PROTECTING THE PUBLIC THROUGH REGULATED EDUCATION AND PRACTICE !

ETHICAL GUIDELINES

FOR

HEALTH PROFESSIONALS

2010

INDEX

1. PROFESSIONAL GUIDELINES

THE SPIRIT OF PROFESSIONAL GUIDELINES

Health professions are based on a relationship of trust with patients. The term "profession" means *"a dedication, promise or commitment publicly made"*.[1] To be a health professional requires a life-long commitment to good professional and ethical practices and unreserved dedication to the good of fellow human beings and society. In essence, the practice of health professions is a moral enterprise. In this spirit, the Health Professions Councils of Namibia (HPCNA) presents the following ethical guidelines:

1. GENERAL ETHICAL GUIDELINES

Being registered as a health professional with the HPCNA confers on us the right and privilege to practice our professions. Correspondingly, health professionals have moral or ethical duties to others and society.

This part contains general ethical guidelines for and general duties of health professionals. Such guidelines are inspirational and value-oriented, expressing the most honourable ideals to which members of a profession should aspire.

By contrast, specific or compliance-based ethical guidelines are more specific rules or duties derived from those general ethical guidelines and duties. They offer more precise guidance and direction for action in concrete situations. They also make it easier to implement sanctions against transgressors.

It is impossible, however, to develop a complete set of specific ethical prescriptions applicable to all conceivable real-life situations. In concrete cases, health professionals may have to work out for themselves what course of action can best be defended ethically. This requires ethical reasoning.

This Annexure has two sections:

- **Section One** lists thirteen core ethical values and standards that underlie professional and ethical practice, and gives a short explanation of how one makes practical decisions through ethical reasoning.

- **Section Two** explains what a duty is, and catalogues the general ethical duties of health professionals.

[1] Pellegrino, ED. Medical professionalism: Can it, should it survive? *J Am Board FAM Pract* 2000; **13**(2):147-149 (quotation on p. 148).

SECTION ONE - ETHICS

1. CORE ETHICAL VALUES AND STANDARDS FOR GOOD PRACTICE

1.1 Everything ethically required of a professional to maintain good professional practice is grounded in core ethical and professional values (in boldface below) and standards (the directives following the core values). Although these core values and standards may be presented as a hierarchy (for example, autonomy and confidentiality may be classified under respect for persons), it is presented as a linear list for the sake of simplicity.

1.2 In concrete cases, the demands of these core values and standards may clash, thus making competing demands on health professionals. The only way to address such clashes is through ethical reasoning.

- **Respect for persons:** Respect patients as persons, and acknowledge their intrinsic equal worth, dignity and sense of value.
- **Best interest or well-being: Non-maleficence:** Do not harm or act against the best interests of patients, even when they conflict with the health professional's own interest.
- **Best interest or well-being: Beneficence:** Act in the best interests of patients even when there are conflicts with the health professional's own interest.
- **Human rights:** Recognise that some interests of individuals may be so important that they acquire the status of human rights in the form of either claims or freedoms to be respected by all.
- **Autonomy:** Honour patients' right to self-determination or to make their own informed choices, living their lives by their own beliefs, values and preferences.
- **Integrity:** Incorporate core ethical values and standards as the foundation for good and upright character and responsible practice.
- **Truthfulness:** In professional relationships with patients, regard the truth and truthfulness as the basis of trust.
- **Confidentiality:** In professional relationships with patients, treat personal or private information as confidential, unless overriding reasons confer a moral right to disclosure.
- **Compassion:** Be sensitive to and empathise with individual and social needs for comfort and support, and seek and create opportunities to translate emotions, such as feelings of sympathy or empathy into action.
- **Tolerance:** Respect the right of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions.
- **Justice:** Treat all individuals and groups in an impartial, fair and just manner.
- **Professional competence and self-improvement:** Continually endeavour to attain the highest level of knowledge and skill required within the health professional's area of practice.

- **Society:** Consistent with his or her professional abilities and standing in the society, a health professional should strive to contribute to the betterment of society.

- **Privacy and the protection thereof.**

2. ETHICAL REASONING

2.1 The core values and standards referred to above are the foundations that ground the general or inspirational ethical guidelines. Being general, such guidelines can be applied to many different concrete cases.

2.2 But how does one proceed from these guidelines to making practical decisions or choices? How does a guideline apply in a specific case and how do we handle difficult cases where two (or more) guidelines prescribe contradictory solutions?

2.3 Briefly, what is needed is **ethical reasoning**. Roughly speaking, such practical reasoning proceeds in four steps:

- **The problem:** Formulate the problem. Is there a better way of understanding it?

- **Information:** Gather all the relevant data (clinical, personal, social, etc.).

- **Options:** Consider all reasonable options, choices or actions under the circumstances.

- **Moral assessment:** Weigh the ethical content of each option by asking the following:

  - What are the likely consequences of each option?

  - What are the most important values, duties and rights of the client/patient and his/her family and social group, and which weighs the heaviest?

  - What are the weaknesses of your view?

  - How would you want to be treated in the circumstances of the case? That is, apply the *Golden Rule*.

SECTION TWO - GENERAL ETHICAL DUTIES

1. WHAT IT MEANS TO HAVE A DUTY

1.1 Ethical guidelines express duties. A duty is an obligation to do or refrain from doing something.

1.2 If we have a duty to another person, it means we are bound to that person in some respect and for some reason. We owe that person something. In addition, he or she may hold a corresponding right or claim against us.

1.3 For example, I reach an agreement with a colleague that he/she would locum for me while I am away on family business. We then have corresponding duties, rights and claims. He/she has a duty to do the locum for me, and I have a right to his/her professional services; she has a right to fair remuneration, and I have a duty to compensate his/her.

1.4 To have a duty is to face the question "What do I owe others?" To have a right is to face the question "What do others owe me?"

1.5 Duties may be ethical, legal, or both. And duties operate in the personal, social, professional or political spheres of our lives.

1.6 Concurrently, health professionals are human beings and fulfill institutional roles. Accordingly, we have different types of duties:

- **As human beings we have "*natural duties*"**, namely unacquired general duties, simply because we are members of the human community. 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, health professionals owe these duties to all other people, whether patients or not, and quite independently of our professional qualifications.

- **As professionals we have *"moral obligations"***, namely general duties we acquire by being qualified and licensed as professionals, that is, professionals entering into contractual relationships with patients, for example the professional duties to provide medical care, relieve pain, gain informed consent, respect confidentiality, respect and consider client choices and be truthful.

- **As professionals working in specific institutions or settings we have *"duties"***, namely, acquired duties specific to our particular institutionalised role or position.

  For example the duties of a nurse or physiotherapist employed by a hospital, a social worker in the employ of a prison, or a general practitioner or specialist in a solus practice. These duties are circumscribed in employment contracts, job descriptions, conventional expectations and similar guidelines.

1.7 Duties listed here fall broadly in the second category – the general, but acquired duties of a health professional as a professional.

1.8 No duty is absolute or holds without exception irrespective of time, place or circumstance. This is not surprising, since different duties may prescribe quite opposite decisions and actions in a specific concrete or real-life situation.

1.9 For example, our duties to our patients may compete with our duties to our employer. Or our duty to respect a patient's confidentiality may clash with our duty to protect innocent third parties from harm (HIV/AIDS examples are particularly perplexing). These are instances of conflicts of interest or dual loyalties.

1.10 Still, it does not follow that we are free to take duties lightly. Some duties are indeed more stringent than others, but all duties need to be taken very seriously, and should only be overridden by an even more stringent competing duty in the concrete circumstances of a specific case. This entails weighing or balancing duties against one another in a process of ethical reasoning.

1.11 No list of such duties is ever complete, but the catalogue of duties below presents a fairly comprehensive picture of what it is, in general, that binds any health professional as a professional to his or her patients, as well as to others. However, it should be noted that these duties, if not honoured without justification, may constitute the basis for sanctions being imposed on professionals by the HPCNA.

1.12 To some extent, any classification of duties is arbitrary, since a specific duty may be owed to different parties simultaneously. The classification system or convention used below should therefore be viewed as no more than a rough compass.

1.13 Bear in mind that underlying, and giving rise to these duties, are the core ethical values and standards for good practice identified in **Section One**.

2. DUTIES TO PATIENTS

2.1 PATIENTS' WELL-BEING OR BEST INTERESTS

A health professional should:

1. Always regard concern for the best interest or well-being of the patients also considering the patients cultural norm.

2. Honour the trust of the patient.

3. Be mindful that a registered health professional is in a position of power over a patient and should at all times avoid abusing his or her position. A health professional should use the power for the benefit of the patient and not for his/her own professional benefit.

4. Within the normal constraints of his or her practice, be accessible to patients when on duty and make arrangements for access when not on duty.

5. Make sure his or her personal beliefs of the profession do not prejudice care of the patients. Beliefs that might prejudice care relate to the patient's race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any other condition of vulnerability.

6. Inform the patient of his or her right to consult another professional should he or she feel that his or her beliefs might affect the treatment provide and should explain to patients.

7. Not refuse or delay treatment because the health professional believes that patients' actions have contributed to their condition, or because he or she may be putting his or her health at risk.

8. Apply his or her mind when making diagnoses and considering appropriate treatment.

9. Act quickly to protect patients from risk if the health professional believes that he or she is impaired.

10. Respond to criticism and complaints promptly and constructively.

11. Not employ any other health professional, e.g. intern, doctor or dentist who has restricted registration with the HPCNA as a *locum tenens*, in community service or otherwise in own or any associated health care practice.

12. Inform his or her patient if in the employ of, working in association with, linked to or have an interest in any organisation or facility that could be interpreted by an average person as potentially creating a conflict of interest or dual loyalty in respect of his or her patient's care.

13. Provide health care in emergency situations within the limits of his or her practice, experience and competency. If unable to do so, refer the patient to a colleague who can provide the required care.

14. Other than in an emergency situation, have the right to refuse provision of care of a patient due to a personal conflict or possible conflicting interests.

2. 2 RESPECT FOR PATIENTS

A health professional should:

1. Respect patients' privacy and dignity.

2. Treat patients politely and with consideration.

3. Listen to the patients and respect their opinions.

4. Honour the opinion of the patient if informed and in a mental condition to make a decision.

5. Avoid improper relationships (for example sexual relationships or exploitative financial arrangements) with the patients, their friends or family members.

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

2.3 INFORMED CONSENT

A health professional should:

1. Give his or her patients the information they ask for or need about their condition, the treatment and prognosis.

2. Give information to patients in the way they can best understand it.

3. Refrain from withholding from his or her patients any information, investigation, treatment or procedure that is in the patient's best interest.

4. Apply the principle of informed consent as an on-going process.

5. Allow patients access to their medical records. **(See Guidelines on keeping of medical records)**.

2.4 PATIENT CONFIDENTIALITY

A health professional should:

1. Recognise the right of patients to expect that the health professional will not pass on any personal and confidential information he or she acquires in the course of his or her professional duties, unless they agree to disclosure, or the health professional has a good and overriding reason to do so. (Examples of such reasons may be any probable and serious harm to an identifiable third party, a public health emergency or any overriding and ethically justified legal requirements.)

2. Not breach confidentiality without sound reason and without the knowledge of the patient.

3. Ask the patients' permission before sharing information with the spouses, partners or relatives.

4. Protect the identity of your patient (e.g. if taking pictures).

2.5 PATIENT PARTICIPATION IN THEIR OWN HEALTH CARE

A health professional should:

1. Respect the right of the patient to be fully involved in decisions about their treatment and care.

2. Respect the right of the patient to refuse treatment or to take part in teaching or research.

3. Inform the patient that they have a right to seek a second opinion without prejudicing their future treatment.

4. Inform on request and make available to the patient the chemical composition and effects of substances used for treatment.

2.6 IMPARTIALITY AND JUSTICE

A health professional should:

Be aware of the rights and laws concerning unfair discrimination 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 in the management of patients or their families as is contained in health rights legislation (see booklet on the patient charter).

2.7 ACCESS TO CARE

A health professional should:

Promote access to health care. If unable to provide a service, he or she should ensure continuity of care by referring the patient to another registered health professional or health care facility that can provide the required service.

2.8 POTENTIAL CONFLICTS OF INTEREST

A health professional should:

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

2. Avoid over servicing. Recommend or refer patients for relevant and necessary investigations and treatment only. Prescribe only treatment or appliances that will serve the patient's needs.

3. Declare to his or her patients verbally or by a notice displayed, any financial interest that the health professional may have in an institution or diagnostic equipment to which the health professional makes referrals.

4. Refrain from placing pressure on patients or their family to give the health professional's gifts or any other undue benefit.

5. Do not offer undue benefits to patients to pressurize them to utilize certain services.

3. DUTIES TO COLLEAGUES AND OTHER PROFESSIONALS

3. 1 REFERRALS TO COLLEAGUES AND POTENTIAL CONFLICTS OF INTEREST

A health professional should:

1. Act in the patient's best interest when making referrals and providing or arranging treatment or care.

2. Not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the health professional's judgement.

3. Not offer such inducements to colleagues.

4. Treat patients referred to the health professional, even when on a temporary basis or

. when acting as a locum *tenens*, according to these guidelines.

5. A health professional should be aware of his limitation and his/her scope of practice.

3. 2 WORKING WITH COLLEAGUES

A health professional should:

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

2. Not discriminate against colleagues, including professionals applying for posts, on the basis of the health professionals views of the patients race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status,HIV/Aids status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability.

3. Refrain from speaking ill of colleagues or other health professionals. Respect different approaches and viewpoints. Appreciate the value of different scopes of practice in the multidisciplinary team, knowledge base and skills and use these to the advance of the patient.

4. Not make a patient doubt a fellow health professional's knowledge or skills by making unfavorable comments about a fellow health professional.

