms of the law.

6.3 Sharing of confidential information with other members of the health care team involved in the patient's care and with individuals who have the patient's consent is an acceptable conduct.

6.4 Sharing of private information when it is justified is acceptable, such as in the public interest. For example, when failure to do so will result in harm to the patient or others.

6.5 Written informed consent of the patient is required before publishing or communicating information (e.g. case histories and photographs) about them in media or on any platform to which the public has access, whether or not a health practitioner believes the patient can be identified by the data, unless there is an acceptable justification.

6.6 If the patient is a minor, written informed consent of the patient's parent or guardian and assent of the minor is required.

6.7 Sharing information or data for purposes other than diagnosis, treatment or education and training through social media without informed consent must ensure that the information is anonymised before the information and data is disclosed.

6.8 Where it may be appropriate to communicate through social media with other health practitioners and professionals, a health practitioner must ensure that the recipient of patient information understands that such information is given to them in confidence, which must be respected.

6.9 Disclosure of health information on social media to the public must be avoided, and if it is not possible at all, it must be kept to the bare minimum necessary in order to protect the rights of patients.

6.10 A health practitioner must be aware that there is always a risk that the information can be disseminated, even in so-called "invisible" groups.

6.11 The obligation to keep patient information confidential remains even after the patient dies.

7. The Health Practitioner-Patient Relationship

7.1 Interaction between a health practitioner and the patient on social media can blur the boundaries of the health practitioner-patient relationship.

7.2 It is advised that no interaction with patients via social media platforms, as such may result in failure to maintain strict professional relationships with patients and may result in other ethical dilemmas.

7.3 The acquisition of data about an individual's health or sex life outside the healthcare setting, for the purpose not related to the collection, processing and storage, and without consent, is unlawful. Health practitioners may find themselves privy to personal patient information that has not been shared in the healthcare setting during social media interactions with patients.

7.4 Sharing personal information by the health practitioner with their patients during face-to-face consultations is common, but social media does not offer a similar level of control over the extent and type of content sharing.

7.5 If a health practitioner performs a non-medical role in their community, maintaining appropriate professional boundaries may be difficult as they may receive requests on social media from patients they know in a non-professional capacity. In these instances, a health practitioner shall consider the circumstances and implications before

accepting these requests. If a patient or a client contacts a health practitioner through social media platforms, such a patient or client should accordingly be directed to an appropriate healthcare establishment for a proper consultation.

7.6 Should a health practitioner receive an inappropriate message from a patient via social media, they should politely re-establish professional boundaries and explain their reasons for doing so.

7.7 Except in an emergency or life-threatening situation, if a patient is seeking health care interventions over social media, the patient shall politely be requested or referred to a formal health establishment to get proper consultation.

7.8 If a patient persists in contacting the health practitioner over social media, a record or a log of all contacts may be kept before advice can be sought from the HPCSA.

7.9 Providing health care advice over social media to individuals with whom the health practitioner does not have a professional relationship is discouraged and should be done with the utmost discretion, if necessary.

7.10 If health care advice is shared online, it must be evidence based, scientifically sound and generic, and the recipient must be directed to consult with a health practitioner in person before following through such advice.

7.11 It is advisable to keep separate professional and personal social media accounts to help maintain the appropriate professional boundaries with patients.

8. The Health Profession’s Image

8.1 If a health practitioner uses social media in their personal capacity, their online activity may nevertheless bring the profession into disrepute.

8.2 The media routinely monitors online activity to research stories or potential stories. Information posted online may be disseminated, whether intended or not, to a larger audience, and may be taken out of context.

8.3 Content posted on social media may also harm the health practitioner’s employability, professional reputation and recruitment prospects, limiting professional development and advancement. Employers also monitor the social media profiles of prospective employees and are known to turn away applicants based on questionable digital behaviour.

8.4 Social media activities that a health practitioner should avoid for example include: - Taking photographs during surgery and other forms of care or treatment; - Making unsubstantiated negative comments about individuals or organisations; - Making informal and derogatory comments about patients; - Making comments that can be perceived as racist, sexist, homophobic or otherwise prejudicial, even if meant in jest or as satire.

8.5 Engagement on full and health debates on health matters is encouraged. However, awareness of the laws regarding defamation, hate speech, copyright etc, is important as such also extend to content shared via social media.

8.6 Prohibition is placed on sharing opinions relating to probity, skill or professional reputation of colleagues on social media, lest the public lose faith in the healthcare professions.

8.7 Online relationships between health practitioners of varying levels of training should only be initiated upon consideration of the purpose of the relationship. In the case of senior staff receiving social media requests from students (or vice versa), the purpose might be mentorship, research or career advice. Regardless of the intent, the traditional boundaries of the trainee-teacher relationship apply even in interactions via social media. These boundaries also extend to staff and other health practitioners.

8.8 If a colleague makes derogatory or inappropriate comments on social media, a health practitioner is advised to bring it to their attention discreetly, and not to engage or respond publicly on the social media platform.

8.9 A disclaimer shall be included in the media profiles, indicating that the views expressed therein are their own and not those of the health profession or the health establishment, they may represent. However, this does not absolve the health practitioner from liability.

9. Communicating Information About Health Services

9.1 Health practitioners must be honest and not mislead the public about their skills, experience, qualifications, professional status, and professional services they provide.

9.2 Information shared shall always be scientific, factual, and shall not exploit the public's vulnerability or lack of medical knowledge.

