

INHERENT BARRIERS TO REPORTING IMPAIRED
MEDICAL PRACTITIONERS IN TERMS OF REGULATIONS
OF THE HEALTH PROFESSIONS COUNCIL OF SOUTH
AFRICA: AN ETHICO-LEGAL ANALYSIS

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Declaration

I declare that this research report is my own work. It has not been submitted before for any other degree or examination at any other university.

Signature: _____

Date: 4/8/2021

Abstract

Impairment of medical practitioners (doctors) is an acknowledged problem in the medical profession. Medical practitioners can become impaired to practice through physical or mental illness but impairment from alcohol and substance abuse disorders is the most difficult to deal with. The Health Professions Act (Act 56 of 1974) governs the practice of the medical profession in South Africa. The Act enables the creation of regulations governing impaired doctors and ethical rules of professional conduct by the Health Professions Council of South Africa (HPCSA). Ethical rule 25 stipulates that doctors are obliged to report themselves or their colleagues to the council if they are impaired. However, many doctors are not so willing to report impairment to the regulatory body. Using a desktop analysis of available literature and legislation, the writer sought to answer a pertinent question regarding the reporting of impairment. The question is whether, the current HPCSA regulations and ethical rules on the prevention and reporting of impaired medical practitioners should be revised to reduce barriers to reporting impairment. Salient factors that prevent practitioners from reporting impairment were identified. These include denial, stigmatisation, family dynamics and psychiatric co-morbidities. Problems with the ethical rules and the regulations were also identified. Further, the writer provides suggestions on how to prevent impairment of medical practitioners and to improve the effectiveness of reporting. These include rectifying the apparent weakness in the rules and early identification of potential cases that may progress to impairment. The report is concluded with an analysis of ethical aspects on impairment of medical practitioners through a perspective of principlism.

Abbreviations

AHPRA – Australian Health Practitioner Regulation Agency

AMA – American Medical Association

FSMB – Federation of State Medical Boards

FSPHP – Federation of State Physician Health Programs

GMC – General Medical Council

HC – Health Committee

HPA – Health Professions Act

HPCSA – Health Professions Council of South Africa

MBA – Medical Board of Australia

MDB – Medical and Dental Board

MPTS – Medical Practitioners Tribunal Service

NHA – National Health Act

PHP – Physician Health Program

SAMA – South African Medical Association

SMB – State Medical Board

SUD – Substance Use Disorder

UK – United Kingdom

USA – United States of America

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Dedication

This work is dedicated to my beloved family who have provided me with the optimal space to satisfy my curiosity. Thank you for the privilege.

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CHAPTER 1

INTRODUCTION

1.1 Research Question

Should the current HPCSA regulations and ethical rules on the prevention and reporting of impaired medical practitioners be revised to reduce barriers to reporting impairment?

1.2 Rationale for the Study

The issue of Impaired Medical Practitioners is important from an ethical and legal perspective. Through the ethical principles of beneficence and non-maleficence doctors have an ethical and legal duty to do right and avoid harm to patients. The relative autonomy enjoyed by doctors in their profession demands of them to evince professionalism. There is a paucity of information on the issue of impaired practitioners in South Africa especially on reporting, and most authorities internationally have tended to focus on the causes, management, and rehabilitation of impaired medical practitioners. Not much attention has been given to factors that may impede reporting impaired practitioners. This report will explore the barriers to reporting impairment in medical practitioners as required by the ethical rules of professional conduct of the HPCSA and this could provide grounds for a review of the rules.

1.3 Background literature analysis

Society generally places enormous trust in medical practitioners (doctors), because of the knowledge and skills they possess. This trust calls for an enduring responsibility on practitioners to serve and treat their patients with utmost skill and rectitude. The Hippocratic Oath taken by doctors during their initiation into the profession has over the millennia encouraged doctors to regulate their profession. Although the relevance of the original Oath has become increasingly questionable in the contemporary practice of medicine¹ its moral echo remains important. Accordingly, the ethical rules of professional conduct reflect this respect. Medical practitioners are bound by ethical rules of professional conduct as published by the Health Professions Council of South Africa (HPCSA).² These rules spell out certain actions by doctors during the performance of their duties, which may be viewed as unprofessional conduct. Although breach of these rules may not necessarily give rise to criminal or civil sanctions against a medical practitioner registered in terms of the Health Professions Act (HPA)³ they are nevertheless enforceable. The rules provide for sanctions which may include censure, reprimand and in extreme cases removal of a practitioner from the medical register. The Health Professions Act (s51) authorises the Minister of Health in consultation with the HPCSA to formulate regulations relating to practitioners who are impaired to practice. The HPA defines impairment as..... “a mental or physical condition which affects the competence, attitude, judgement, or performance of professional acts by a registered practitioner”³. Pertinent to this mandate is ethical rule 25 which specifically relates to impairment.