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

7. Refer patients back to the referring health professional upon completion of care contemplated in the referral.

4. DUTIES TO PATIENTS REFERRED BY OTHER HEALTH PROFESSIONALS

A health professional should avoid or minimize:

4.1 Risk of harm to patients referred by other health professionals

1. Act quickly to protect the patient from risk if the health professional regards a colleague to be impaired.

2. Report violations and seek redress in circumstances where he or she has good or persuasive reason to believe that the rights of patients are being violated.

5. DUTIES TO SELF

5.1 KNOWLEDGE, SKILLS AND ATTITUDES

A health professional should:

1. Maintain and improve the standard of his or her performance by keeping professional knowledge and skills up to date throughout the working life. In particular, regularly take part in educational activities that relate to the branch or discipline.

2. Acknowledge the limits of his or her professional knowledge and competence by not pretending to know everything.

3. Observe and keep abreast with laws that govern aspects of professional health care practice that affect his or her practice.

5.2 MAINTAINING A PROFESSIONAL PRACTICE

A health professional should:

1. Keep equipment in good working order.

2. Maintain proper hygiene in the working environment.

3. Keep accurate and up-to-date patient records.

4. Refrain from engaging in activities that may affect the health of the health professional and lead to impairment.

6. DUTIES TO YOUR PROFESSION

6.1 REPORTING UNPROFESSIONAL CONDUCT

A health professional should:

1. Report violations and seek redress in circumstances where he or she has good or persuasive reason to believe that the rights of patients are being violated.

2. Where it is in the health professional's power, protect someone who reports misconduct from victimisation or intimidation.

7. DUTIES TO SOCIETY

7.1 ACCESS TO SCARCE RESOURCES

A health professional should:

1. Deal responsibly with scarce health care resources.
2. Refrain from providing a service that is not needed, whether it provides financial gain or not.
3. Refrain from wastage.
4. Refrain from participating in improper financial arrangements, especially those that escalate costs and disadvantage individuals or institutions unfairly.
5. Refrain from improper and unfair practices that could have a financial disadvantage on individuals or institutions.

7.2 HEALTH CARE POLICY DEVELOPMENT

A health professional should:

Include ethical considerations and human rights as well as ethics of care in the development of health care policies.

8. DUTIES TO THE ENVIRONMENT

8.1 CONSERVATION OF NATURAL RESOURCES

A health professional should:

Recognise that natural resources are limited and guard against it's over exploitation.

8.2 DISPOSAL OF HEALTH CARE WASTE

A health professional should:

Strive to protect the environment and the public by assuring that health care waste is disposed of legally and in an environmentally friendly manner.

9. RESEARCH

A health professional should:

1. Obtain authorization from relevant authorities when engaging in research.

2. Make results publicly known and to give feedback on the results in an accessible and understandable form to the participants.

3. Compensate participants for any material loss or costs incurred.

4. Have informed consents from participants.

5. Apply justice and make sure that people whose indigenous knowledge is used will get compensated for this.

6. Make sure that participants understand that they may withdraw from the research at any time during the research without adverse consequences.

7. Guard to protect person’s privacy and maintain confidentiality.

2. GUIDELINES FOR MAKING PROFESSIONAL SERVICES KNOWN

1. INTRODUCTION

1.1 Health professions in this country have long accepted the convention that health professionals should refrain from self-promotion, because the health professional who is most successful at getting publicity may not necessarily be the most appropriate one to treat a patient. Furthermore, patients (and their families) experiencing health problems are often particularly vulnerable to persuasive influences via unprofessional advertising.

1.2 It is primarily to protect the fundamental rights of patients, and health professionals themselves, that governance of notifications and advertisements is imperative.

1.3 Health professionals are encouraged to approach their professional associations, unions or societies for guidance if they have doubts as to the appropriateness and/or acceptability of an advertisement or notification.

2. GUIDING PRINCIPLES

2.1 Patients are entitled to expect that health professionals will give them comprehensive professional advice and guidance on alternative treatments and second opinions, where appropriate. Failure to respect these patient rights can erode the health professional/patient relationship on which good professional practice depends.

2.2 Health professionals are at all times responsible for their own professional conduct.

2.3 Patients are entitled to protection from misleading promotional, advertising or improper competitive activities among health professionals. Publications, improperly drawing attention to the titles, professional attainments, personal qualities, superior knowledge or quality of service of a particular health professional, or improperly drawing attention to the health professionals practice or reduced prices offered, may be construed as unprofessional conduct. In such cases account will be taken of:

2.3.1 The motive of the health professional concerned in arranging for or agreeing to such publication;

2.3.2 The nature, content and presentation of the material;

2.3.3 Whether the material seeks to suggest the health professional has particular abilities as compared to other practitioners;

2.3.4 Whether the material is published in a manner likely to attract patients to the health professional, or to promote his or her professional advantage or financial benefit;

2.3.5 Whether the material is likely to encourage patients to refer themselves directly to a particular health professional or organisation.

2.4 Advertising in an unprofessional manner or canvassing and touting for patients are regarded as unethical behaviour, and would constitute a breach of professional conduct.

3. INFORMATION THAT MAY BE INCLUDED IN NOTIFICATIONS

The aim of publication of notices is to inform patients of the whereabouts of practitioners. It is not intended to be an instrument for promoting individual practices.

3.1 A health professional may make information about his or her practice known by publishing notices in any medium, printed or electronic, including the Internet and television, provided that they comply with all the provisions of these guidelines.

3.2 There are no limitations on the size or number of times a notice may be published.

3.3 Direct mailing of pamphlets is permissible, i.e. mailing to post boxes or direct delivery to homeowners.

3.4 Bulk pamphlets may be made available for issue individually to existing patients at the rooms of health professionals and also at local information centres such as libraries and museums to persons enquiring about a health professional's practice or available services.

3.5 Bulk distribution of pamphlets, for example, at shopping malls and to passing motorists, is not permissible.

3.6 The use of passport photographs on notifications is permissible.

3.7 The following information may appear on notifications namely:

3.7.1 First name(s) and surname;

3.7.2 Profession (only the practitioner's profession, as registered with the relevant Council, may be specified: Descriptive names, such as *"nose surgeon"* or *"family dentist"* or *"eye specialist"* are not permissible);

3.7.3 Registered qualifications;

3.7.4 Registration category and registration number with Council under the relevant Health Professions Act.

3.7.5 Professional category registered with Council under the relevant Act;

3.7.6 Practice address and, where necessary, a map with regard thereto;

3.7.7 Consulting hours;

3.7.8 Telephone number(s);

3.7.9 **Field (s) of practice:**

If a health professional chooses to make known that he or she practises in a specific field, such health professional assumes a legal and ethical responsibility for having acquired a level of professional competence within that field of expertise which must be demonstrable and acceptable to his or her peers.

Note that "field of practice" is not the same as "field of interest" and that an indication of a field of practice is only permissible if a practitioner limits, or for the most part, limits his or her practice to that field of practice;

Information on financial arrangements:

Such information must be limited to statements relating to formal arrangements, e.g.: acceptable credit cards, preferred form of payment *("cash only")*, etc. Reference may not be made to discounts or *quantum* of fees.

Telephone directories:

Entries in bold letters are permissible, but no logos, body or anatomical parts are permitted to be published in the telephone directory or any other similar publication.

4. ADVERTISING OF EMPLOYMENT OPPORTUNITIES

It is permissible to advertise an employment opportunity for health professionals in newspapers and/or relevant professional journals as well as online professional web pages.

5. DUTY OF HEALTH PROFESSIONAL IN RELATIONSHIP WITH OR IN THE EMPLOY OF AN INDEPENDENT ORGANISATION

5.1 The duty of a health professional who is in relationship with or employed by independent organisations offering or advertising clinical, diagnostic or medical advisory services such as a private hospital, clinic, screening centre, nursing home or advisory bureau or agency or who intends to enter into such relationship or employment, except non remunerative professionals working for non profit organizations.

5.1.1 Can only do so on the basis of a written contract or agreement that should be available to the Council on request;

5.1.2 Must satisfy himself or herself before entering into a contract or written agreement with such organisation that:

a. The advertisements of or promotional activities of the organisation concerned are factual;

b. Such advertisements do not promote the personal qualities or services of individual health professionals connected with it;

c. Such advertisements do not make invidious comparisons with the services of the public sector or with those of other organisations or health professionals;

d. The organisation discourages patients from approaching it without first consulting their own practitioners;

e. Patients referred to him or her are not likely to be attracted by misleading or promotional advertisements issued by the organisation or by counselling centres or other agents;

f. No commission or other payment has been made or will be made on behalf of the organisation for the referral of such patients;

5.1.3 Ensure in such a relationship that the autonomy of the health professional is maintained at all times.

5.2 Should avoid personal involvement in promoting the services of such an organisation, for example by public speaking, broadcasting, writing articles or signing circulars;

5.3 Should not permit the health professionals qualifications and status to be used in the organisation's promotional activities;

5.4 Should not allow that the health professional's personal address or telephone number(s) or other electronic contact details to be used as an enquiry point on behalf of such organisations;

5.5 Should be satisfied that organisations that provide specialist services with regard to the services referred to in item 5.1 should also observe these guidelines;

5.6 Should ensure that his or her name and qualifications are not used on reports, notices, notepaper or other stationery of such organisations.

6. PRACTICE NOTICES TO PATIENTS

6.1 Health professionals may communicate with their *bona fide* patients via practice notices, but such communications may not be distributed to the public at large.

6.2 These notices may include information about the health professionals own practice arrangements (e.g. new partners), health care information (e.g. flu vaccinations) and changes in tariff structures.

7. COMMUNICATION WITH COLLEAGUES

7.1 It is permissible common practice and should be encouraged amongst health professionals to communicate the setting up of a new practice or practice address changes to fellow health professionals.

7.2 Despite the limitation on the information that should be included in notifications and advertisements as stated above, communications to colleagues may include information on field of practice, e.g. "treatment of AIDS patients".

8. DIRECTORIES AND PUBLIC LISTS

8.1 Prospective patients and other health professionals should have ready access to accurate, comprehensive, and well-presented information about the health professionals practicing in their area in order to make informed choices.

8.2 Directories and public lists with the names of health professionals and their practice details, including other factual information as specified under item 3 of this section, may be distributed for the benefit of members of the public and peers, with the written consent of the individual health professional.

8.3 All health professionals in a specific area should be eligible for inclusion in such directories or public lists.

8.4 The names and particulars of health professionals listed in such directories and public lists should be of the same size and format normally on offer. Bold entering should be on offer permissible.

9. INFORMATION ON PROFESSIONAL STATIONERY

9.1 Professional stationery may contain the following information:

9.1.1 Names (including references to an incorporated company, e.g. “Dr XYZ Incorporated”; a partnership, e.g. “Dr XYZ and Partners”);

9.1.2 Profession;

9.1.3 Registration category and registration number and registered field of specialisation (if applicable);

9.1.4 Registered professional qualifications;

9.1.5 Academic qualifications (other than professional qualifications) and honorary degrees in abbreviated form;

9.1.6 Address (es);

9.1.7 Telephone numbers;

9.1.8 Hours of consultation; and

9.1.9 Practice number(s);

9.1.10 Trade name;

9.1.11 Fax number;

9.1.12 Company or CC registration number, as required by law;

9.1.13 VAT registration number;

9.1.14 Electronic contact details (e-mail address);

9.1.15 Website address;

9.1.16 Logo.

9.2 A health professional who is a director of a company may include his or her title, name and qualifications, or as otherwise directed by statute, on the company’s official documentation. This also applies to stationery used in a non-professional capacity. A practitioner may also make mention of associates and assistants affiliated to his or her practice.

9.3 Reference to a health professional’s achievements is not allowed.

9.4 The use of business or appointment cards is permissible.

9.5 Logos may be used on professional stationery and outside signboards, but may not depict anatomical structures, graphics and/or pictures which may be misleading.

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9.6 The expression anatomical structure means:

9.6.1 A structure which forms part of the body; but

9.6.2 A picture or drawing, for example of a sprinting athlete, would be considered a picture or a drawing of a human being and not to be an anatomical structure;

9.7 In addition to the title “doctor”, a person who is permitted to use the title “professor” (even after retirement) may use it on his or her stationery, but such reference shall not be allowed on other notices or outside signs.

10. OUTSIDE SIGNS AND NAMEPLATES

10.1 Signs and nameplates may contain some or all of the following information, but nothing more:

10.1.1 Names (initials) and surname of the health professional;

10.1.2 Profession (e.g. medical doctor, occupational therapist);

10.1.3 An indication of the location of the practice (e.g. room number, street number, name of the building);

10.1.4 Telephone number(s);

10.1.5 Consulting hours;

10.1.6 The Red Cross and Red Crescent symbols may not be used by health professionals:

This emblem was adopted by the International Federation of Red Cross and Red Crescent Societies and may only be used as authorised in terms of the ‘1991 Regulations on the use of the Emblem’.

10.2 Only one outside sign may be used, except in the case of a large complex with more than one entrance where a sign may be placed at each entrance. The sign should be placed on the premises where the practice is situated or at most, at the street corner closest to the premises.

10.3 A nameplate may be used on the door of the consulting room.

10.4 In the case of occupants of large complexes where special provision is made in the entrance hall and on the various floors to indicate the tenants, it shall be permissible to make use of such provision.

10.5 If necessary, in large complexes, a nameplate with the name of the health professional only, may be used in the corridor for the direction of the patients.

10.6 An outside sign indicating “PRIVATE PARKING FOR ……..” (indicating the street name and number only) will be permissible (for example PRIVATE PARKING FOR 23 FORD STREET).

10.7 In the event of a change in the membership of a company, partnership, or association, the original nameplate may be displayed for a period not longer than six months after which a nameplate with the correct information should be displayed. Should a practice move to other premises, the name of the practice and the new address may also be displayed at the vacated address for a period not longer than six months.

10.8 If an illuminated sign is used, the only source of illumination may be a constant light.

11. PRACTICE NAMES

11.1 Health professionals may use as the name of a practice, their own names and/or the names of their partners, directors or associates or the name of one or of certain partners or associates or directors, together with the words “and partners”, “incorporated” or “and associates”, as the case may be.