9.3 When sharing information about specific health interventions, health practitioners should adequately inform of the associated risks, benefits and complications. The need for a proper health consultation must be made clear.

9.4 Misrepresentation of facts or allowing others to misrepresent facts is not acceptable.

10. Conflicts of Interest

10.1 Social media is also a popular tool for the advertisement and promotion of goods and services, with the growing online market being one of the most emphasised in business practice.

10.2 When using social media, even if via personal or anonymous blogs, a health practitioner must comply with the HPCSA rules on advertising practice, (including not engaging in active or passive touting and canvassing or allowing others to do so on their behalf), and must make sure that declaration of financial interests in hospitals is done (see Booklet 2 Ethical and Professional Rules of the Health Professions Council of South Africa and Booklet 11 Guidelines on Overservicing, Perverse Incentives and Related Matters).

10.3 **Touting** involves drawing attention to one's professional goods or services by offering guarantees or benefits that fall outside one's scope of practice. An example is advertising air-conditioned rooms for patients' enjoyment while waiting for their consultations. Health practitioners are also not allowed to barter health services with social media exposure.

10.4 **Canvassing** involves the promotion of one's professional goods and services by drawing attention to one's personal qualities, such as superior knowledge, quality of service, professional guarantees, or best practice. An example of canvassing is a health practitioner declaring on social media or posting patient reviews that state he or she is 'the best health practitioner in the country'. Exploitation of professional relationships with patients by trying to gain advantage from their social standing or social media influence, is not acceptable.

10.5 It is not acceptable for a health practitioner to advertise, endorse or encourage the use of any hospital, medicine or health-related product and services on social media for purposes of financial gain or other valuable consideration.

10.6 However, health practitioners are not prohibited from endorsing non-healthcare products or non-medicinal products, provided that there is a clear disclaimer to indicate that such promotions are paid. Health practitioners shall clearly disclose any sponsorships, financial incentives, or any other information which would likely affect the patient's perception of the health practitioner's services offered or product being endorsed.

10.7 A failure to follow these guidelines when using social media undermines the public trust in the health profession.

11. Precautionary Measures When Using Social Media

11.1 A health practitioner must be aware that, even with a pseudonym, anonymity on social media platforms is never guaranteed. The identity and location of the user can be easily traced through their linked accounts or IP address.

11.2 If social media is being used in the personal capacity, it is advised that an adjustment of privacy settings is made to restrict public access. However, even with advanced security measures and end-to-end encryption, complete privacy on social media cannot be guaranteed. There is always the risk that the content can be shared beyond the scope of the health practitioner's personal network.

11.3 Once content is shared online, it is difficult to remove. Social media is used with the understanding that the information they post will remain on the internet permanently.

11.4 Even if the information is deleted on a social media site, it does not necessarily mean the content has been removed completely. Content may be copied or reproduced by other users before it has been deleted, and many websites and internet browsers use cache and cookie systems that inconspicuously store data.

11.5 It is recommended to avoid using social media when stressed, tired, upset or under the influence of alcohol.

11.6 It is advised to err on the side of caution when using social media. If uncertain about whether it is ethically and legally permissible to share particular content via social media, it is best not to do so until advice has been obtained.

BOOKLET 17: Ethical Guidelines on Palliative Care

2019

Acknowledgements

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1. Preamble

1.1 The World Health Organisation (WHO) defines palliative care as 'an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'.

1.2 Palliative care: - provides relief from pain and other distressing symptoms; - affirms life and regards dying as a normal process; - intends neither to hasten or postpone death; - integrates the psychological and spiritual aspects of patient care; - offers a support system to help patients live as actively as possible until death; - offers a support system to help the family cope during the patient's illness and in their own bereavement; - uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated; - will enhance quality of life, and may also positively influence the course of illness; - is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

1.3 With the spread of HIV, South Africa shoulders a significant disease burden, and the Department of Health's National Policy Framework and Strategy on Palliative Care 2017–2022 acknowledges the importance of integrating palliative care as an essential component of health service delivery.

2. When is Palliative Care Provided

2.1 Palliative care is provided to those living with and dying from any advanced, progressive and incurable condition regardless of age or setting.

2.2 Palliative care is provided throughout the journey, from diagnosis to end of life.

2.3 As the patient's disease progresses, the need for palliative care will increase and the level of curative treatment will decrease.

2.4 The WHO recognises that palliative care is required for a wide range of diseases, including but not limited to: - Cardiovascular disease - Cancer - Chronic respiratory diseases - AIDS - Diabetes - Kidney failure - Chronic liver disease - Multiple sclerosis - Parkinson's - Rheumatoid arthritis - Neurological disease - Dementia - Congenital anomalies - Drug-resistant tuberculosis

3. Why is Palliative Care Provided

3.1 Palliative care is recognised by the United Nations as part of the human right to health.

3.2 The goal of palliative care is the achievement of the best possible quality of life for patients and their families, even if life expectancy is short.

3.3 Palliative care is an extension of the South African Constitutional rights of human dignity and access to healthcare.

3.4 The Constitution also guarantees the right to basic healthcare for children which includes the provision of paediatric palliative care, and not merely access to such care, as is the case with adults.

3.5 Evidence suggests that palliative care can reduce unnecessary hospitalisation and use of health care services, which lessens the costs of the health system.

4. Who Provides Palliative Care?

4.1 Palliative care is provided by all health practitioners and other health care professionals working with people with life-threatening conditions.