This rule forms the basis for this report (see footnote)¹.

Many doctors are reluctant to report themselves or their colleagues when they are impaired to practice, as stipulated by the ethical rules.⁴⁻⁷ This report will examine the factors that might be responsible for the reluctance by doctors to report impairment. It will demonstrate that there are barriers to reporting impairment as required by the rules, not least of which is the fear of self-incrimination and stigmatisation. These aspects will be explored more extensively in the chapter on barriers to reporting impairment, with a suggestion of possible remedies. In the paragraphs that follow, the issue of impaired practitioners will be contextualised with a review of literature from leading authorities. Current literature and available statistics from South Africa and foreign jurisdictions on impairment of doctors will be considered. By contextualising the issue of impairment, the reader will in due course make out a case that there are barriers to reporting impairment by medical practitioners. Further, the review will attempt to show that certain traits that manifest in adolescence and early adulthood might be precursors to the development of impairment.

Doctors are not exempt from the adversity of the various illnesses that affect mankind. For example, they may suffer from physical illnesses such as hypertension, diabetes,

¹ Reporting of impairment or of unprofessional, illegal or unethical conduct

(1) A student, intern or practitioner shall –

(a) report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired;

(b) report his or her own impairment or suspected impairment to the board concerned if he or she is aware of his or her own impairment or has been publicly informed, or has been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment, and

(c) report any unprofessional, illegal or unethical conduct on the part of another student, intern or practitioner.

poor eyesight, and dementia. They may also suffer from mental conditions such as depression, anxiety, alcohol, and substance abuse. The condition may be severe enough to result in the affected practitioner becoming impaired to practice medicine. This review focusses on impairment to practice medicine, irrespective of the cause of the impairment. However, of the various causes of impairment among practitioners, substance abuse disorder is the most difficult to deal with and has been studied more extensively⁸; it will thus feature more prominently in this report. A substance abuse disorder is a condition where there is overindulgence or dependence on an addictive substance, especially alcohol or drugs. Evidence suggests that alcohol is the most abused substance among doctors, compared to illicit drugs, narcotics, sedatives and stimulants which are also commonly abused.⁹⁻¹¹ There is also a strong association between substance use disorder and mental health conditions.⁸ In South Africa, statistics indicate that as at May 2018, 225 medical practitioners out of a total of 345 healthcare professionals were under the management of the Health Committee (appointed by the HPCSA to manage impaired practitioners) in the of the HPCSA.¹² This translates to 65% of the total number of healthcare professionals under management for impairment. The high percentage of medical practitioners that are under management reflects the high proportion of registered medical practitioners in comparison to other health professionals on the HPCSA registers. If the number of the affected medical practitioners is rationed against the total number of medical practitioners on the medical register (45,533) as at that time,¹³ it represents 0.5% of the group. In a report by the American Medical Association (AMA) it was estimated that more than 10% of doctors will develop an addictive disorder during their career life and

that one third will suffer a condition (physical, psychological or mental) that will negatively affect their ability to practice with reasonable skill and safety, at some stage in their career.¹⁴ In another survey conducted in 2019 of over 400 doctors based in the United Kingdom, it was found that 45% engaged in binge drinking and 5% were categorizable as alcohol dependent.¹⁵ The actual prevalence of impairment among doctors would always be difficult to accurately establish given that there is reluctance to confront the problem.¹⁶⁻¹⁸ Nevertheless, these figures help to highlight and contextualise the issue of impairment among doctors.

There is evidence from international sources to suggest that the groundwork for alcohol and substance abuse among medical practitioners is laid much earlier during training at medical school.¹⁹⁻²¹ The arduous training programmes may impel students to look for means of coping with the stress, with some of them in the long run, risking addiction and consequent impairment to practice medicine. Jackson et al²² in a study of over 4,000 medical students found that there was a strong correlation between burnout and alcohol abuse. In South Africa, Vorster et al²³ in a self-administered questionnaire of a sample of 171 second and third year students at the faculty of Health Sciences, at the University of the Free State, revealed worrisome statistics. 78% of second years and 82% of third years reported using alcohol. They also found that 22% of second year students and 24% of third year students reported cannabis use. It is also possible that some students clandestinely start using alcohol and illicit drugs before entry into medical school, during high school. Moreover, there is reduced parental control for those students at university who do not continue to stay with their parents or guardians. This may indirectly encourage risky behaviour including substance abuse.^{24,25} Various