11.2 Descriptive trade names for health professionals in solus practices, partnerships, associations and incorporated practices may be used, but may not be touting, soliciting or misleading in nature.

11.3 Health professionals in any of the types of practices referred to above would, however, be permitted to name such practices after their own name or the names of their associates or partners, without limitation on the duration thereof, for example the name or names of a partner or associate could be retained by the practice even after the death of such a partner or associate.

11.4 The use of an expression such as “hospital”, “clinic” or “institute” or any other special term which could create the impression that a practice forms part of, or is in association with a hospital, clinic or similar institution, may not be used.

11.5 A building occupied by health professionals who are registered with the Health Professions Council of Namibia may have a name indicating the profession of the occupants only if there are at least two such independent professional practices in the building. Should only one such professional practice (e.g. a medical practitioner, psychologist or optometrist) be conducted in the building and the name of the building refers to that profession (e.g. medical centre, psychology centre, optometry centre) the impression may be created that that single practice is more important than other individual practices. In the case of registered health professionals of different professions such as a medical practitioner, psychologist and optometrist practicing in the same building, the name “Health Practices”, however, may be used.

12. HEALTH PROFESSIONALS AS AUTHORS

12.1 A health professional who is the author or co-author of books or articles may mention his or her own name as author or co-author, as the case may be, and indicate his or her professional standing as this promotes the profession’s duty to disseminate information about advances in health sciences.

12.2 Health professionals with the necessary knowledge and skills may participate in the presentation and discussion of health topics by means of public addresses or through the printed or electronic media to lay audiences, provided that no information about their standing is given which may imply that a practitioner is the only, the best, or the most experienced in his or her particular field.

12.3 Health professionals should not divulge details of their practices when participating in the aforementioned presentations or discussions as this may be construed as touting or canvassing for patients.

12.4 Health professionals should preferably remain anonymous or use a pseudonym when participating in radio, television or Internet programmes. Health professionals acting as spokespersons for an organisation or institution may be named. It should also be stated explicitly that health professionals cannot offer individual advice or see patients who heard the programme or read the article.

13. GENERAL

13.1 Notifications about health professionals, who stand in a relationship with private hospitals, clinics, and the like, must in all respects conform to these guidelines. Notifications about health professionals with registered specialties must also conform to these guidelines.

13.2 It is not possible for the HPCNA to consider, on an individual basis, notifications to be published by health professionals. Furthermore, it should be noted that the HPCNA retains the final authority for deciding on the acceptability or not of the content and format of notifications put out by health professionals. .

13.3 In the case of uncertainty about the application of these guidelines or in the case of intended promotional action or notifications that are not covered within these guidelines, health professionals should consult their professional associations or societies or unions for appropriate guidance. Professional associations, unions or societies should on their part, in the case of intended promotional actions or notifications not covered in these guidelines, consider to make appropriate recommendations to the relevant Council on how to deal with such matters within three months of being called upon by the Council to do so.

EXAMPLE OF NOTIFICATION

NO RESTRICTION ON SIZE OR TYPESTYLE

Dr A B SMITH	Name
MB BCh, Dip Med COG(SA) FRCOG	Registered qualifications
GYNAECOLOGIST & OBSTETRICIAN	Profession/speciality/professional category
INFERTILITY TREATMENT	Field of practice
CONSULTATION BY APPOINTMENT ONLY	
MON-FRI 08h00-13h00 MON-FRI 13h30-18h30 Windhoek North SOUTH BUILDING Windhoek 120 HARVEY STR (Opp Rhino Park Hospital)	Hours of practice Practice address
TEL: (061) 202046 TEL: (061) 203259	Practice Tel No
EMERGENCY TEL: (061) 235374	Emergency hours Tel No
CREDIT CARDS ACCEPTED	Financial arrangements (E.g. SMBA, Infinity, 3rd party payments) no mention of discounts or quantum of fees to be made)
REGISTRATION NO: 000000000000	Health Professions Council registration no.
PRACTICE NO: 00000000	*Practice Number*

3. POLICY STATEMENT PERTAINING TO PERVERSE INCENTIVES AND RELATED MATTERS FOR HEALTH PROFESSIONALS

1. INTRODUCTION

1.1 The HPCNA holds the view that a health professional should at all time act in the best interest of the patient and place the clinical need of the patient paramount. To this end, a health professional should always try to avoid potential conflicts of interests and maintain professional autonomy, independence and commitment to the appropriate professional and ethical norms. Any conflicts of interests or incentive or form of inducement which threatens such autonomy, independence or commitment to the appropriate professional and ethical norms or which does not accord first priority to the clinical need of a patient, is unacceptable. The ownership and use of high technology equipment creates a special problem, not only because of inappropriate use by health professionals not duly qualified, but also due to over-servicing by appropriately qualified health professionals. In general, problems related to the usage of high technology equipment are already covered by the relevant stipulations of this policy statement. It needs to be emphasized, however, that **over-servicing of whatever nature is unacceptable**.

1.2 In this policy statement, the HPCNA seeks to identify those incentive schemes and forms of inducement which it finds unacceptable. It must be clearly stated that the perverse incentives or potential conflicts of interests set out in this document should not in any way be regarded as an exhaustive list. The principles underlying these listed perverse incentives will apply in every case of alleged unprofessional conduct on the part of a health professional and where applicable will form the basis for an investigation by the Councils.

1.3 The policy statements pertaining to perverse incentives as contained in this document shall be applicable to health professionals in both the public and private sectors.

1.4 It should further be noted that in terms of this policy statement, it would be an offence either to offer an inducement or to accept one.

1.5 In addition to any action which Council might take in terms of other legislation that governs the Councils, Council may lay a charge against any person(s), or corporate body (ies) or other legal entity in terms of the Anti Corruption Act 2003 (Act No. 8 of 2003), should the actions or omissions of such person(s), body (ies) or other legal entity be in breach of the provisions of the said Act or any other legislation (e.g. internal or relevant Act).

2. DEFINING OF CONCEPTS

For the purpose of this policy statement, the following concepts will have the meanings as indicated below, unless the context otherwise indicates. It should be noted that these concepts have not been defined for legal purposes, but merely to clarify the meaning of the policy statement. It should further be noted that some of these definitions have been based on various pieces of legislation.

2.1 "**Advertise**" in relation to any health establishment, orthodox medicine, complementary medicine, medical device, scheduled substance, health related product or service means any written, pictorial, visual or other descriptive matter or verbal statement or reference in respect thereof:

a. appearing in any newspaper, magazine, pamphlet, journal or any other publication; or

b. distributed to members of the public; or

c. brought to the notice of members of the public in any other manner whatsoever,

which is intended to promote the sale of that orthodox medicine, complementary medicine, medical device, scheduled substance or health related product or to attract patients to any particular health establishment or health related service.

2.2 "**Complementary medicine**" means any substance, or mixture of substance, which:

a. originates from a plant, mineral or animal, and which may be, but is not limited to being classified as herbal, homoeopathic, ayurvedic or nutritional; and

b. is used or intended to be used for, or manufactured or sold for use in, or purported to be useful in, complementing the healing power of a human body or for which there is a claim regarding its effect in complementing the healing power of a human in the treatment, modification, alleviation or prevention of a disease, abnormal physical or mental state or the symptoms thereof in a human being and

c. is used in, but not limited to, the disciplines of Western herbal, African traditional, traditional Chinese, Homoeopathy, Ayurveda, Aromatherapy and Nutritional supplementation; or

d. because of its origin, intended use or use in a discipline, is determined by the relevant authority, by notice in the government gazette, to be a complementary medicine.

2.3 "**Endorse**" means any action whereby a person or body attaches approval to or sanctions any health establishment or orthodox medicine, complementary medicine, medical device or scheduled substance or other health related product or service with a view to encouraging or promoting the preferential use or preferential sale thereof for the purpose of financial gain or other valuable consideration for oneself or for another health professional.

2.4 "**Health establishment**" means an institution, facility, building or place where persons receive treatment, diagnostic or therapeutic interventions or other allopathic or complementary health services and it includes facilities such as a clinic, mobile clinic, hospital, community health centre, maternity home or unattached delivery suite, convalescent home, consulting room, dispensary of health related treatment or aids and appliances, first aid station, orthopaedic workshop, dental laboratory or workshop, ambulance, unattached operating theatre, sanatorium, laboratory, pharmacy, occupational health clinic, radiological clinic, and health spa or hydro or any other registered place where health professionals practice their profession.

2.5 "**Health related product**" means any commodity other than orthodox medicine, complementary medicine, medical device or scheduled substance which is produced by

human effort or some mechanical, chemical, electrical or other human engineered process for medicinal purposes or other preventive, curative, therapeutic or diagnostic purposes in connection with human health.

2.6 "**Improper financial gain or other valuable consideration**" means money, or any other form of compensation, payment, reward or benefit which is not legally due or which is given on the understanding, whether express, implied or tacit, that the recipient will engage or refrain from engaging in certain behaviour in a manner which is either:

a. illegal; and/or

b. contrary to ethical or professional rules; and/or

c. which, in the opinion of the Council, may adversely affect the interests of a patient or group of patients,

in order to procure some direct or indirect advantage, benefit, reward or payment for the person offering or giving the said money, compensation, payment, reward or benefit.

2.7 "**Medicinal purposes**" in relation to a scheduled substance, means the purpose of treatment or prevention of a disease or some other definite curative or therapeutic purpose, but does not include the satisfaction or relief of a habit or a craving for the substance used or for any other scheduled substance, except where the substance is administered or used in a hospital or similar institution maintained wholly or partly by the Government or approved for that purpose by the relevant Minister.

2.8 "**Orthodox medicine**" or "**Medicine**" means any substance or mixture of substances intended to be used by, or administered to human beings, for any of the following therapeutic purposes:

a. treating, preventing or alleviating symptoms of disease, abnormal physical or mental state or the symptoms thereof;

b. diagnosing disease or ascertaining the existence, degree or extent of a physiological condition;

c. otherwise preventing or interfering with the normal operation of physiological function, whether permanently or temporarily and whether by way of terminating, reducing, postponing or increasing or accelerating the operation of that function.

2.9 "**Medical device**" **or** "**device**" means any instrument, appliance, material, machine, apparatus, implant or diagnostic reagent or any other article, whether used alone or in combination, including software necessary for its proper application used for or purporting to be suitable for use or manufactured or sold for use in or on a human or animal body:

a. in the diagnosis, prevention, monitoring, treatment or alleviation of disease; or

b. in diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap; or

c. in the diagnosis of pregnancy, or the control of conception or termination of pregnancy,

d. in investigation, replacement or modification of the anatomy or of a physiological process; or

and which does not achieve its principal intended action in or on the human body by chemical, pharmacological, immunological or metabolic means, but which may be assisted in its function by such means.

2.10 "**Over-servicing**" means the 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 or which is not in accordance with the recognised treatment protocols and procedures, without due regard to both the financial and health interests of the patient.

2.11 "**Promote**" means any action taken by a person(s) or body or allowed to be taken by such person(s) or body to further or to encourage the preferential use of any health establishment, orthodox medicine, complementary medicine, medical device, scheduled substance, health related product or service or to further or encourage the preferential sale of any such product or service for the purpose of financial gain or other valuable consideration. This definition does, however, not prohibit the normal practice of those professions where, in terms of their scopes of practice, it is appropriate to sell at market related prices.

2.12 "**Health professional**" means any person registered in terms of the applicable Act which governs the functioning of any of the Councils.

2.13 "**Scheduled substance**" means any medicine prescribed under section 1 of the Medicines and Related Substances Control Act, 2003 (Act No. 13 of 2003) amended by the Medicines and Related Substances Control Act, 2007 (Act No.8 of 2007)

2.14 "**Spouse**" means a person's partner in marriage and includes for the purpose of this policy statement, a person with whom another person lives as if they were married or with whom one habitually cohabits.

2.15 "**Trade**" means an act or instance of buying, selling or purchasing goods and services for the purpose of financial gain or other valuable consideration.

3. POLICY STATEMENTS

The following is not permissible for any health professional, nor is it ethical for any health related body to encourage a health professional to engage in the following acts:

3.1 OVER-SERVICING

Engage in any activity or action that could be regarded as over-servicing

3.2 MANUFACTURING

Either manufacture or to participate in the manufacture, for commercial purposes or trade, of orthodox medicine, complementary medicine, medical device or scheduled substance or health related product, except where such medicine or device or substance or product forms an integral part of the normal scope of practice of a health profession or where explicit permission was granted to a health professional by the Council to manufacture or to participate in the manufacture of such medicine, device, substance or product.

3.3 ADVERTISING

Advertise, endorse or encourage the use of any health establishment, orthodox medicine, complementary medicine, medical device, scheduled substance, health related product or service in a manner that preferentially promotes the practice of a particular health professional or a health facility for the purpose of improper financial gain or other valuable consideration.

3.4 PREFERENTIAL USAGE OR PRESCRIPTION

Engage in or advocate the preferential usage of any health establishment or medical device, health related service or prescribe any orthodox medicine, complementary medicine or scheduled substance, if any improper financial gain or other valuable consideration is derived from such preferential usage or prescription or the advocacy of preferential usage by the health professional, unless entitled by law.

3.5 REFERRAL

3.5.1 Self-referral

Self-referral of clients or patients to any health establishment in which the health professional or a close family member or business associate has a financial interest or potential conflicts of interest (e.g. X-ray facilities, Cathlab, Pathlab, or other such services) if such referral would constitute over-servicing.

3.5.2 Other referral

Referral of clients or patients to any health establishment or to other health professionals if such referral would constitute over-servicing.

3.6 TECHNOLOGICAL EQUIPMENT

3.6.1 The use of high-technological equipment has become an integral part of health care and has made a significant contribution to the rendering of accurate and high standards of healthcare in modern times.

3.6.2 New technological equipment is being introduced by manufacturers on an ongoing basis and a niche in clinical medicine is subsequently being sought in respect thereof. Aggressive marketing campaigns have, as a result, become rife.