4.2 Health practitioners providing palliative care should possess the requisite knowledge, skills and attitudes to meet the physical, psychological, practical, social and spiritual needs of their patients.

4.3 Health practitioners providing palliative care should keep their skills up to date.

4.4 As a result of the current inadequate provision of palliative care services in the country, the National Department of Health has developed a strategy to increase the scope of palliative care services in its National Policy Framework and Strategy on Palliative Care 2017-2022.

4.5 It is imperative that all healthcare professionals play an advocacy role on the importance of palliative care services in the public health sector and for palliative care to be included in the curriculum of health practitioners.

5. Where is Palliative Care Provided

5.1 Palliative care can be provided in public, private facilities and patient's homes.

5.2 According to the National Department of Health National Policy Framework and Strategy on Palliative Care the different palliative care service delivery settings are: - Home-based palliative care - Mobile outreach services - Outpatient care - Inpatient palliative care facilities - Hospital based palliative care teams - Day care palliative services - Frail care and other care homes - Workplace programs - Correctional services

6. How Palliative Care is Used

6.1 Health practitioners must deliver care in a manner that upholds these principles, and the rights and values of the patient and their family, even in the midst of a dehumanising environment or in noisy facilities/areas.

6.2 Health practitioners providing palliative care should apply the bioethical principles of autonomy, beneficence, non-maleficence and justice that require respect for the worth, dignity and human rights of their patients when managing them.

6.3 Patients and their families faced with life-threatening illnesses are likely to be vulnerable and anxious during this time. Health practitioners providing palliative care will find the bioethical principles helpful in guiding decision-making.

6.4 Health practitioners must establish trust in the patient and their family through availability, listening, providing honest answers, and having a non-judgmental attitude.

6.5 In administering palliative care, health practitioners should also adhere to the HPCSA's general ethical guidelines and the National Department of Health's National Policy Framework and Strategy on Palliative Care 2017–2022.

7. Patient Autonomy and Palliative Care

7.1 Meaning of Patient Autonomy

7.1.1 Patient autonomy recognises the ability of patients to make decisions for themselves regarding palliative care, and is in accordance with the constitutional rights to human dignity and bodily and psychological integrity.

7.1.2 Patient autonomy presumes that patients have the required information and capacity to make rational decisions about palliative care and that the circumstances allow them to give an informed consent.

7.1.3 When obtaining informed consent from patients, health practitioners providing palliative care must comply with the National Health Act 61 of 2003 and the HPCSA's guidelines on Seeking Patients' Informed Consent: The Ethical Considerations (Booklet 4).

7.2 Capacity to Consent to Palliative Care

7.2.1 Health practitioners providing palliative care should assume that every mentally competent adult patient and every sufficiently mature child patient over the age of 12 years have legal capacity to consent to, or oppose, medical interventions - unless it is shown that they clearly cannot understand the information given to them.

7.2.2 It is for the patient, and not the health practitioner providing palliative care, to determine what is in the patient's best interests.

7.2.3 Although health practitioners providing palliative care may recommend a course of treatment, they may not pressurize or manipulate the patient into accepting their advice.

7.2.4 Health practitioners providing palliative care must understand and respect that a patient's decision-making may be guided by values, customs and beliefs different from the practitioner's.

7.2.5 If a mentally and legally competent patient, who is fully informed of the benefits and risks of treatment, consents to or refuses a particular course of treatment, their decision must be respected, even if the health practitioner providing palliative care believes it will result in serious harm or even death.

7.2.6 Respecting patient autonomy, however, does not mean that patients are entitled to illegal, unethical or medically inappropriate treatment simply because they have requested it.

7.2.7 Health practitioners providing palliative care should only recommend and provide treatment options that are both scientifically grounded, and are, in their best medical judgement, reasonably expected to yield the intended benefits.

7.2.8 Should a patient request illegal, unethical or medically inappropriate treatment, the health practitioner providing palliative care should reassure them and their family of the sound treatment options available to the patient - subject to consent by the latter or his or her surrogate.

7.3 Advanced Palliative Care Planning

7.3.1 Patient autonomy includes the need to protect patients with diminished autonomy.

7.3.2 Health practitioners providing palliative care should encourage competent patients to indicate their wishes regarding treatment options in an advance directive, such as a living will, and in such a document or a written nomination of a surrogate in terms of the National Health Act, to mandate a person to make decisions on their behalf if they become incapacitated.

7.3.3 An advance directive helps ensure consideration of the patient's values and preferences, even when they lack the capacity to express them.

7.3.4 Health practitioners providing palliative care should record any conversations with a competent patient regarding their goals for care in their medical records, and should review such goals regularly and as circumstances change.

7.3.5 The advance directive or other records of the patient's wishes should be kept inside the patient's file, with stickers indicating that the advance directive is available for ease of reference.

7.3.6 The Patient's Rights Charter introduced by the National Department of Health requires patients to advise their healthcare provider of their wishes regarding death, and to take care of any medical records in their possession – see HPSCA National Patient's Rights Charter (Booklet 3).

7.3.7 An advance directive should include the following: - the patient's wishes and preferences with regard to future treatment; - any beliefs or values that may influence the patient's decisions and preferences; - the family members or surrogates that should be involved in decision-making; - any interventions that should be considered and implemented in case of emergency, such as CPR; - the patient's preferred place of care; and - the patient's need for religious, spiritual, and other personal support.

7.3.8 As is the case with life-threatening illness, towards the end-of-life, it is not uncommon for a patient's mental capacity to be impaired.