studies have demonstrated an increasing rate of alcohol use among adolescents at high school and also a reduction in the age at which adolescents start drinking alcohol.²⁶⁻²⁸ A counter argument to the findings in the various studies mentioned above would be that, these are just studies that show young people in their adolescent reality and use of alcohol does not necessarily translate into addiction and impairment. However, it is submitted that one can only become addicted to alcohol or if he/she uses alcohol, although it does not follow that whoever uses it gets addicted. To put it differently, it is only from a cohort of alcohol users that an addicted individual will emerge. The studies are used in the context to demonstrate that the seed for future impairment as a medical practitioner may in some cases be planted earlier than entry to medical school or during the training period at medical school.

Another setting that may inadvertently create an opening for impairment is the prescription of medication. As part of their job doctors have authority to prescribe medication and in South Africa, they are also allowed to dispense medicines if they have a dispensing licence.²⁹ Moreover, medical practitioners do regularly self-prescribe medication for their own personal use.³⁰⁻³² The access to potentially addictive substances in the course of the their job coupled with the deep knowledge of the workings of these substances, is a potential avenue for unlawful self-use and subsequent addiction leading to impairment for some practitioners.²¹ There are different scenarios in which medical practitioners practise their profession, including, as private practitioners (quite often in solo practice) or in contract employment with institutions of government and private entities. In terms of the Medicines and Related Substances Act³³ there are specific measures and precautions that have to be followed, when

prescribing and controlling stock of potentially addictive medicines (Schedule 6 and 7 drugs). These measures are meant to impose restrictions on potential abuse by medical or nursing personnel. However, institutional, or individual weaknesses in the prescription and stock control of these substances can lead to breach of the regulatory measures. This creates an opportunity for illicit use and abuse by some practitioners ultimately leading to impairment.³⁴ Each scenario of practice has its own peculiar circumstances and nuances (such as the type of medication or substances in most use) that should ideally, call for control measures specific to the entity concerned to prevent unlawful use.^{32,35,36} A self-employed doctor in solo practice may become impaired from unlawful use of addictive substances because of easy accessibility, without this being addressed for a long time due to reluctance to report himself or colleagues unwilling to get involved.

Impairment may also manifest because of mental illness or psychological problems suffered by the doctor. Practising medicine can be unduly stressful, and studies indicate that stress among medical practitioners is a worldwide problem.³⁷⁻³⁹ Stress can lead to psychiatric morbidity such as anxiety, depression and addiction, leading to impairment. Liebenberg et al⁴⁰ found high rates of stress and burnout among doctors working in rural hospitals in the Western Cape. Their findings were also comparable to an earlier study done in the Cape Town metropolitan areas.⁴¹ Doctors are generally reluctant to seek help and many times lack the self-awareness of the symptoms of stress to seek assistance⁶. The fear of stigmatisation and a potential feeling of shame, denial of one's state of circumstances, fear of loss of income and social standing are some of the reasons that derail the decision to come forward for assistance.⁴

Doctors can also become impaired to practice because of deterioration of their cognitive (intellectual) abilities. The cognitive decline may be caused by injury to or diseases of the brain such as dementia, and by advancing age.⁴² The decline in cognitive abilities will in time lead to impairment which may initially be subtle. For example, Peisah et al⁴³ reviewed the records of doctors who had been referred for assessment for infringements such as inappropriate prescribing and behavioural problems. They found that 54% of the referred doctors were cognitively impaired. It is however important to recognise that, advancing age does not imply that all elderly medical practitioners are necessarily impaired. In fact, it would be deemed discriminatory to remove from the medical register names of elderly registered medical practitioners on the presumption that they are impaired to practice because of their advanced age. There is an emerging trend where, medical practitioners in their 70s and 80s are becoming an increasing group in the medical fraternity,⁴³ mainly because of the choice to retire later, increasing life expectancy and concerns about financial security. This can conceivably be beneficial especially in communities with scarce resources, considering the expertise and experience of elder practitioners. In reality however, advancing age may in some instances bring with it significant negative changes, not least of which could be cognitive decline, that may affect the doctor to the point of impairment.⁴²⁻⁴⁴ In such circumstances, if the affected medical practitioner satisfies the definition of impairment (in terms of the HPA), colleagues are legally obliged to report him or her, in the interest of patient safety. Furthermore, some of the regulatory and employment authorities in the USA, UK, Canada and New Zealand have voluntary and in some cases mandatory programmes to periodically assess the performance of elder doctors who elect to

continue in their profession further.⁴⁵⁻⁴⁷ The measures have caused consternation as some people have interpreted them as discrimination against the elderly. There is currently no similar programme in South Africa.