3.6.3 Technological equipment should only be owned and used by a health professional if it forms an integral part of the scope of practice of that health professional and on condition that the health professional concerned has received appropriate training in using and managing such equipment.

3.6.4 Over-servicing by health professionals in whatever form, is in direct conflict with clause 3.1 of this policy statement.

3.7 SHAREHOLDING

3.7.1 A professional relationship is based on trust and the interests of the patient or client are paramount. Clinicians frequently have to advise patients to be admitted to hospital or to undergo particular tests or procedures. Any suspicion that such advice could be influenced in part by the clinician's own financial interest will undermine that relationship of trust. Furthermore, over-servicing by ordering or providing more tests, procedures or care than is strictly necessary, is a common problem in modern healthcare services. It is, therefore, morally hazardous for a health professional to refer patients to a facility or for a procedure in which that professional has a financial interest. All health professionals have an obligation to help to reduce this moral hazard and to protect the professional relationship and the long-term interests of the professions.

3.7.2 The intention is to reduce perverse incentives and, therefore Council will be expected to enforce these guidelines on ownership of shares in a reasonable manner. For example, ownership of a few shares in a publicly listed company which itself owns some of the shares in a private hospital group, is unlikely to act as a significant incentive to refer excessively to a particular hospital. However, regular referral of patients to a hospital by a health professional who, for example, owns 10% of the shares in that hospital is clearly a matter of concern. Similarly, referral of patients to a facility in which a health professional or his family have been offered and have accepted free shares is totally unacceptable.

3.7.3 It needs to be emphasised again that the intention is to address perverse incentives, for example over-servicing and not to interfere with the rights of health professionals. For example, a retired health professional who owns a substantial percentage of shares in a hospital or healthcare facility in which he or she has shares or who practices in a different professional field than what is provided by the hospital or healthcare facility in which he or she has shares, might not derive any direct financial gain from such hospital or healthcare facility. It would, therefore, not be required of such a health professional to declare his or her shares. It will, therefore, not be permissible for a practising health professional to:

a. Receive or acquire shares or any financial interest free of charge, or at a price which is less than the market value, in any undertaking which renders healthcare services or which sells, manufactures, markets or distributes any product which is used in healthcare;

b. Own shares or any financial interest in an undertaking which is not a company listed on any Stock Exchange, except in accordance with (c) below;

c. Own shares or any financial interest in any undertaking other than a company listed as described in paragraph (b), unless the following criteria have been met.

3.7.4 Where the health professional wishes to acquire shares or any financial interest in an undertaking, whether a body corporate or not, the following applies:

a. The arrangement in terms of which the shares or any financial interest in an undertaking, whether a body corporate or not, which render or provide healthcare services, are acquired, is reduced to writing and signed by all of the parties to the transaction; and furthermore, that the document thus signed by the parties concerned, contains the following information, namely the number and present value of the shares held; the name and address of the undertaking in which the shares are held; the number of shares held as a percentage of the total number of shares issued; the circumstances in which the shares were acquired (e.g. were they purchased or is the health professional a founder member of the undertaking, were they granted free of charge by the undertaking concerned or at a reduced rate; were they granted on an understanding of certain performance on the part of the health professional); the length of time for which the shares have been held.

b. The written document referred to in paragraph (a) is submitted by the health professional concerned to the Council together with an application in the prescribed form for approval of the ownership of the shares or other financial interest by the said health professional.

3.7.5 Where the health professional has acquired shares in a healthcare undertaking prior to the coming into force of this policy and the acquisition of such shares was not previously approved by the appropriate Council acting in accordance with any law or ethical or professional rule, the health professional shall:

a. Submit a written application to the relevant Council detailing the number and

present value of the shares held; the name and address of the undertaking in which the shares are held; the number of shares held as a percentage of the total number of shares issued; the circumstances in which the shares were acquired (e.g. were they purchased or is the health professional a founder member of the undertaking, were they granted free of charge by the undertaking concerned or at a reduced rate; were they granted on an understanding of certain performance on the part of the health professional); the length of time for which the shares have been held;

b. If there is a written document reflecting the nature of transaction in terms of which the shares in the undertaking were acquired, furnish a certified copy of such document together with the application referred to in paragraph (a);

c. Supply together with the application referred to in paragraph (a), details of any relationship or association, other than that of shareholder, which that health professional has with the undertaking in which the shares are held. For example, the shareholder may also conduct a practice from the premises of the undertaking, or be a tenant of the undertaking, or be the landlord of the undertaking, or be a director or member of the undertaking or a participant in the undertaking, etc.

d. Furnish details of any additional reasons or motivation which may support the ownership of shares in the undertaking by the health professional, including, for example, any barriers to over-servicing which may exist; the interests or needs of the community served by the health professional; the interest of the health professional, other than financial, in owning the shares in the undertaking; the absence of any other party interested in owning the shares; the absence of perverse incentives for the health professional; etc.;

e. Via the application referred to in paragraph (a), obtain the approval of the relevant professional body of his or her ownership of the shares in question, failing which the health professional shall divest himself or herself of ownership of the said shares within a period of three years as from the date of such failure.

3.7.6 Health professionals in rural areas and in areas where there is a severe lack of health care facilities could submit, subject to the conditions as spelt out in 3.7.4, a motivated application to own shares in or to establish a private hospital or clinic where such need existed or arises.

3.7.7 A health professional who has, subject to the above conditions, been given permission to have a financial interest in a private clinic or hospital and who wishes to refer his or her patients to such a clinic or hospital should display a conspicuous notice in his or her waiting room indicating that he or she has a financial interest in such clinic or hospital.

3.8 RENTALS

3.8.1 Pay rentals in lease agreements between health professionals and health establishments which are not market related or are at preferential rates.

3.8.2 Should a health establishment or service wish to rent its consulting rooms at a particular rate, such rental must, however, not be conditional on the health professional to achieve a certain turnover, nor may a particular rental rate be selectively applied.

3.8.3 All relevant information pertaining to as well as a certified copy of that rental agreement should be made available to the Council on request.

3.9 COMMISSION

3.9.1 Accepting commission

Accept commission, financial gain or other valuable consideration from any person(s), body (ies) or service(s) in return for the purchase, sale or supply of any goods, substances or materials used by the health professional in his or her practice. In cases of doubt, health professionals should consult the relevant professional associations of which they are members who, in turn, will assist the relevant Council to arrive at a decision.

3.9.2 Paying commission

Pay commission or render any financial gain or other valuable consideration to any person for recommending patients.

3.10 CHARGING OR RECEIVING FEES

3.10.1 For referring patients

Charge a fee or receive any financial gain or other valuable consideration for referring patients for participating in drug trials or other research trials of a similar nature.

3.10.2 For seeing representatives

Charge a fee or receive any financial gain or other excessive valuable considerations for seeing a medical representative.

3.10.3 For services not personally rendered

Charge or receive fees for services not personally rendered by either a health professional himself or herself or by an unregistered person in his or her employ, except for services rendered by another health professional or person registered in terms of the relevant Health Professions Act, that regulates the particular profession, with whom the health professional is associated as a partner, shareholder or *locum tenens*.

3.11 SHARING OF FEES

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

3.12 CONTRACTS

3.12.1 Enter into a contract to work in a particular health establishment or service on the understanding that a health professional generates a particular amount of revenue for such health establishment or service.

3.12.2 A health establishment or service that equips a theatre, ward or other facility for a specific health professional according to his or her specifications may enter into a contractual agreement with such health professional on the condition that such health establishment or service may not stipulate any turnover targets for the health professional concerned.

3.13 CONTINUING PROFESSIONAL DEVELOPMENT

With regard to the matter of Continuing Professional Development, the following should be noted:

3.13.1 Collaborative efforts

Historically there has been a close collaboration between health professionals and the pharmaceutical and health supply industry which extended particularly to continuing professional development. Health care is, to a large extent, self-governing and practitioners must ensure that their participation in such collaborative efforts is in keeping with their duties towards patients and society.

3.13.2 Educational needs of targeted group

Continuing professional development activities should address the educational needs of the targeted healthcare group. Generic names of products should be used rather than trade names in the course of continuing professional development activities.

3.13.3 Healthcare Provider Organisations

The decision on content and choice of continuing professional development activities, as well as funding arrangements lies ultimately with the healthcare provider organisations such as professional associations, its branches and groups who should not be in a position of conflict of interest by virtue of any relationship with the funding body. The organisers may acknowledge financial or other aid received, but should not identify any specific products.

3.13.4 Funding

Funds for continuing professional development activities should preferably be in the form of an educational grant payable to the health care provider organisation arranging the activity.

3.13.5 Travel, lodging and other expenses with regard to the attendance of CPD events

Travel or lodging costs or other expenses could be paid by the industry for individual health professionals to attend a CPD event. Scholarships, grants or other special funding, to permit students and other deserving health professionals to attend CPD activities are permissible, provided the funds are paid for expenses directly related to the CPD activity. The organisers may extend reasonable honoraria and imbursement for travel, lodging and meal expenses to speakers. The principal event should at all times centre around education and not around meals, entertainment or other hospitality, the cost of which should not exceed that level which the recipients might reasonably be expected to incur for themselves under similar circumstances.

3.13.6 Travel, lodging and other expenses with regard to the attendance of international conferences

It is a well-established practice and an acknowledged fact that practising health professionals and educators should be exposed to new knowledge and insight into their respective professions and/or disciplines by the attendance of international conferences, either locally or overseas. It is, however, also of utmost importance that young and upcoming health professionals and educators and those from disadvantaged backgrounds be given an equal opportunity to expand their knowledge and understanding with regard to their respective professions and/or disciplines by the attendance of such international conferences.

It will, therefore, be permissible for companies to sponsor delegates to attend international conferences, either directly or through professional associations/societies, with the proviso that a fair and transparent process should be followed in the election and sponsoring of delegates to attend such events, especially with regard to the attendance of such conferences by young and upcoming health professionals and educators and those from disadvantaged backgrounds.

Such sponsorships should furthermore be earmarked for specific educational events/conferences and not for leisure purposes.

- At least five (5) hours of CPD activity should be held per day *pro rata* in events lasting more than one day.

- After having attended a sponsored CPD activity, delegates are obliged to provide feedback to other members of the applicable profession.

3.13.7 Distinction between education, training and product promotion

A distinction should be made between education and training on the one hand and product promotion on the other (See HPCNA CPD Guidelines).

4. GUIDELINES FOR THE MANAGEMENT OF PATIENTS WITH HIV INFECTION OR AIDS

1. PREAMBLE

1.1 HIV infection and AIDS have emerged as the most challenging health matter of modern times. The pandemic has created not only medical, but also ethical, legal, social, political and fiscal concerns.

1.2 It should, however, be realised that the matter concerning HIV/AIDS is a highly sensitive and quite often a controversial issue to address. Thus, it was necessary to follow an approach of compromise in selecting the most appropriate and suitable information for inclusion in this guidelines.

1.3 The guidelines are now much in keeping with international best practice and they reflect to a large extent, if not fully, the views of organisations such as the United Nations Joint Programme on HIV/AIDS (UNAIDS) and of the World Health Organisation (WHO).

2. PREMISES

2.1 HIV INFECTION AND AIDS

HIV is incurable at present; AIDS is considered a manageable life-threatening disease.

2.2 MODES OF TRANSMISSION

2.2.1 HIV is transmitted primarily in three ways:-

a. Sexually;

b. Perinatally; and

c. via Blood-borne infections (e.g. sharing of injection equipment).

2.2.2 It has, therefore, become impossible and unjustifiable to identify and focus on "high risk groups or individuals".

2.3 OCCUPATIONAL TRANSMISSION OF HIV

2.3.1 The risk of transmission of HIV infection in the healthcare area from patient to patient, patient to health professional and from health professional to patient, through inoculation of infected blood or other body fluids, has been shown scientifically to be very small. Fears, which are not always based on reality, have thus tended to exaggerate the risks out of proportion.

2.3.2 Health workers and patients are exposed not only to HIV. It should be recognised that, at present, infection by the hepatitis B virus poses a far greater risk. Universal precautions against blood-borne infections should, therefore, be adhered to in all healthcare encounters to minimise exposure of health workers and their patients.

2.3.3 Post-exposure treatment of health workers in whom inoculation or significant contamination might have occurred, may be beneficial and should be considered in consultation with the Infection Control Officer, or other designated person of the institution. When there has been a risk of contamination, Post Exposure Prophylaxis (PEP) should also be strongly recommended and the health worker should receive thorough counselling about the possible benefits of PEP in reducing the risk of seroconversion.

2.3.4 PEP treatment should be available immediately after exposure.

2.4 RESPONSIBILITIES OF HEALTH WORKERS

2.4.1 In the management of the HIV positive patient, the health worker has a primary responsibility towards the individual patient. The health worker also has certain responsibilities towards other health workers and other parties that might be in danger of contracting the disease from the patient.

2.4.2 No health worker may ethically refuse to treat any patient solely on the grounds that the patient is, or may be, HIV seropositive. Equally, no health worker may withhold normal standards of treatment from any patient solely on the grounds that the patient is seropositive, unless such variation of treatment is determined to be in the patient's interest. Treatment should not be suboptimal because of a perceived potential risk to health workers. It is accepted that a health worker will examine or treat a patient only with the informed consent of the patient.

2.4.3 Health professionals are being reminded that an HIV diagnosis, without further examination (such as assessment of the stage of disease progression by history and physical examination, measuring viral load or CD4 cell counts), provides no information about a person’s prognosis or actual state of health. Unilateral decisions not to resuscitate people with HIV are a violation of fundamental human rights and may lead to disciplinary action being taken against a health professional who finds himself or herself guilty of such action.

2.5 CONFIDENTIALITY

In order to encourage patients to be tested and/or treated for HIV infection, it is essential that the confidentiality of the patient’s HIV status be maintained. It is also in the interest of public health that confidentiality is maintained.