7.3.9 When a patient becomes mentally incompetent, and an advance directive is available, health practitioners providing palliative care should give effect to the patient's wishes – provided that the directive is applicable to the present circumstances and represents the patient's current wishes.

7.3.10 If no advance directive is available, and no surrogate has been appointed, the health practitioner providing palliative care must, in consultation with the patient's family, determine the treatment option that is in the patient's best interest.

7.3.11 In determining an incapacitated patient's best interests during the decision-making process, the health practitioner providing palliative care must consider: - the medically appropriate treatment options available; - any previous requests of the patient when he or she was mentally competent; - what the practitioner knows about the background and preferences of the patient, in consultation with the patient's healthcare team; - information regarding the patient's values, beliefs and preferences from third parties who may have other knowledge of the patient due to their relationship (e.g. a parent, sibling, child or spouse); - where more than one treatment option is reasonably in the patient's best interests, the practitioner must, in consultation with the patient or the patient's surrogate, choose the option that least restricts the patient's future choices.

7.3.12 The health practitioner providing palliative care must take appropriate action in the case of illegal, unethical or inappropriate behaviour that jeopardises the best interests of the patient.

7.4 Communication

7.4.1 Health practitioners providing palliative care must communicate effectively and timeously with the patient and their family, and the rest of the palliative care team.

7.4.2 Health practitioners providing palliative care must take into account the emotional toll that the circumstances regarding the use of palliative care may have on the patient and their family, and should

communicate with them in an empathic and understandable manner.

7.4.3 If a patient's communication skills are compromised by their illness, health practitioners providing palliative care must communicate with the patient through verbal and non-verbal means.

7.4.4 Irrespective of the patient's level of consciousness, health practitioners providing palliative care should communicate any proposed interventions to the patient, based on the understanding that hearing is the last sense to die.

8. Beneficence and Palliative Care

8.1 Meaning of Beneficence

8.1.1 The principle of beneficence requires the health practitioner providing palliative care to do good for their patients.

8.1.2 The health practitioner providing palliative care must weigh up the costs, risks and benefits of particular forms of palliative care and recommend those that are most beneficial to the patient, while leaving the final decision to the patient or their surrogate.

8.1.3 From the moment of diagnosis of a life-threatening condition, the health practitioner providing palliative care must monitor the patient and keep abreast of relevant medical advancements, and ensure that their knowledge and understanding of palliative care is up to date.

8.1.4 If the health practitioner providing palliative care is not able to manage severe or refractory symptoms, it is important for such practitioner to refer the patient to a health practitioner who is qualified to do so.

8.2 Withholding or Withdrawal of Treatment

8.2.1 The health practitioner providing palliative care is required to balance the intended benefits of palliative care against the risks and burdens of treatment.

8.2.2 In some instances, the quality of life which follows palliative treatment may raise questions as to whether such treatment is in the best interests of the patient.

8.2.3 Treatment can legally and ethically be withheld or withdrawn if the patient refuses further treatment, further treatment is futile, or if it is no longer in the patient's best interests (e.g. when treatment merely prolongs the dying process).

8.2.4 The decision to withhold or withdraw treatment must not be taken lightly, and must be considered by the health practitioner providing palliative care in consultation with the patient and their family.

8.2.5 When the possibility of withholding or withdrawal of treatment arises, the health practitioner providing palliative care should discuss with the patient and their family, arrangements for basic care and other appropriate treatments.

8.2.6 At end-of-life, discussions about withholding or withdrawal of treatment should include plans to manage the final stages of the lives of patients, before they are incapacitated, and include personal matters such as wills, as well as any other concerns that patients believe are important to ensure that they die with dignity.

8.2.7 When dealing with end-of-life decisions health practitioners providing palliative care must approach the withholding or withdrawal of treatment in a manner consistent with the HPSCA's Guidelines for the Withholding and Withdrawal of Treatment (Booklet 7).

9. Non-Maleficence and Palliative Care

9.1 Non-maleficence requires health practitioners providing palliative care not to harm their patients and complements beneficence and the balancing of risks and benefits.

9.2 Euthanasia and doctor-assisted suicide are often perceived as inconsistent with the principle of non-maleficence.

9.3 Euthanasia and doctor-assisted suicide are presently prohibited under South African law, and the courts frequently do not distinguish between the two when it comes to culpability.

9.4 **Euthanasia** is the employment of any medical intervention primarily aimed at ending a patient's life (e.g. giving a patient lethal drug or injection).

9 .5 **Doctor-assisted suicide** occurs when the health practitioner provides the means necessary to enable the patient to end their own life (e.g. handing a patient a lethal drug or prescribing a lethal drug for a patient).

9.6 At present, South African courts have acknowledged that both euthanasia and doctor-assisted suicide are fundamentally incompatible with a practitioner's role as a healer, and a practitioner guilty of either is regarded as having acted unethically and unlawfully.

9.7 Due to the stress of extreme pain and the prospect of facing a life-threatening illness, a patient may request a health practitioner providing palliative care to end their life.

9.8 The role of the health practitioner providing palliative care in this instance is to discuss the concerns and fears that have led to the patient's request, and to provide alternate approaches to address these issues.

9.9 When medical treatment relieves suffering - but has the effect of accelerating the dying process - the health practitioner providing palliative care must consider whether the palliative benefits justify the shortened life expectancy before pursuing that course of treatment.

9.10 Palliative care treatment where life is shortened as a side effect, is not regarded as unlawful or unethical – provided the patient or their surrogate has given informed consent.