Although most cases of impairment to practice are related to substance use disorder and mental illness,^{8,13} physical illness can also take its toll on a practitioner potentially leading to impairment. The physical illness may cause permanent impairment to practice or in some cases the cause may be of a temporary nature necessitating a period of withdrawal from professional practice until the doctor has recovered sufficiently enough to resume practice. In some instances, doctors may become physically impaired to practice when they unfortunately contract health conditions that may be a result of occupation related exposure or application, in the field of medicine in which they practice.^{48,49}

It is submitted that, medical practitioners are only obliged to report themselves or colleagues when they are impaired to practice and not necessarily when they suffer from a specific physical or mental disease³. The ethical guidelines refer to impairment to practice. For example, there is no obligation for colleagues to report a practitioner because he/she suffers from diabetes. However, if in the course of the practitioner's professional life, suspicion arises that his/her eyesight is failing as result of complications from diabetes, and that patient care and safety is being compromised, it then becomes an obligation on the practitioner or colleagues to report the issue of failing eyesight for assessment and investigation by the HPCSA. Similarly, a practitioner who suffers from a mental health problem such as depression or a bi-polar disorder, is not deemed impaired if controlled on medication, and provided that his/her competence,

attitude, judgement or performance of professional acts are not affected. The writer is of the view that impairment should be distinguished from potentially impairing disease.

This aspect will be explored more extensively in Chapter 5 of this report.

In this section the writer has provided an overview of impairment in medical practitioners to lay the foundation for an ethico-legal analysis of barriers to report impairment among medical practitioner in South Africa, which is the purpose of this research report.

1.4 Aim and Objectives of report

The aim of the report is to demonstrate that the current HPCSA legal and ethical rules are ineffective in encouraging and supporting medical practitioners in South Africa to report impairment.

The objectives are:

- (i) To critically evaluate the current rules and regulations of the Health Professions Council of South Africa on the prevention and reporting of impaired medical practitioners and argue that there are gaps in them that negatively affect compliance in reporting impairment.
- (ii) To critically review applicable regulations of similar bodies from a selection of countries and determine whether some aspects thereof can be adopted by the HPCSA to achieve more compliance in reporting impairment.
- (iii) To suggest changes that can be made to the HPCSA rules and regulations aimed at achieving more compliance in reporting impairment.

1.5 Research Method

The methodology used in compiling the report is a desktop analysis of literature from academic journals and legal sources, through literature search, current legislation as well as policy documents from the HPCSA and the Medical Association of South Africa (MASA) about impaired medical practitioners.

1.6 Argumentative Strategy

In this report I argue that:

Doctors are hesitant to report themselves when impaired to practice for fear of stigmatisation and loss of accreditation.

- (i) There are difficulties with current legislation and ethical rules not considering the doctor's right not to self-incriminate as well as the apprehension associated with incriminating colleagues.
- (ii) The cause of the impairment influences the decision to report.
- (iii) I will compare regulations from regulatory bodies in other countries to determine whether South Africa has kept pace with international trends on reporting impairment in medical practitioners and also whether there are some aspects from those regulations that can be adopted by the HPCSA.
- (iv) A workable regulatory framework for impaired medical practitioners for South Africa is needed, for doctors to fulfil their ethical obligation to maintain professionalism through the application of ethical values of principlism.

1.7 Outline of Chapters

In Chapter 2 the current legal framework of the HPCSA will be outlined and analyse.

Chapter 3 will explain the processes followed by the HPCSA in dealing with impaired medical practitioners in South Africa. Chapter 4 will give an analysis from a selection of jurisdictions, of the regulations and processes followed in dealing with impaired doctors.

Chapter 5 will discuss the barriers to report impaired medical practitioners in South Africa, suggest remedies to these barriers and provide a normative analysis.