2.6 HIV TESTING

2.6.1 HIV testing should only take place with the voluntary, informed consent of the individual and in accordance with the guidelines set out below. A requirement of routine or universal testing of patients in the healthcare setting is unjustifiable and undesirable. However, it is important that HIV testing be offered to all patients in health care settings using an "opt – out " approach. This is in line with Namibia's policy of "provider – initiated counseling and testing ".

2.6.2 The attention of patients should be drawn to the potential abuse of HIV test kits that are nowadays available on the market. Any person who wishes to use such kits should ascertain from his or her doctor or another credible source whether such kits are reliable and safe. New forms of HIV testing should only be adopted if they conform to the guidelines set out in this policy document.

2.7 LIMITING THE SPREAD OF HIV

Health professionals should support all efforts to keep the spread of HIV infection in the community as low as possible. Such measures include appropriate education regarding the infection, alteration of lifestyle, improved management of predisposing and aggravating factors, including other sexually transmitted diseases, mobilising support from the community and disseminating information regarding preventive measures and be committed thereto that patients suffering from whatever disease will have improved access to healthcare and treatment.

3. EDUCATION

3.1 Education and training are essential components of the successful implementation of universal precautions, i.e. those precautions which should be universally applied to prevent transmission of HIV and other diseases in the healthcare setting. These precautions have proven to be the most effective measures to protect health workers. These, and all other measures instituted to prevent the transmission of infections in the healthcare setting will, however, probably fail if they are not supported by an ongoing educational programme.

3.2 To be effective, such educational schemes should be:

3.2.1 **Structured** and preferably assessed by formal examinations;

3.2.2 **Ongoing** throughout the period of employment; and

3.2.3 **Continuously** evaluated and monitored.

4. OBLIGATIONS OF EMPLOYING AUTHORITIES

Health workers, who are employed, may take irrational and scientifically unjustifiable steps to minimize the perceived risk of acquiring HIV infection from patients, if there is a notion that their employers are unconcerned and not willing to minimise the risk of occupational infection of health workers.

An employer should have a clear-cut policy statement that declares the responsibility of the employer towards his employees who become infected whilst performing official duties.

This policy should state the procedures the employee should follow after occupational exposure. This should include guidelines with regard to the reporting of the incident for purposes of compensation, counseling and HIV testing of the health worker and, where informed consent can be obtained, sourcing the patient and access to post-exposure prophylaxis within an hour of the incident. Where a patient is unable to give consent in this case, it shall be deemed as the patient having consented.

Employers should ensure that all employees are insured against the consequences of such infections. Although HIV/AIDS is not listed as one of the occupational diseases in terms of labour legislation, an employee who can show that he/she was infected as a result of an exposure during the course of carrying out his/her occupational duties, may claim compensation.

Students in various health fields, who are not legally recognised as employees, should also be insured, either by their university or by the hospital where they undergo their training, against such incidents.

There is consensus that adherence to universal precautions is the most important, and possibly the only, action that will significantly protect health workers against HIV infection and other blood-borne pathogens. (Immunisation against hepatitis B is an exception)

For the above reason the following must be in place:

4.7.1 All employers must make available to health workers facilities to institute universal precautions.

4.7.2. Such facilities should be provided to the full spectrum of health workers and should include those paramedical personnel who initially come into contact with the patient, as well as auxiliary and unskilled workers who handle the patients, or could be exposed to contaminated materials. Such facilities should also be available to students, who, because they are technically inexperienced and not recognised as official employees, are particularly vulnerable.

4.7.3. The facilities available should include the additional sophisticated precautionary measures which may have to be instituted to protect the health worker performing invasive procedures known to be associated with a high risk of inoculation with patients' blood.

5. KNOWLEDGE OF THE HIV STATUS OF PATIENTS

5.1 There is persuasive scientific evidence that knowledge of the HIV status of a patient does not provide additional protection to health workers treating the patient. Nevertheless, there is a perception amongst some health workers that, under exceptional circumstances, the knowledge of the HIV status of a patient may be useful in order to ensure the use of *"extended"* universal precautionary measures such as special gloves, clothing and face masks, and that inexperienced personnel should not be allowed to perform surgery on such patients. It is argued that selective use of such expensive measures will be cost-effective. Exceptional circumstances are defined as palpation of a needle-tip in a body cavity, or the simultaneous presence of the health worker's fingers and needle or other sharp object or instrument in a poorly visualised or highly confined anatomic cavity. Orthopaedic and other procedures where there is an aerosol of blood, bone fragments or bloody fluids, also qualify as exceptional circumstances.

5.2 Where certain well-defined high risk or exposure-prone procedures are contemplated, the patient should be informed of the concerns and asked to consent to HIV testing. It should be emphasised that the condoning of pre-operative or pre-treatment HIV testing, when high-risk procedures are contemplated, should not be abused to justify routine HIV testing of all patients, nor should patients be told that pre-HIV testing is mandatory in such circumstances. All patients have a right to refuse testing, and where a patient refuses to test for HIV under such circumstances, the patient may not be refused treatment on this basis. However, a patient who declined to be tested for HIV should be managed by health professionals as if such patient was HIV positive.

5.3 Health workers should realise that there are factors which make it unrealistic to rely on HIV testing of patients to protect themselves against occupational exposure. Thus, health workers must appreciate the significance of the window period of infectivity; the ever-increasing prevalence of HIV infection, especially among hospital patients; the time it takes to obtain a reliable HIV test result; and the need to treat, under less than ideal conditions, patients outside hospitals and in emergency care units.

5.4 These factors are not under the control of the health worker and strengthen the view that, to minimise the risk of infection, health workers should adopt appropriate universal

precautions in all clinical situations rather than rely on knowledge of the HIV status of patients.

6. TESTING PATIENTS FOR HIV-ANTIBODIES

A patient should be tested for HIV-infection only if he or she gives **informed consent**. Such informed consent is made up of the following important elements:

6.1 INFORMATION

6.1.1 The patient should be given information regarding the purpose of the laboratory test; what advantages or disadvantages testing may hold for him or her as patient; why the surgeon or physician wants this information; what influence the result of such a test will have on his or her treatment; and how his or her medical protocol will be altered by this information. The psychosocial impact of a positive test result should also be addressed.

6.1.2 All such communication should be conducted in a language that is easily understood by the patient.

6.2 UNDERSTANDING

6.2.1 Furthermore, the patient should clearly understand the information provided, so that he or she may agree to the HIV test, based on such understanding. The importance of the patient's ability to understand the information given means that, if posters are displayed in an attempt to inform patients that testing for HIV may be undertaken, these must be supplemented by a verbal pre-test counselling of the patient by the health worker in order to appropriately obtain the patient's informed consent.

6.2.2 The principle of informed consent entails that the health worker accepts that, if the patient were HIV-positive, appropriate post-test counselling will follow. The health worker must, therefore, ensure that the patient is directed to appropriate facilities that will oversee his or her further care and, if possible, counsel his or her family and/or sexual partners.

7. REFUSAL TO HAVE BLOOD TESTED FOR HIV ANTIBODIES

7.1. It is justifiable to test for HIV antibodies without the patient's consent, but only in the circumstances set out in the National Policy on Testing for HIV, which hereby follows:

7.1.1 As part of unlinked and anonymous testing for epidemiological purposes undertaken by the national, regional or local health authority or an agency authorised by any of these bodies, provided that HIV testing for epidemiological purposes is carried out in accordance with national legal and ethical provisions regarding such testing.

7.1.2 Where statutory provision or other legal authorisation exists for testing without informed consent.

7.1.3 In emergency situations where infection is suspected and it is impossible to obtain consent, subject to the conditions in paragraphs 7.2 and 7.3 below.

7.2. In an emergency situation, where a patient's health is in serious danger and immediate treatment is necessary the patient should be treated as if he/she is HIV positive.

7.3. Where a health worker has sustained a risk-bearing incident such as a needle stick injury, this may be determined to be an emergency situation.

7.4 In view of the fact that immediate post-exposure measures may be beneficial to the health worker, information as to the HIV status of the source patient may be obtained in the following ways:

7.4.1 Testing any existing blood specimen. This should be done with the source patient's consent, but if consent is withheld, the specimen may nevertheless be tested, but only after informing the source patient that the test will be performed and providing for the protection of privacy. The information regarding the result may be disclosed to the health worker, but must otherwise remain confidential and may only be disclosed to the source patient with his or her informed consent.

7.4.2 If the patient is unable to give informed consent and is likely to remain unable for a significant length of time in relation to the prophylactic needs of the health worker or other patients, then every reasonable attempt should be made to obtain appropriate vicarious consent. **Vicarious consent** means the consent of the patient's closest relative or, in the case of a minor, the consent of the medical superintendent in the absence of a parent or guardian.

8. THE HEALTH PROFESSIONALS DUTY TOWARDS HIV POSITIVE PATIENTS

8.1 No health professional may ethically refuse to treat any patient solely on the grounds that the patient is, or may be, HIV seropositive.

8.2 No health professional may withhold normal standards of treatment from any patient solely on the grounds that the patient is HIV seropositive, unless such variation of treatment is determined to be in the patient's interest and not by perceived potential risk to the health worker.

9. CONFIDENTIALITY

9.1 The test results of HIV positive patients should be treated at the highest possible level of confidentiality.

9.2 Courts have recognised that confidentiality regarding HIV status extends to other medical colleagues and health professionals. Other health professionals may not be informed of a patient’s HIV status without that patient’s consent. The need for transmission of clinical data to those medical colleagues and health workers directly involved with the care of the patient should be discussed with the patient in order to obtain his or her consent for disclosures considered to be in the patient’s best interest in terms of treatment and care.

9.3 The principle of confidentiality applies in respect of the patient. The decision whether to divulge the information to other parties involved must, therefore, be in consultation with the patient. If the patient's consent cannot be obtained, ethical guidelines recommend that the health worker should use his or her discretion whether or not to divulge the information to other parties involved who are at clear risk or danger. To date, there hasn’t been legal clarity regarding whether this situation is an acceptable limitation of the right to confidentiality. Therefore such a decision must be made with the greatest care, after explanation to the patient and with acceptance of full responsibility at all times. The following steps are recommended:

9.3.1 Counselling the patient on the importance of disclosing to his or her sexual partner and for taking other measures to prevent HIV transmission.

9.3.2 Providing support to the patient to make this disclosure.

9.3.3 Where the patient still refuses to disclose his or her HIV status or refuses to consider other measures to prevent infection, counselling the patient on the health worker's ethical obligation to disclose such information and requesting consent to do so is necessary.

9.3.4 Disclosing such information.

9.3.5 When informing the patient about the importance of disclosure, the attention of the patient should be drawn to the possibility of violence and other adverse consequences that such disclosure may hold in store for the patient concerned.

9.4 The report of HIV test results by a laboratory, as is the case with all laboratory test results, should be considered confidential information. Breach of confidentiality is, however, more likely to occur in the ward, hospital or doctor's reception area than in the laboratory. It is, therefore, essential that healthcare institutions, pathologists and doctors formulate a clear policy as to how such laboratory results will be communicated and how confidentiality of the results will be maintained.

10. HEALTH PROFESSIONAL INFECTED WITH HIV

10.1 No health professional is obliged to disclose his or her HIV status to an employer nor may any employee be unfairly discriminated against or dismissed as a result of his or her HIV status.

10.2 The benefits of voluntary HIV testing should be explained to all health workers and they should be encouraged to consider HIV testing. Any health professional, who finds himself or herself to be HIV positive, should be encouraged, to seek counselling from an appropriate professional source. Counsellors must of course be familiar with recommendations such as those of the Centre's for Disease Control (CDC) so that unnecessary, onerous, and scientifically unjustifiable restrictions are not placed on the professional activities of an HIV positive health worker.

10.3 An infected health professional may continue to practice, however, they must seek and implement the counsellor's advice on the extent to which they should limit or adjust their professional practice in order to protect their patients.

11. BASIC ELEMENTS OF PRACTICALLY APPLICABLE AND UNIVERSAL PRECAUTIONS

11.1 These precautions are designed to prevent:

a. Penetration of the skin by contaminated sharp objects;

b. Contamination of the skin, especially non-intact skin and mucous membranes, in particular the conjunctivae.

As a general principle, disposable instruments should only be used once, and re-usable items should be sterilised.

11.2 Body Fluids Which Should Be Handled With the Same Precautions as Blood:

- Cerebrospinal fluid
- Peritoneal fluid
- Pleural fluid
- Pericardial fluid
- Synovial fluid
- Amniotic fluid
- Semen
- Vaginal secretions
- Breast milk
- Saliva in association with dentistry.
- Unfixed tissues and organs.
- Any other body fluid which is blood stained.

11. 3 Body Fluids Such as Urine, Sweat and Saliva:

These body fluids do not pose any risk, (except in the context of dentistry).

11. 4 Avoidance of Injuries with *"Sharps"*:

A health professional should:

11.4.1 Recognise risky objects, not only needles and knives, but less obvious ones such as towel-clips, suction drain introducers, bone spicules, etc.

11.4.2 Never allow a sharp object, especially a contaminated one, to come near one's fingers. (Do not resheath needles, use instruments to load and unload scalpel blades, etc.)

11.4.3 Be personally responsible for the immediate safe disposal of all 'sharps' that one uses into an approved container.

11.4.4 Never handle a 'sharp' without looking at it.

11.4.5 Never put down a 'sharp' except in an agreed neutral area.

11.4.6 Use the safest 'sharp' that will do the job; knives and sharp needles only for skin, scissors and blunt (round-nosed) needles for tissues.

11.4.7 Never feel for a needlepoint (or other sharp object) with fingers.

11.4.8 Never put his or her fingers in an area or wound where someone else is using a 'sharp'.

11.4.9 Avoid use of wire sutures.

11.4.10 Use heavy duty gloves (ring-link or similar) in danger situations (broken bones, sharp foreign bodies).

11. 5 Avoidance of Skin/Mucous Membrane Contamination:

11.5.1 Three risks are identified:

a. Blood or body fluid on hands;

b. Spillage on the health care worker's body;

c. Spray/Aerosol to eyes and face.