10. Justice or Fairness and Palliative Care

10.1 The World Health Organisation (WHO) states that 'palliative care needs to be provided in accordance with the principles of universal health coverage'.

10.2 This means that everyone, 'irrespective of income, disease type or age, should have access to a nationally determined set of basic health services, including palliative care' and is consistent with the South African Constitution.

10.3 The WHO also states that 'financial and social protection systems need to take into account the human right to palliative care for poor and marginalized population groups'.

10.4 Palliative care should be available to all patients from birth until death, and should be accessible at all levels of the health care service and this is what the National Department of Health's National Policy Framework and Strategy on Palliative Care 2017–2022 aspires to do.

10.5 Health practitioners providing palliative care must treat patients equally and without discrimination.

10.6 According to the National Department of Health's National Policy Framework and Strategy on Palliative Care 2017–2022 health practitioners providing palliative care must give special consideration to the following groups of people in their provision of palliative care services: - Persons with disabilities - Children (including neonates and adolescents) - Older persons including those living in residential care settings and frail care facilities - Asylum seekers and refugees - Inmates of correctional services - Persons in long term care facilities such as TB and psychiatric hospitals or residential care facilities

10.7 Palliative care practitioners should use the country's limited health care resources responsibly, fairly and effectively to ensure all patients receive appropriate palliative care.

11. References

11.1 National Department of Health. National Policy Framework and Strategy on Palliative Care 2017-2022.

11.2 National Health Service Scotland. Scottish Palliative Care Guidelines (2014).

11.3 American Medical Association. Opinions on Caring for Patients at End of Life (2016).

11.4 General Medical Council. Treatment and Care towards End of Life: Good Practice in Decision-Making (2010).

11.5 Irish National Clinical Programme for Palliative Care: Palliative Care Needs Assessment Guidance (2014).

11.6 Republic of Kenya Ministry of Health. National Palliative Care Guidelines (2013).

11.7 Australian Medical Association. Position Statement on End of Life Care and Advance Care Planning (2014).

11.8 Canadian Medical Association. Palliative Care National Call to Action (2015).

BOOKLET 19: Guidelines for Health Practitioners on Matters Relating to Ethical Billing Practices

June 2024

1. Definitions

Balance billing: Practitioner bills patient for amount not covered by medical scheme and provides two identical accounts to both patient and scheme indicating full amount, specifying portion owed/paid by patient.

Charge: The amount a health practitioner sets for services before applying any discounts.

Co-payment: A fixed payment paid by patient for health services at point of seeking care, not covered by insurance.

Cost: The total amount incurred in providing a service. Actual cost is typically lower than price paid.

Emergency: A situation where there is threat to life or limb (including a perceived threat).

Fee for service: Fixed payment for each unit of service without regard to outcomes, typically paid retrospectively.

Global fee: A prospective lump sum payment to cover aggregate costs over a specific period for a set of services independent of actual volume provided.

Payment: A unit of agreed rand amount to reimburse a rendered service or procedure.

Split-billing: Patient billed separately for amount not covered by medical scheme, and medical scheme billed separately in line with medical scheme's benefits. (Account to patient only reflects patient's portion; claim to medical scheme only reflects amount medical scheme is prepared to pay and does not reflect out-of-pocket payment.)

2. Introduction

Health practitioners have responsibility to ensure patient's best interests are always upheld in healthcare service delivery.

These guidelines must be read in conjunction with: - Booklet 1: General Ethical Guidelines for Healthcare Professions - Booklet 2: Ethical and Professional Rules of Conduct - Booklet 4: Seeking Patients' Informed Consent - Booklet 11: Guidelines on Overservicing, Perverse Incentives and related matters

3. Good Practice Framework

3.1 The National Health Act, 2003

Patients should be given information about: - Their health status - Range of diagnostic procedures and treatment options - Benefits, risks, costs and consequences associated with each option - Patient's right to refuse

health services and implications of refusal

3.2 Section 53 of the Health Professions Act, 1974

Every registered person shall, unless circumstances render it impossible, before rendering professional services inform the person to whom services are rendered of the fee which he or she intends to charge: - When so requested - When such fee exceeds that usually charged (must also inform of usual fee)

Any health practitioner who claims payment from any patient shall furnish patient with detailed statement of account within a reasonable period.

3.3 Ethical and Professional Rules

A practitioner shall not: - Accept commission from any person in return for purchase, sale or supply of goods used in professional practice - Pay commission to any person for recommending patients - Offer or accept any payment or benefit calculated to induce to act in a particular way not scientifically, professionally or medically indicated - Offer or accept incentives to under-service, over-service or over-charge patients - Share fees with any person who has not taken commensurate part in rendering services - Charge or receive fees for services not personally rendered (except for services by employee, partner, shareholder or locum tenens)

A practitioner shall explain to patients the benefits, costs and consequences associated with each service option offered.

3.4 General Ethical Guidelines

Health practitioners should: - Give patients information they ask for or need about condition, treatment and prognosis - Give information in a way patients can best understand - Not withhold information, investigation, treatment or procedure that would be in patient's best interests - Apply principle of informed consent as an on-going process - Allow patients access to their medical records

3.5 National Patient's Rights Charter

Everyone has a right to be given full and accurate information about their illnesses, diagnostic procedures, proposed treatment, risks associated, and costs involved.