A health professional should:

11.5.2 Never have contact with patients, soiled linen, etc. if skin of hands is not intact (cuts, eczema, etc.), unless the lesions can be completely isolated by impermeable adhesive tape.

11.5.3 Glove Use:

a. Latex gloves to be used by every health professional handling blood/body fluid.

b. Torn glove to be removed immediately and contamination washed away.

c. Double gloving reduces skin contamination during operations by 80%, and may reduce the risk associated with 'sharps' injuries.

11.5.4 In case of spillage:

a. Where risk of spillage exists, use plastic aprons and impermeable boots.

b. Ensure that all spillage is immediately cleaned.

c. Double seal all containers of blood and body fluid.

11.5.5 In case of spray/aerosol.

a. Where risk exists, use face/eye protection (face shields, eye-goggles).

b. Laser and fulguration smoke should be continuously aspirated by suction.

Routine implementation of these simple, logical measures, which are not time consuming, nor significantly expensive, by all members of the healthcare team, should reduce the risk of infection of health professionals by patients, and of patients by health professionals to very nearly zero. Disciplined implementation of these precautions in dealing with all patients should make pre-treatment determination of a patient's HIV status irrelevant in terms of the safety of health professionals.

5. GUIDELINES FOR CANVASSING PATIENTS FROM ABROAD

1. It shall not be permissible for health professionals to become involved in the canvassing of patients from abroad.

2. In the event of patients being so canvassed by private organisations or health providers, such canvassing is to be undertaken on the basis of the following guidelines:

2.1 A scheme for canvassing of patients from abroad should be available and to the benefit of all health professionals registered under the relevant Health Professions Act who may wish to participate in and use such a scheme.

2.2 Health professionals should not be approached directly to participate in such a scheme, but only through recognised professional organizations such as associations, unions or societies.

2.3 The clinical diagnosis and decisions as to whether or not a specific treatment or invasive procedure should be followed or carried out, may not in any way be compromised by the fact that the patient was canvassed from abroad.

2.4 Payment of accounts for services rendered is to be guaranteed in advance in order to ensure that the financial burden for the care of such patients shall not be diverted onto the public sector.

2.5 Accounts may not be issued for services still to be rendered. The HPCNA would, however, not object to an arrangement whereby a financial institution, acting on behalf of such a patient, guarantees payment of an account still to be rendered. Quotation estimates and deposits are acceptable.

2.6 Appropriate arrangements would have to be in place in advance whereby the patient shall be covered in the event of additional expenses having to be incurred due to a final diagnosis which differs from the diagnosis made abroad or from unexpected complications.

2.7 The treating health professional would have to be adequately indemnified even against any unexpected complications.

2.8 In an effort to overcome the danger of “importing” into Namibia, infectious diseases from other parts of the world, especially from countries which do not have sophisticated control systems in place, only patients needing elective treatment may be canvassed, i.e. “cold cases” and not “hot” or “emergency” cases.

2.9 Patients requiring organ transplants may not be canvassed from abroad since human tissue for transplant purposes is being regarded as a national asset and shall not be transplanted into such patients.

2.10 Patients shall not be canvassed for treatment from countries belonging to the Southern African Development Community (SADC) if such patients could receive similar treatment in member countries in order not to prevent those countries, their economies, facilities and practitioners from gaining experience or developing and improving their own capacity.

6. GUIDELINES FOR PROTECTING THE RIGHTS AND CONFIDENTIALITY OF PATIENTS

1. INTRODUCTION

1.1 To ensure the realisation of the right of access to healthcare services as guaranteed in chapter 3 of the 'Constitution of the Republic of Namibia', the various Health Professions Councils are committed to upholding, promoting and protecting this right and, therefore, proclaim these guidelines as a common standard for achieving the realisation of this right.

1.2 The Ministry of Health and Social Services, in consultation with various other bodies, developed a patient charter of Namibia (hereafter referred to as the "Patient Charter") which was published in July 1998. The former Health Professional Boards also submitted input into the different drafts that were circulated for comments and was launched by the Honourable Minister of Health and Social Services.

1.3 The various Health Professions Councils of Namibia are obliged to help the patient ensure these rights.

The document contained herein should be read in conjunction with the Patient Charter.

2. PATIENT'S RIGHTS

2.1 HEALTHY AND SAFE ENVIRONMENT

Everyone has the 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 in making decisions on matters affecting his or her own health.

2.3 ACCESS TO HEALTHCARE

Everyone has the right of access to healthcare services, which include:

a. **Receiving timely emergency care** at any healthcare facility that is open, regardless of one's ability to pay;
b. **Treatment options, providing a diagnosis and rehabilitation** that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
c. **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;
d. **Counselling** without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
e. **Provision of supportive and palliative care** that is affordable and effective.
f. **A positive disposition** displayed by health professionals that demonstrates courtesy, human dignity, patience, empathy and tolerance.
g. **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 best 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.

A health professional can, at the request of the member, help a member in the interaction with his/her medical aid scheme or health insurance in a supportive way.

2.5 CHOICE OF HEALTH SERVICES

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

2.6 TREATMENT BY AN IDENTIFIABLE HEALTH PROFESSIONAL

Everyone has a right to know the name of the person and the rank of that person, if applicable, who is providing healthcare and, therefore all health professionals and their staff should be identifiable by means of a clearly visible name tag that also reflects the rank.

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 the right to be given full and accurate information about the nature of his or her illnesses, diagnostic procedures, the proposed treatment 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, but the health professional should consider whether it would be in the best interest of the patient should he or she withdraw from involvement in the management of the proposed treatment plan.

2.10 A SECOND OPINION

Everyone has the right, on request, to be referred for a second opinion to a health professional of his or her choice and should be provided with the relevant documentation and information.

2.11 CONTINUITY OF CARE

No one shall be abandoned by a health professional or a health facility which initially took responsibility for his or her health, without arrangement for replacement.

2.12 COMPLAINTS ABOUT HEALTH SERVICES

Everyone has the right to complain about healthcare services, to have such complaints investigated and to receive a full response on the outcome of 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 professionals.

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

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

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

3.7 To advise health professionals of the existence of a living will.

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.

3.11 To take care of medical devices and/or medicine in their care or possession (In order not to neglect their own health, but also to protect others from potential dangers of non appropriate medicine exposure and children from taking medicine that was left in an unsafe place).

7. CONFIDENTIALITY: PROVIDING AND PROTECTING INFORMATION

1. INTRODUCTION

Being registered under the relevant Act, gives the registered person rights and privileges as a health professional. In return, a health professional has a duty to meet the standards of competence, care and conduct set by the relevant Health Professions Council.

Health professionals hold information about patients which is private and sensitive. This information must not be given to others, unless the patient consents or one can justify the disclosure. Guidelines on when disclosures may be justified are provided as part of this Annexure.

When the health professional is satisfied that information should be released, he or she should act promptly to disclose all relevant information. This is often essential and in the best interests of the patient, or to safeguard the well-being of others.

The guidelines on confidentiality place new responsibilities on health professionals to keep patients informed about and get agreement to the disclosure of information. They set out a framework for respecting patients' rights, while ensuring that information needed to maintain and improve healthcare is passed to those who need it.

The additional duties to obtain consent and to keep data anonymous tie in with developments in law. Guidelines given herein should form the basis for establishing privacy-friendly relationships between patients and practitioners and should be assisting health professionals in complying with their obligations.

GLOSSARY

This section defines the terms used in this document. These definitions have no wider or legal significance.

"Anonymised data" means data from which the patient cannot be identified by the recipient of the information. The name and address must be removed, together with any other information which, in conjunction with other data held by or disclosed to the recipient, could identify the patient. Patient reference numbers or other unique numbers may be included only if recipients of the data do not have access to the 'key' to trace the identity of the patient using that number.

"Consent" means an agreement to an action based on knowledge of what the action involves and its likely consequences.

"Express consent" means consent which is expressed orally or in writing (except where patients cannot write or speak, when other forms of communication may be sufficient).

"Healthcare team" means the health professionals who comprise the people providing clinical services for each patient as well as administrative staff who directly support those services.

"Patients" means competent patients and parents of, or those with parental responsibility for, children who lack maturity to make decisions for themselves. (Adult patients who lack the capacity to consent have the right to have their confidentiality respected. Guidance on disclosure of information about such patients is included in paragraph 5.2.3 hereof)

"Personal information" means information about people with whom health professionals become involved within in a professional capacity and from which individuals can be identified.

"Public interest" means the interest of the community as a whole, or a group within the community or individuals.

2. PATIENTS' RIGHT TO CONFIDENTIALITY

2.1 RETAIN CONFIDENTIALITY

2.1.1 Patients have a right to expect that information about them will be held in confidence by the health professional. Confidentiality is central to trust between fellow health professionals and patients. Without assurances about confidentiality, patients may be reluctant to give practitioners the information they need in order to provide good care. If a health professional is asked to provide information about patients, he or she should:

a. Seek patients' consent to disclosure of information wherever possible, whether or not he or she judges that patients can be identified from the disclosure;

b. Anonymise data where unidentifiable data will serve the purpose;

c. Keep disclosures to the minimum necessary.

2.1.2 The health professional must always be prepared to justify his or her decisions in accordance with these guidelines.

2.2 PROTECTING INFORMATION

2.2.1 When a health professional is responsible for personal information about patients he or she must make sure that it is effectively protected against improper disclosure at all times.

2.2.2 Many improper disclosures are unintentional. The health professional should not discuss patients where he or she can be overheard or leave patients' records, either on paper or on screen, where they can be seen by other patients, unauthorised healthcare staff or the public. Whenever possible he or she should take steps to ensure that his or her consultations with patients are private.

3. SHARING INFORMATION WITH PATIENTS

3.1 Patients have a right to information about the healthcare services available to them, presented in a way that is easy to follow, use and comprehend.

3.2 Patients also have a right to information about any condition or disease from which they are suffering. This should be presented in a manner easy to follow and use, and should include information about a diagnosis, the prognosis, treatment options, outcomes of treatment, common and/or serious side-effects of treatment, likely time-scale of treatments and costs, where relevant. A health professional should always give patients basic information about treatment they propose to provide, but should respect the wishes of any patient who asks not to give them detailed information. This places a considerable onus upon health professionals. Yet, without such information, patients cannot make informed choices, as partners in the healthcare process.

3.3 It is good practice to give patients information about how anonymised information about them may be used to protect public health, to undertake research and audits, to teach or train health workers and students and to plan and organise healthcare services.

4. DISCLOSURE OF INFORMATION: SHARING INFORMATION WITH OTHERS PROVIDING CARE

4.1 Where patients have consented to treatment, express consent is not usually needed before relevant personal information is shared to enable the treatment to be provided. For example, express consent would not be needed before general practitioners disclose relevant personal information so that a medical secretary can type a referral letter. Similarly, where a patient has agreed to be referred for an X-ray, referring practitioners may make relevant information available to diagnostic radiologists when requesting an X-ray. Practitioners cannot treat patients safely, nor provide the continuity of care, without having relevant information about the patient's condition and medical history.

4.2 A health professional should make sure that patients are aware that personal information about them will be shared within the health care team, unless they object, and offer reasons for this. It is particularly important to check that patients understand what will be disclosed if it is necessary to share personal information with anyone employed by another organisation or agency providing health or social care. He or she must respect the wishes of any patient who objects to particular information being shared with others providing care**,** except where this would put others at risk of death or serious harm.

4.3 A health professional must make sure that anyone to whom he or she discloses personal information understands that it is given to them in confidence, which they must respect. Anyone receiving personal information in order to provide care is bound by a legal duty of confidence, whether or not they have contractual or professional obligations to protect confidentiality.

4.4 Circumstances may arise where a patient cannot be informed about the sharing of information, for example because of a medical emergency. In these cases he or she should pass relevant information promptly to those providing the patient’s care.

5. DISCLOSURE OF INFORMATION OTHER THAN FOR TREATMENT OF THE INDIVIDUAL PATIENT

5.1 PRINCIPLES

5.1.1 Information about patients is requested for a wide variety of purposes including education, research, monitoring and epidemiology, public health surveillance, clinical audit, administration and planning. A health professional has a duty to protect patients' privacy and respect their autonomy. When asked to provide information he or she should follow the guidance herein, i.e.:

a. seek patients' consent to disclosure of any information wherever possible, whether or not he or she judge that patients can be identified from the disclosure;

b. Anonymise data where unidentifiable data will serve the purpose;

c. keep disclosures to the minimum necessary.

5.1.2 The paragraphs which follow deal with obtaining consent and what to do where consent is unobtainable, or where it is impracticable to seek consent.

5.2 OBTAINING CONSENT

Seeking patients' consent to disclosure is part of good communication between health professionals and patients and is an essential part of respect for patients' autonomy and privacy.

5.2.1 Consent where disclosures will have personal consequences for patients

A health professional must obtain express consent where patients may be personally affected by the disclosure, for example when disclosing personal information to a patient's employer. When seeking express consent, he or she must make sure that patients are given enough information on which to base their decision, the reasons for the disclosure and the likely consequences of the disclosure. The health professional should also explain how much information will be disclosed and to whom it will be given. If the patient withholds consent, or consent cannot be obtained, disclosures may only be made where it can be justified in the public interest, usually where disclosure is essential to protect the patient, or someone else, from risk of death or serious harm.

5.2.2 Consent where the disclosure is unlikely to have personal consequences for patients

a. Disclosure of information about patients for purposes such as epidemiology, public health safety, or the administration of health services, or for use in education or training, clinical or medical audits, or research is unlikely to have personal consequences for the patient. In these circumstances the health professional should still obtain patients' express consent to the use of identifiable data or arrange for members of the healthcare team to Anonymise records.

b. However, where information is needed for the purposes of the kind set out in paragraph (a) and the health professional is satisfied that it is not practicable either to obtain express consent to disclosure, nor for a member of the healthcare team to Anonymise records, data may be disclosed without express consent. Usually such disclosures will be made to allow a person outside the healthcare team to anonymise the records. Only where it is essential for the purpose, may identifiable records be disclosed. Such disclosures must be kept to the minimum necessary for the purpose. In all such cases the health professional must be satisfied that patients have been told, or have had access to written material informing them:

    i. That their records may be disclosed to persons outside the team which provided their care;

    ii. Of the purpose and extent of the disclosure, for example to produce anonymised data for use in education, administration, research or an audit;

    iii. That the person given access to records will be subject to a duty of confidentiality; and

    iv. That they have a right to object to such a process and that their objection will be respected, except where the disclosure is essential to protect the patient, or someone else, from risk of death or serious harm.

b. Where the health professional has control of personal information about patients, he or she must not allow anyone access to that information for the purposes of the kind set out in paragraph 5.1.1, unless the person has been properly trained and authorised by the relevant authority and is subject to a duty of confidentiality in their employment or because of their registration with a statutory regulatory body.

5.2.3 Disclosures in the public interest

a. In cases where the health professional has considered all the available means of obtaining consent, but is satisfied that it is not practicable to do so, or that patients are not competent to give consent, or exceptionally, in cases where patients withhold consent**,** personal information may be disclosed in the public interest where the benefits to an individual or to society of the disclosure outweigh the public and/or the patients' interest in keeping the information confidential.

b. In all such cases the health professional must weigh the possible harm (both to the patient, and the overall trust between practitioners and patients) against the benefits which are likely to arise from the release of information.

c. Ultimately, *'public interest'* can be determined only by the courts, but the various Health Professions Councils may also require the health professional to justify his or her actions if a complaint is received about the disclosure of personal information without a patient's consent.

6. PUTTING THE PRINCIPLES INTO PRACTICE

The remainder of this booklet deals with circumstances in which health professionals are most frequently asked to disclose information, and to provide advice on how the principles in section 4 should be applied.

It will also be prudent to obtain a written undertaking from employees not registered with any of the health professions to maintain confidentiality as stipulated in the following regulations made under the relevant Acts:

- Nursing Council : Regulation No.2040 (28 January 1999)
- Medical and Dental Council : Regulation No. 2851 (08 November 2002)
- Pharmacy Council : Regulation No.299 (15 November 1996)
- Social Work and Psychology Council : Regulation No.2637 (1 November 2001)
- Allied Health Professions Council : Regulation No.3951 (13 December 2007)

6.1 DISCLOSURES WHICH BENEFIT PATIENTS INDIRECTLY

6.1.1 Monitoring public health and the safety of medicines and devices

a. Professional organisations and Government regulatory bodies which monitor the public health or the safety of medicines or devices, as well as registries of notifiable conditions, rely on information from patient records for their effectiveness in safeguarding public health. For example, the effectiveness of the system of notifiable conditions depends on information provided by clinicians. The health professional must co-operate by providing relevant information wherever possible. The notification of some communicable diseases is required by law and in other cases the health professional should provide information in anonymised form, wherever that would be sufficient.

b. Where personal information is needed, the health professional should seek express consent before disclosing information, whenever that is practicable. For example, where patients are receiving treatment there will usually be an opportunity for a health professional to discuss disclosure of information with them.

c. Personal information may sometimes be sought about patients with whom health professionals are not in regular contact. Practitioners should therefore make sure that patients are given information about the possible value of their data in protecting public health in the longer-term, at the initial consultation or at another suitable occasion when they attend a surgery or clinic. Patients should be given the information set out in paragraph 5.2.2.b. It should be clear that they may object to disclosures at any point. The health professional must record any objections so that patients' wishes can be respected. In such cases, he or she may pass on anonymised information if asked to do so.

d. Where patients have not expressed an objection, the health professional should assess the likely benefit of the disclosure to the public and commitment to confidentiality of the organisation requesting the information. If there is little or no evident public benefit, he or she should not disclose information without the express consent of the patient.

e. Where it is not practicable to seek patients' consent for disclosure of personal information for these purposes, or where patients are not competent to give consent, the health professional must consider whether disclosures would be justified in the public interest, by weighing the benefits to public health of the disclosure against the possible detriment to the patient.

f. The automatic transfer of personal information to a registry, whether by electronic or other means, before informing the patient that information will be passed on, is unacceptable, save in the most exceptional circumstances. These would be where a court has already decided that there is such an overwhelming public interest in the disclosure of information to a registry that patients' rights to confidentiality are overridden; or where the practitioner is willing and able to justify the disclosure, potentially before a court or to the Council, on the same grounds, alternatively an answer can be given under protest or a request to explain in camera first should be considered.

6.1.2 Clinical Audit and Education

Anonymised data will usually be sufficient for clinical audit and for education. When anonymising records, the health professional should follow the guidance on obtaining consent in paragraph 5.2.2 above. The health professional should not disclose non-anonymised data for clinical audit or education without the patient's consent.

6.1.3 Administration and Financial Audit

a. The health professional should record financial and other administrative data separately from clinical information and provide it in anonymised format whenever possible.

b. Decisions about the disclosure of clinical records for administrative or financial audit purposes, for example where medical scheme staff seek access to patients' records as part of the arrangements for medical benefit payments, are unlikely to bring the health professional’s registration into question, provided that, before allowing access to patients' records, he or she follow the guidance in paragraph 5.2.2. Only the relevant part of the record should be made available for scrutiny.

6.1.4 Medical Research

Where research projects depend on using identifiable information or samples, and it is not practicable to contact patients to seek their consent, this fact should be drawn to the attention of a research ethics committee so that it can consider whether the likely benefits of the research outweigh the loss of confidentiality.

Disclosures may otherwise be improper, even if the recipients of the information are registered practitioners. The decision of a research ethics committee would be taken into account by a court if a claim for breach of confidentiality were made, but the court's judgment would be based on its own assessment of whether the public interest was served.

6.1.5 Publication of Case-histories and Photographs

The health professional must obtain express consent from patients before publishing personal information about them as individuals in media to which the public has access, for example in journals or text books, whether or not he or she is convinced that the patient can be identified. Express consent must, therefore, be sought to the publication of, for example case histories about or photographs of patients. Where the health professional wishes to publish information about a patient who has died, he or she should take into account the guidance in paragraph 5.2 and get the consent of the executor and next of kin before deciding whether or not to do so.

6.2 DISCLOSURES WHERE HEALTH PROFESSIONALS HAVE DUAL RESPONSIBILITIES

6.2.1 Situations arise where practitioners have contractual obligations to third parties, such as companies or organisations, as well as obligations to patients. Such situations occur, for example when health professionals:

a. provide health services for employees of a company or organisation;

b. are employed by an organisation such as an insurance company;

c. work for an agency assessing claims for benefits;

d. provide healthcare to patients and are subsequently asked to provide health reports or information for third parties about them;

e. work as district surgeons;

f. work in the armed forces;

g. work in the prison service.

6.2.2 If the health professional is asked to write a report about and/or examine a patient, or to disclose information from existing records for a third party to whom the health professional has contractual obligations, he or she must:

a. be satisfied that the patient has been told at the earliest opportunity about the purpose of the examination and/or disclosure, the extent of the information to be disclosed and the fact that relevant information cannot be concealed or withheld. The health professional might wish to show the form to the patient before completing it to ensure the patient understands the scope of the information requested;

b. obtain, or have seen, written consent to the disclosure from the patient or a person properly authorised to act on the patient's behalf. The health professional may, however, accept written assurances from an authorised public officer that the patient's written consent has been given;

c. disclose only information relevant to the request for disclosure: Accordingly, the health professional should not usually disclose the whole record. However, the full record may be relevant to some benefits paid by government institutions;

d. include only factual information he or she can substantiate, presented in an unbiased manner;

e. patients may wish to see reports written about them before they are disclosed in some circumstances. In all circumstances, the health professional should check whether patients wish to see their report, unless patients have clearly and specifically stated that they do not wish to do so.

f. patients can receive reports in an open envelope and will have the choice of reading the contents to prevent alterations. A copy could be kept by the health professional.

6.2.3 Disclosures without consent to employers, insurance companies, or any other third party, can be justified only in exceptional circumstances, for example when they are necessary to protect others from risk of death or serious harm.

6.3 DISCLOSURES TO PROTECT THE PATIENT OR OTHERS

6.3.1 Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk or death or serious harm. Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, the health professional should seek consent to disclosure where practicable. If it is not practicable, the health professional should disclose information promptly to an appropriate person or authority. Such health professional should generally inform the patient before disclosing the information.

6.3.2 Such circumstances may arise, for example:

a. where a colleague, who is also a patient, is placing patients at risk as a result of illness or other medical conditions. If a health professional is in doubt about whether disclosure is justified, he or she should consult an experienced colleague, or seek professional advice. The safety of patients must come first at all times;

b. where a patient continues to drive or fly against medical advice, when unfit to do so. In such circumstances the health professional should disclose relevant information to the medical adviser of the driver or pilot and the relevant licensing agency without delay;

c. where a disclosure may assist in the prevention or detection of a serious crime. Serious crimes, in this context, will put someone at risk of death or serious harm, and will usually be crimes against the person, such as abuse of children.

6.4 CHILDREN AND OTHER PATIENTS WHO MAY LACK COMPETENCE TO GIVE CONSENT

6.4.1 Problems may arise if a health professional considers that a patient is incapable of giving consent to treatment or disclosure because of immaturity, illness or mental incapacity. If such patients ask the health professional not to disclose information to a third party, the health professional should try to persuade them to allow an appropriate person to be involved in the consultation. If they refuse and he or she is convinced that it is essential, in their medical interests, he or she may disclose relevant information to an appropriate person or authority. In such cases the health professional must tell the patient before disclosing any information, and, where appropriate, seek and carefully consider legal advice or the view of the legal guardian. The health professional should document in the patient's record the steps he or she has taken to obtain consent and the reasons for deciding to disclose information.

6.4.2 If the health professional believe that his or her patient is or was a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, he or she should give information promptly to an appropriate responsible person or statutory agency, where he or she believe that the disclosure is in the patient's

best interests. The health professional should usually inform the patient that he or she intends to disclose the information before doing so.

Such circumstances may arise in relation to children, where concerns about possible abuse need to be shared with other agencies such as social services. Where appropriate, the health professional should inform those with parental responsibility about the disclosure. If, for any reason, he or she believes that disclosure of information is not in the best interests of an abused or neglected patient, such health professional must still be prepared to justify his or her decision.

6.5 DISCLOSURE AFTER A PATIENT'S DEATH

6.5.1 A health professional is obliged to keep personal information confidential after a patient dies. The extent to which confidential information may be disclosed after a patient's death will depend on the circumstances. These include the nature of the information, whether that information is already public knowledge or can be anonymised, and the intended use to which the information will be put. The health professional should also consider whether the disclosure of information may cause distress to, or be of benefit to, the patient's partner or family.

6.5.2 A health professional may be asked to disclose, or wish to use, information about patients who have died, namely:

a. to assist in connection with an inquest or fatal accident inquiry. In these circumstances, such health professional should provide the relevant information;

b. as part of any clinical audit or for education or research. The publication of properly anonymised case studies would be unlikely to be improper in these contexts;

c. on death certificates. The law requires that a health professional complete death certificates honestly and fully;

d. to obtain information relating to public health surveillance. Anonymised information should be used, unless identifiable data is essential to the study.

6.5.3 Particular difficulties may arise when there is a conflict of interest between parties affected by the patient's death. For example, if an insurance company seeks information in order to decide whether to make a payment under a life assurance policy, the health professional should release information in accordance with the requirements of or with the authorisation of the executor of the person’s estate who should consider the consequences of disclosure. It may also be appropriate to inform those closest to the patient.

7. DISCLOSURE IN CONNECTION WITH JUDICIAL OR OTHER STATUTORY PROCEEDINGS

7.1 A health professional must disclose information to satisfy a specific statutory requirement, such as notification of a known or suspected communicable disease.

7.2 A health professional must also disclose information if ordered to do so by a judge or presiding officer of a court. He or she should object to the judge or the presiding officer if attempts are made to compel him or her to disclose what appears to him or her to be irrelevant matters, for example matters relating to relatives or partners of the patient, who are not parties to the proceedings and if still compelled should only do so under protest.

7.3 The health professional should not disclose personal information to a third party such as a lawyer, police officer or officer of a court without the patient's express consent, except in the circumstances described in paragraphs 6.3; 6.4.2; and 6.5.

7.4 The health professional may disclose personal information in response to an official request from a statutory regulatory body for any of the health professions, where that body determines that this is necessary in the interests of justice and for the safety of other patients. Wherever practicable, the health professional should discuss this with the patient. There may be exceptional cases where, even though the patient objects, disclosure is justified.

7.5 Should a health professional decide to disclose confidential information, he or she must be prepared to explain and justify his or her decision.

8. ELECTRONIC PROCESSING OF INFORMATION

A health professional must:

8.1 Be satisfied that there are appropriate arrangements for the security of personal information when it is stored, sent or received by fax, computer, e-mail or other electronic means.

8.2 If necessary, take appropriate authoritative professional advice on how to keep information secure before connecting to a network and record the fact that he or she has taken such advice.

8.3 Make sure that his or her own fax machine and computer terminals are in secure areas. If he or she send data by fax, he or she should satisfy himself or herself, as far as is practicable, that the data cannot be intercepted or seen by anyone other than the intended recipient.

8.4 When deciding whether and in what form to transmit personal information, the health professional should note that information sent by e-mail, may be intercepted.

9. DISCLOSURE OF INFORMATION ABOUT PATIENTS TO DRIVER AND PILOT LICENSING AGENCIES. THIS ALSO APPLIES TO PILOTS OPERATING BOATS, SHIPS AND AEROPLANES OR ANY OTHER MEANS OF PUBLIC TRANSPORT OR MASCHINERY.

9.1 The driver and pilot licensing authorities are legally responsible for deciding if persons are medically unfit to drive or fly. These agencies need to know when license holders have a condition which may now, or in the future, affect their safety as a driver or a pilot.