4. Guidelines to Health Practitioners

- Have a fixed, transparent and documented billing policy and set of charges
- Manner in which cost of services or charges is determined must be rational and documented (based on affordability, time spent, complexity, etc.)
- How charges are levied must be clear (e.g., fee for service, global fees)
- Acceptable to use national benchmarks if widely recognized and consistently applied
- Fees based on contractual agreements must be consistent with ethical guidelines
- Charges should be consistently applied and can be discounted in appropriate circumstances
- Patient must be aware of fees prior to commencement of fee generating activities

Specifically: - Patient must be aware of specific costs associated with consultations - Additional charges during consultation should only be performed after express consent - When patient is advised to undergo a procedure, actual professional fees must be discussed - Patient must be informed if additional charges may apply and under what circumstances - Patients on medical aid must be informed of implications of fee structure on their ability to claim - Costs related to other health services (hospitalization, theatre, laboratory, diagnostic testing, anesthesia) must be discussed; inform where such information can be obtained if not available

5. Non-Payment for Health Services Rendered

- Receive informed financial consent in writing from patient or designated person before proceeding
- Informed financial consent should be periodically reviewed to ensure patient maintains their obligation
- If patient cannot agree on quantum of reimbursement, practitioner may decline to provide health services and refer to other facilities (except for emergency services or if refusal would cause patient to suffer or die)
- Not allowed to withhold and/or withdraw outcomes of medical treatment or laboratory investigations on basis of non-payment
- Use legal debt collection mechanisms to recover outstanding fees

6. Billing in Emergency

- In emergency circumstances, continue to provide necessary medical treatment
- When patient is able to comprehend financial responsibilities, bring cost to patient, guardian or caregiver
- Health practitioner is entitled to be reimbursed for emergency services; billing practices remain applicable

7. Payment Plans

- May make arrangements with patient for reimbursement; written consent should be obtained
- This should not be perceived as a credit agreement
- Not allowed to charge and receive interest on accrued debt as per National Credit Act, 2005
- Where patient has not settled account and medical aid has rejected payment, practitioner can revoke discounted price offer and charge up to 2% interest every month from date amount becomes due
- Reasonable attempts to engage indebted patient should be considered before formal debt collection measures

8. Billing Codes

- Health practitioners should be cognisant of challenges regarding billing codes when requesting reimbursement
- Utilise appropriate billing codes for services rendered from resident practice, including offsite and mobile practices
- Where no specific code exists, consider use of a code that involves or includes the procedure or service rendered

9. Invoices

- Invoice serves as record of treatment, bill, and provides itemised breakdown of all health services, contact details, costs, and when payment is due
- Quotations and invoices can be used as cost estimate and cost confirmation documents
- Both can be used as part of records for informed financial consent
- Invoices are ordinarily placed separate from other consumer’s credit bill
- Invoices are part of reference documents for health record

Split billing is not an acceptable practice, but balanced billing is acceptable.

10. Statements

- Statement of account reflects all transactions for a given period
- Includes amounts paid by patient or medical scheme (in part or full)
- Reflects balance due by patient for services rendered as agreed
- Must be furnished within a reasonable period

11. Communication

- Always ensure signed financial informed consent is obtained in written document
- Invoice and statement should be provided in written document
- Can be transmitted in any manner convenient to patient

12. Advance Payment of Services

Health practitioner shall not charge fees for health services not yet rendered, **except for:** - Costs of prostheses - Co-payment at medical aid rates required from patient - Foreign patient requiring health services in South Africa - Custom made medical devices which cannot be used or supplied to another patient, or modified for another patient, to recover cost incurred

13. Financial Audits

Medical schemes are entitled to access any treatment records held by managed health care organisation or health practitioner and any other information pertaining to diagnosis, treatment, and health status of beneficiary.

Such information may not be disclosed to any other person without express consent of the beneficiary.

BOOKLET 20: Ethical Guidelines on the Use of Artificial Intelligence

September 2024

1. Definitions

Artificial Intelligence (AI): A branch of computer science, statistics and engineering that uses algorithms or models to perform tasks and exhibit behaviour such as learning, making decisions and making predictions. AI in healthcare is primarily utilised in an assistive role, emphasizing that its design enhances human intelligence rather than replaces it.

Automated decision making: Any technology that either assists or replaces the judgment of human decision-makers.

Algorithm: A set of detailed, ordered instructions followed by a computer to solve a mathematical problem or complete a computer process.

Computer vision: An interdisciplinary scientific field dealing with how computers can gain high level understanding from digital images or videos and seeks to automate tasks that the human visual system can do.

Data mining: An interdisciplinary subfield of computer science and statistics with overall goal to extract information (with intelligent methods) from a data set and transform information into a comprehensible structure for further use.

Machine learning: The scientific study of algorithms and statistical models that computer systems use to effectively perform specific tasks with minimal human interaction and without using explicit instructions, by learning from data and identification of patterns.

Natural language processing: A subfield concerned with interactions between computers and human (natural) languages, particularly how to program computers to process and analyze large amounts of natural language data.

Training data: Data used to train an algorithm; generally consists of a certain percentage of an overall dataset along with a testing set. The better the training data, the better the algorithm performs.

2. Introduction

The HPCSA supports innovation in healthcare delivery while ensuring and promoting safe practice. The HPCSA does not regulate or approve new technologies or medical devices.

While the HPCSA acknowledges the enormous potential for AI to improve accessibility, enhance quality, and reduce administrative burden, it recognises significant ethical, legal, and professional challenges, including relating to over-reliance.