9.2 Therefore, where patients have such conditions the health professional should:

a. Make sure that patients understand that the condition may impair their ability to drive or fly. If a patient is incapable of understanding this advice, for example because of dementia, the health professional should inform the said authorities immediately;

b. Explain to patients that they have a legal duty to inform the authorities about the condition.

9.3 If patients refuse to accept the diagnosis or the effect of the condition on their ability to drive or fly, the health professional can suggest that such patients seek a second opinion and make appropriate arrangements for the patients to do so. The health professional should advise patients not to drive or fly until a second opinion has been obtained and record that this advice was given.

9.4 If patients continue to drive or fly when they are not fit to do so, the health professional should make every reasonable effort to persuade them to stop. This may include telling their next of kin.

9.5 If the health professional cannot manage to persuade patients to stop driving or flying, or is given or find evidence that a patient is continuing to drive or fly contrary to advice, the health professional should disclose in writing relevant medical information immediately to the licensing authority.

9.6 Before giving information to the licensing authority, the health professional should try to inform the patient of his or her decision to do so. Once the authority has been informed, he or she should also write to the patient, to confirm that a disclosure has been done.

10. FREQUENTLY ASKED QUESTIONS

Deciding whether to disclose information is often difficult. These guidelines set out the principles which should be followed. The following notes, explain how those principles apply in circumstances in which health professionals often find themselves or find hard to deal with.

A health professional should consider placing a paragraph on the original patient registration form explaining the issue and also inform the patient of the right to change his or her mind and to indicate yes or no to the relevant questions.

10.1 My health authority wants to conduct a post-payment verification for claims I've made. Can I give them free access to the records?

10.1.1 Some disclosures, for example, to the police or employers may cause significant harm or distress to patients, but others, such as disclosures for audit or planning, are unlikely to affect patients. In these cases consent based on the patients' understanding and acceptance of the disclosure will be sufficient.

10.1.2 It is good practice to tell patients how their records might be used to help the running and development of a healthcare service. The health professionals should make sure patients know they have a right to object to such disclosures and provide clear instructions about how they can do so. A health professional can do this by providing leaflets for those attending the surgery, clinic or hospital; discussing the issues at a suitable consultation or at clinics or when new patients join a practice or attend a hospital for the first time; or by writing to patients.

10.1.3 Where a health authority asks for access to records for audit purposes, a health professional should:

a. Review whether he or she has already informed patients about the use of records for audit and administration, and about their right to object;

b. Identify any patients who have expressed objections;

c. If he or she is not satisfied that patients have received this information, ask such health authority whether the patients whose records will be checked have been identified, and if so whether the authority has their permission to look at the records. If not, ask the health authority to do so, or contact the patients and ask whether they object to their records being examined.

10.1.4 When an audit takes place a health professional should:

a. Make sure that he or she discloses only the minimum information necessary for the audit;
b. Check with the health authority that staff are trained in handling confidential information and that they have a contractual or professional duty to respect patients' privacy.

10.2 A patient of mine suffers from a serious mental illness. He is often erratic and unstable. I know that he drives, although I have warned him that it is unsafe for him to do so. He insists that his illness does not affect his judgment as a driver. Should I tell the driver and licensing authority?

If the health professional thinks the patient may be a danger to himself or others when driving and he or she cannot persuade him to stop driving or to inform the authorities himself, then he or she should disclose the information to a medical adviser of that authority. The health professional should let the patient know of his or her decision to disclose the information.

10.3 Sometimes administrative staff in my practice needs access to patients' records. At present they can call up the whole record on screen. Is that permissible?

It is best practice to ensure that administrative staff has immediate access to information only on a need to know basis. When using computerized records, make sure that administrative data, such as names and addresses, can be accessed separately from clinical information so that sensitive data is not automatically displayed. This will also help to reduce the risk of accidental breaches of confidentiality in reception areas or other areas to which patients have access. In addition, all staff who have access to clinical information must have a full understanding of their duty of confidentiality, and understand their responsibilities. Make sure new staff are properly trained and sensitized on the need for confidentiality.

10.4 A minor patient of mine has recently been admitted to hospital suffering serious injuries from abuse. His or her father is now being prosecuted. I've been asked to provide information about the child and her family for a Children's Court inquiry. I'm the General Practitioner to the child's father and he refuses to consent to the release of information, what should I do?

This inquiry is intended to identify why the child has been seriously harmed, to learn lessons from mistakes and to improve systems and services for children and their families. The overall purpose is to protect children from a risk of serious harm. The health professionals should therefore co-operate with requests for information, even where the child's family does not consent, or if it is not practicable to ask for their consent. Exceptionally, he or she may see a good reason not to disclose information; in such cases the health professionals should be prepared to explain his or her decision to the Council.

10.5 A patient of mine is a fellow health professional. I am concerned that he has a drinking problem which could affect his judgment. It has taken me a long time to get him to admit to any problems, and if I disclose the information to his employer or to the Council now, he will probably deny everything and find another health professional. What should I do?

This patient has the same right to good care and to confidentiality as other patients. But, there are times when the safety of others must take precedence. If the health professional is concerned that his or her problems mean that he is an immediate danger to his own patients, the health professional must tell his or her employing authority or the relevant Council straight away. If the health professional thinks the problem is currently under control, he or she must encourage him or her to seek help from counselling services. The health professional must monitor his or her condition and ensure that, if the condition deteriorates, he or she takes immediate action to protect the patients in his or her care.

11. CONFIDENTIALITY: KEY PRINCIPLES

Confidentiality is central to trust between health professionals and patients. Without assurances about confidentiality, patients may be reluctant to give the health professionals the information they need in order to provide good care. If the health professional is asked to provide information about patients the health professional should:

a. Seek patients' consent for disclosure of information wherever possible, whether or not he or she suspects that patient can be identified from the disclosure;

b. Anonymise data where unidentifiable data will serve the purpose;

b. Keep disclosures to the minimum.

8. GUIDELINES ON KEEPING OF PATIENT RECORDS

These guidelines are applicable to health professionals in private practice (including managed health care organizations), as well as to those in the employ of the public service.

1. DEFINITION OF A MEDICAL RECORD

According to de Klerk, the expression a *medical record* may be defined as follows:
"A medical record is constituted by any record made by a medical practitioner at the time of or subsequent to a consultation with, an examination of, or the application of a medical or surgical procedure to his or her patient and which is relevant thereto."

DEFINITION OF A NURSING RECORD

Nursing records are developed to enable nurses to gather information, make discussions, plan, implement and evaluate the outcomes of care, thus reflecting the progress healthcare users are making or not making (Geyer 2005).

The above definitions can be extrapolated to any record prepared by a health professional.

2. WHY DOCUMENTS OR MATERIALS SHOULD BE RETAINED

Documents and materials need to be retained in order to:

a. Further the diagnosis or ongoing clinical management of the patient;

b. Conduct clinical audits;

c. Promote teaching and research;

d. Use the data for administrative or other purposes;

e. Keep as direct evidence in litigation;

f. Use as research data;

g. Keep for historical purposes;

h. Promote good clinical and laboratory practices;

i. Make case reviews possible;

3. COMPULSORY KEEPING OF RECORDS

Health professionals shall enter and maintain at least the following information for each patient consulted:

3.1 Personal particulars of the patient.

3.2 Bio-psychosocial history of the patient, including allergies and other individual characteristics.

3.3 The time, date and place of every consultation.

3.4 The assessment of the patient's condition.

3.5 The proposed clinical management of the patient and responses to the proposed treatment.

3.6 The treatment period, e.g. medication and dosage prescribed and other interventions.

3.7 Details of referrals, if any.

3.8 The patient's reaction to treatment or medication, including adverse effects.

3.9 Special investigation results.

3.10 Information on the times that the patient was booked off from work and the relevant reasons upon which sick leave may be issued.

3.11 Written proof of informed consent, where applicable.

3.12 Or any other records applicable to various health professions.

Records shall be kept in indelible black ink and erasure fluid must not be used.

4. ALTERATION OF RECORDS

4.1 No information or entry may be removed from a healthcare record.

4.2 An error or incorrect entry discovered in the record may be corrected by deleting it with a single line in black ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible.

4.3 Additional entries added at a later date must be dated and signed in full.

4.4 The reason for an amendment and/or error should also be specified on the record

5. RETENTION OF RECORDS

5.1 Records shall be stored in a safe place and if they are in electronic format, safeguarded by passwords. Health professionals should satisfy themselves that they are informed of the Councils guidelines with regards to the retention of patient records in electronic format.

5.2 Records shall be stored for a period of not less than six (6) years as from the date of the last patient contact. In the case of minors and those patients who are *non compos mentis*, health professionals should use their own discretion whether the records concerned should be kept for a longer period.

5.3 Records for minor patients should be kept for a minimum period of six months after such minor reached 21 years of age. This is to ensure records are available should the minor consider litigation after reaching the age of consent.

5.4 Having kept no records is tantamount to not having performed the treatment. In the case of litigation, no records equals no defense.

6. OWNERSHIP OF RECORDS

6.1 Where records are created as part of the functioning of a private practice, the records belong to the health professional responsible for the care of the patient.

6.2 The records, including specialist reports, X-ray films and pathology reports prepared in connection with the treatment of any patients at a state health facility, are the property of the Ministry of Health and are to be filed at such a facility.

6.3 Should a health professional in private practice (both in a solus practice and in a partnership) pass away, his or her estate, which includes the records, would be administered by the executor of the estate.

6.4 Should the practice be taken over by another practitioner, the executor shall carry over the records to the new practitioner. The new practitioner is obliged to inform all patients in writing regarding the change in ownership and that the patient could remain with the new practitioner or could request that his or her records be transferred to another practitioner of his or her choice.

6.5 Should the practice not be taken over by another practitioner, the executor should inform all patients in writing accordingly and transfer those records to other practitioners as requested by individual patients.

6.6 The remaining files shall be kept in safe keeping by the executor for a period of at least twelve (12) months with full authority to further deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

6.7 It should be noted that certain partnership agreements may make specific provision for the management of a deceased partner's share in the partnership which would include the records. It is advisable that a will should contain this codicil.

6.8 In the event of a health professional in private practice who decides on closing his or her practice for whatever reason, the health professional shall timeously inform in writing all his or her patients of the following:

a) That the practice is being closed as from a specified date;

b) That requests could be made that records be transferred to other practitioners of their choice;

c) That after the date concerned, the undistributed records would be kept in safekeeping for a period in accordance with 5.2.

7. ACCESSIBILITY TO RECORDS

7.1 A health professional shall provide any person of age 18 years or older with a copy or abstract or direct access to his or her own records on request.

7.2 Where the patient is under the age of 18 years, the parent or legal guardian may make the application for access to the records.

7.3 Information about the termination of pregnancy may not be divulged to any party, except the patient herself, regardless of the age of the patient.

7.4 No health professional shall make information available to a parent or legal guardian regarding a patient who is over the age of 16 years, but under the age of 18 years without written authorization of the patient.

7.5 No health professional shall make information available to any third party without the written authorization of the patient or his or her legal representative.

7.6 A health professional may make available the records to a third party without the written authorization of the patient or his or her legal representative under the following circumstances

a. Where a health professional is a witness in a trial between a patient and another party or where a patient has instituted action in court against a health professional and is ordered to testify on the patient's health condition or to produce the records, he or she should request that such testimony be given *in camera* in accordance with of the *Criminal Procedure Act,* 1977 (Act No. 51 of 1977).

b. Where a patient sues a health professional and the latter testifies in his or her own defense.

c. Where the Health Professions Councils has instituted disciplinary proceedings and the health professional has to answer to a charge or defends himself or herself.

d. Where the health professional is under a statuary obligation to disclose certain medical facts, e.g. reporting a notifiable disease or in terms of the Childrens Act, 1960 (No 33 of 1960), reporting any case of suspected child abuse.

e. In the event where the ailment of a patient becomes known to a health professional and the nature thereof is such that the health professional concerned is of the opinion that the information ought to be divulged, in the interest of the public at large. Before the information is divulged the relevant information shall be given to the patient and voluntary authorization shall be sought from the patient.

7.7 In public health facilities the records shall be kept under the care and control of the superintendent. Access to such records shall be subject to compliance with such conditions as may be approved by the superintendent.

8. RETENTION OF PATIENT RECORDS IN ELECTRONIC FORMAT

8.1 Storage of clinical records in electronic format would be permissible, provided that protective measures are in place.

8.2 Protective measures referred to in paragraph 8.1 would entail that:

a. Only electronic storing device technology is used, i.e. designed to record a CD once only so that old information cannot be overwritten but new information can be added;

b. All clinical records stored on electronic format and copies thereof are to be encrypted and protected by a password in order to prevent unauthorized persons to have access to such information;

c. A back-up copy of the said electronic storage must be kept and be stored in a physically different site in order that the two devices could be compared in the case of any suspicion of tampering;

d. Effective safeguards against unauthorized use or retransmission of confidential patient information.

9. CHECKLIST FOR PATIENT RECORD-KEEPING

The following checklist may serve to guide health professionals in the appropriate keeping of patient records:

a. Good notes imply good practice.

b. Records should be complete, but concise and in chronological order.

c. Records should be consistent.

d. Avoid self-serving or disapproving comments in patient records.

e. Use a standardized format. Notes should contain in order the history, physical findings, investigations, diagnosis, treatment and outcome or disposal.

f. Avoid conclusive comments, describe the facts, and make conclusions only essential for patient care.

g. If the record needs alteration in the interest of patient care, then show no intent to hide by lining out items, signing in full and dating the changes and, when possible, entering a new note that refers to the correction without altering the initial entry.

h. Release a copy of records only after receiving proper authorization.

i. Design the electronic patient record so that clinical and billing records remain separate.

j. Always label attached documents such as diagrams, lab results, photographs, charts, etc. Never rely on sheets of patient records to remain identifiable by being bound or stapled together.