AI's potential in healthcare is vast, but accompanied by risks such as: - Bias and discrimination due to historical data biases - Automation bias - Potential erosion of clinical skills amongst health practitioners - Privacy concerns as AI systems rely on large datasets that may compromise patient confidentiality

Common examples of AI applications in healthcare: - Computer vision systems to analyze medical images - Natural language processing to review clinical notes - Predictive algorithms and advanced data analytics to forecast clinical trends - Voice recognition to support clinical documentation - Chatbots to provide patient education - Dictation and speech recognition software - Electronic medical record macros or templates - Automated decision making and pathways, protocols, and clinical scores - Analysis of diagnostic information or identify pharmacological interactions and contraindications - GenAI (evolving technology capable of building upon advances in complex algorithms, advanced data analytics and machine learning)

3. Ethical Principles

- Health practitioners have responsibility to ensure patient's best interests remain their primary concern
- Patient's confidentiality, privacy, choices and dignity must always be respected
- AI systems must always adhere to these values
- Use of AI should be patient-centred for benefit of patients' health and well-being and to improve health outcomes
- Interest of patients and wider community should be primary and guiding focus of all AI applications
- AI should serve as a tool to support and enhance clinical decision-making rather than replace it
- AI should complement expertise of health practitioner, ensuring human judgment remains central to patient care
- Use of AI should not undermine rights of patients to make informed decisions
- Must respect and preserve clinical independence and professional autonomy of health practitioners
- Automated decision-making AI tools must respect clinical independence and professional autonomy
- Health practitioner should always make final decision on patient care, maintaining accountability and oversight
- Use of AI for treatment and diagnosis should include express accountability for any errors
- AI in healthcare must only occur with appropriate ethical oversight
- Use of AI must support protection of patient health information privacy
- Where unidentifiable data will serve the purpose, anonymized data should be used

4. Disclosure

- Health practitioner shall only utilise a form of treatment, apparatus or health technology that is not a secret or claimed to be secret
- Health practitioner shall assess whether AI tool suits its intended purpose (up-to-date, valid, reliable, transparent, explainable, capable of producing good and interpretable output, repeatable)
- Acknowledge potential risks and issues they could create
- Only apparatus or health technology which proves capable of fulfilling claims made may be considered
- Health practitioner must understand it and be assured of its appropriateness
- Disclosure should be made to patient whether AI system utilising

machine learning employs algorithm programmed to learn from training data
- Health practitioner shall understand and disclose to patients whether tool is a “continuous learning system” or “locked learners”
- Being able to trace source of training data is critical to understanding risk
- If AI tool fits or is incorporated onto a medical device, must comply with SAHPRA requirements

5. Accountability

- AI tools must be guided by health practitioners to create positive and transparent interactions that instill trust
- AI use shall be consistent with prevailing standards for any technology used in healthcare
- Health practitioners are ultimately responsible for their use of AI tools and may be held accountable for any harms that flow from use
- Extent of accountability will depend on relationship between AI being used and risk that it may create patient harm or impact professional obligations
- Health practitioners should always reflect on their own clinical reasoning and professional judgment, even during AI use
- AI tools are only intended to assist and complement clinical care, not to replace
- Take steps to mitigate or avoid over-reliance on AI tools that jeopardizes independent professional judgment and vigilance
- Developers of AI systems are also liable with user of such systems for adverse events resulting from malfunction(s) or inaccuracy in output

6. Equity and Transparency in AI Application

- AI technologies must be applied in a way that does not exacerbate disparities in healthcare (race, gender, socioeconomic status)
- Health practitioner is expected to respect dignity, diversity, cultural values, and rights of patients and colleagues
- Avoid using AI to create or disseminate content that is discriminatory, offensive, or harmful
- Patients must be informed when diagnosis or treatment recommendations were determined or assisted by AI
- Information on how algorithms are used in clinical diagnosis and decision-making should be available to patients, including any biases and associated risks
- Informed consent is not a list of AI-generated risks and benefits, but a meaningful dialogue and shared decision-making
- For informed consent to be valid, patient must be adequately informed about diagnosis, treatment options, risks, benefits, and reasonable alternatives
- Lack of transparency regarding AI’s role and inadequate communication can undermine trust

Transparency and disclosure of AI tool should be done prior to its use and include: - Discussion of capabilities and limitations of the tool - Discussion of safeguards to manage bias and ensure validity and reliability - Ability to independently explain components of diagnosis and treatment options

7. Safety and Quality of Care

- All interventions must take place under appropriate conditions and surroundings
- No practitioner may embark upon an intervention unless it is in patient’s interest and safe to do so (except in life or limb threatening emergency)
- AI systems must be transparent, reproducible and trusted by both health practitioners and patients
- Usability should be tested by participants who reflect similar needs and practice patterns of the end user
- Systems must work effectively with people

8. Continuing Professional Development

- Health practitioners have professional and ethical duty to maintain requisite level of skill, knowledge and judgment to provide competent and safe care, including in usage of AI tools
- As AI tools are increasingly incorporated into healthcare delivery, health practitioners should:
  - Follow significant developments within their field
  - Update their skills
  - Strive to understand how the technology works, its limitations, benefits, risks, and privacy implications
- Health practitioners must strive to be involved, learn or understand how AI is improving healthcare delivery
- Development and application of AI to healthcare must be inclusive, undertaken with appropriate consultation with health professionals, patients and wider community

9. Clinical Decision Making

- Responsibility for decision making on patient care should always remain with the health practitioner, irrespective of assistance or tools employed
- Health practitioners are accountable for clinical decisions and held liable for their decisions
- It is contrary to good practice for AI to be applied as the final decision maker
- Only a person registered in terms of the Act may partake in diagnosis, treatment or giving advice in respect of illness, treatment, deficiency or rehabilitation

10. Data Privacy and Protection

- Personal information about patient must be effectively protected against improper disclosures at all times
- Patient's health information must not be given to others unless patient provides consent or healthcare practitioner can justify disclosure
- Health practitioners have obligation to safeguard patient health information against unauthorized access and inappropriate use

11. Regulation

Regulators with specific mandates in South Africa: - **HPCSA:** Regulates the health practitioner - **Office of Healthcare Standards and Compliance (OHSC):** Protects and promotes health and safety of users by monitoring and enforcing compliance with norms and standards - **South African Health Product Regulatory Authority (SAHPRA):** Ensures regulation of health products through licensing of manufacturers, wholesalers, distributors of medicines and medical devices, radiation emitting devices and radioactive nuclides - **Information Regulator (IR):** Regulates processing of personal information and promotion of access to information

Government has crucial role in ensuring synergy between regulators for appropriate application of AI in healthcare.

Regulatory tools for AI in South Africa are currently underdeveloped. As tools develop, regulatory framework should significantly and continually change.

Adaptive regulation is necessary to ensure participants (health practitioners and patients) feel safe in application of AI, promoting innovation and progress.

12. Pillars of AI

The pillars of AI tools are fundamental components supporting successful implementation:

12.1 Ethics

AI tools should support ethical matters such as respect for patient autonomy, privacy, and confidentiality.

12.2 Legal

Any platforms operating in South Africa must meet legal standards in line with applicable legislation (Protection of Personal Information Act, Promotion of Access to Information Act, others).

12.3 Technical

Healthcare AI tools should have express and available defined criteria, features, functionalities, and capabilities to meet intended objectives and fulfill health practitioner and patient needs. AI applications should be safe, reliable, and sufficiently robust to meet data quality management, interoperability, and cybersecurity standards.

13. Opportunities

- AI can offer transformative set of tools and has potential to make healthcare safer and more efficient by automating processes and increasing productivity
- Data mining may improve electronic health records and access to relevant patient information
- Results of data mining may provide evidence to inform resource allocation and utilization decisions
- New insights into diagnosis and best practices for treatment may be produced
- Potential to improve patient experience, patient safety, and treatment adherence
- Applications of AI to continuing medical education, training simulations, learning assistance, coaching for students may provide objective assessment tools to evaluate competencies

14. Challenges

- Some AI tools do not fall under definition of medical device requiring Regulator’s approval, making them difficult to regulate
- Effective use of AI may be hampered by:
  - Evolving regulatory oversight to strengthen safety and clinical efficacy
  - Lack of widely accepted standards
  - Liability issues
  - Need for clear laws and regulations governing data uses
  - Lack of shared understanding of terminology and definitions
- AI systems must ensure proper disclosure and note benefits, limitations, and scope of appropriate use
- Health practitioners are required to understand AI methods and systems to rely upon as aid for clinical recommendations
- Anonymization of data does not provide enough protection when machine-learning algorithms can identify an individual from among large complex data sets with as few as three data points
- Viable technical solutions to mitigate confidentiality risks are not yet robust enough
- Data structure and integrity are major challenges
- Data sets on which machine learning systems are trained are created by humans and may reflect bias and contain errors
- Data sets may ‘normalize’ errors and biases inherent in their data sets
- Minorities and marginalized populations may be disadvantaged because there is less data available about their populations
- How a model is evaluated for accuracy involves very careful analysis of training data set and its relationship to evaluation data set
- There is currently limited research-based evidence to guide approach to use of advanced AI tools by health practitioners
- Inadequate risk assessment may result in incorrect tool usage

List of All HPCSA Ethical Guidelines Booklets

The following booklets are separately available:

1. **Booklet 1:** General ethical guidelines for health care professions
2. **Booklet 2:** Ethical and professional rules of the health professions council of South Africa
3. **Booklet 3:** National Patients' Rights Charter
4. **Booklet 4:** Seeking patients' informed consent: The ethical considerations
5. **Booklet 5:** Confidentiality: Protecting and providing information
6. **Booklet 6:** Guidelines for the management of chronic diseases
7. **Booklet 7:** Guidelines on withholding and withdrawing treatment
8. **Booklet 8:** Guidelines on reproductive health management
9. **Booklet 9:** Guidelines on patient records
10. **Booklet 10:** Guidelines for the practice of Telemedicine
11. **Booklet 11:** Guidelines on overservicing, perverse incentives and related matters
12. **Booklet 12:** Guidelines for the management of health care waste
13. **Booklet 13:** General ethical guidelines for health researchers
14. **Booklet 14:** Ethical guidelines for Biotechnology research in South Africa
15. **Booklet 15:** Research, development and the use of chemical, biological and nuclear weapons
16. **Booklet 16:** Ethical Guidelines on social media
17. **Booklet 17:** Ethical Guidelines on Palliative Care
18. **Booklet 19:** Ethical guidelines on matters relating to ethical billing practices
19. **Booklet 20:** Ethical Guidelines on the Use of Artificial Intelligence

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This combined document was compiled from official HPCSA publications. Booklets included: 1, 3, 4, 5, 9, 11, 16, 17, 19, 20 Original documents available at: http://www.hpcsa.co.za