CHAPTER 2

AN ANALYSIS OF SELECTED SECTIONS OF THE HEALTH PROFESSIONS ACT AND HPCSA ETHICAL RULES

2.1 Introduction

The delivery of health services to the community is one of the most challenging tasks for any government.⁵⁰ In South Africa, the political system of apartheid significantly contributed to the skewed distribution of health services in the country.^{51,52} The new political dispensation of 1996, ushered in the Bill of Rights as part of the new Constitution. Chapter 2 of the Constitution of the Republic of South Africa embodies the Bill of Rights. Section 27(a) states that everyone shall have the right to have access to health care services which includes reproductive health. One of the mechanisms to achieve this was the promulgation of new legislation in the form of the National Health Act (NHA)⁵³. The new legislation brought under one umbrella many of the previously fragmented health services. In light of this, the Health Professions Act (HPA) was also amended to amalgamate the three medical councils that were responsible for regulating medical practice. However, this is not to suggest that these statutes are the exclusive mechanisms required for an effective delivery a health service. Nevertheless, they make an appreciable contribution to the lattice of the health care system. The provision of health services as demanded by the Constitution involves an interplay of several legal instruments which cannot all be listed here. For example, without a regulatory framework for doctors it would be difficult to monitor accreditation criteria and professional standards of medical practice. This section of the research report will

provide an analysis of selected sections of the Health Professions Act and the ethical rules of conduct of the HPCSA, that are pertinent to the issue of impairment.

2.2 The Health Professions Act

The Health Professions Act is the enabling legislation for the regulatory functions of the HPCSA. This legislation provides for the establishment of the Health Professions Council of South Africa and its constituent professional boards. The purpose of these structures is to provide oversight on the education, training, registration, and professional practice of health professions registered under the Act as well as matters incidental thereto.³ The HPCSA is the statutory body established in terms of the HPA for the purpose of regulating all health professions in South Africa with the exception of the nursing and pharmacy professions. These two professions are regulated by the South African Nursing Council and Pharmacy Council of South Africa respectively. In terms of section 15 of the HPA the Minister of Health on the recommendation of the HPCSA shall establish a professional board for each of the health professions under its jurisdiction. There are currently eleven professional boards administering matters related to each of the health profession categories that fall under the regulatory body. The medical and dental board (MDB) is responsible for the guidance of professional practice in medical practice (medical practitioners, clinical associates, and medical specialists), dental practice (dentist practitioners and dental specialists) and medical science (genetic counsellors, medical physicists, and medical biological scientists). The HPA is a broad piece of legislation that exercises control over training institutions for health professions as well as individual practitioners. For a medical practitioner whose

name is on the register of the MDB in terms of the HPA, there are salient sections of the Act that bear relevance; for the purposes of this report section 51 is most relevant. In terms of this section the Minister of Health in consultation with the HPCSA, has the authority to make regulations regarding inquiries on medical practitioners who are deemed to be impaired. Such regulations will entail aspects of the assessment of a practitioner's condition, the conditions to be imposed on their registration or practice, their suspension or removal from practice, rescission of conditions, and suspension or removal from the register. The regulations are available in the government gazette². Further, the regulations also authorise suspension or removal from the register, for unprofessional conduct committed during assessment or investigations for impairment. It is submitted that this section of the legislation is crucial in protecting patients from impaired practitioners. However, it also provides an opportunity for an impaired practitioner to preserve his/her career through rehabilitation. The regulations made through the HPA enable recommendations to be made for treatment and rehabilitation for doctors found to be impaired. The writer is also of the view that, doctors generally enjoy relative autonomy in the practice of their profession, but this should not be at the expense of patient safety.

There are other sections of the HPA that are of importance to medical practitioners. Section 17 deals with the prerequisite to register as a medical practitioner before a doctor commences with practice in South Africa. There is a prescribed process to obtain the registration which includes payment of applicable fees. In terms of this section, it is a criminal offence to practice without registration with the HPCSA, and the guilty party may face imprisonment, a fine or both. In conjunction with section 51, the prerequisite

to register before a practitioner can practice in South Africa, is aimed at ensuring that only persons who are appropriately qualified and can treat patients. To fulfil this obligation the HPCSA has an established inspectorate division in its administrative structure.³³ The inspectorate is mandated to monitor the registration of doctors and ensure that all accreditation is current and appropriate. It is submitted that in some cases an impaired doctor may have lapses in maintaining administrative obligations. This might be caused by the effects of the illness causing impairment.

The provisions in section 19 of the HPA are also of key relevance to medical practitioners. They specify the conditions under which a medical practitioner's name may be removed or restored to the register. Further, it provides for a practitioner who may elect to voluntarily have his/her name removed from the register, to be done in a prescribed manner. In fulfilling the prescribed process s19(c), provides that a practitioner *may* (emphasis added) be required to provide an affidavit to the effect that there are no pending proceedings for unprofessional conduct or criminal acts. The inference of this is that it is not mandatory but may be required. Furthermore, the HPCSA should ordinarily have records of any pending proceedings of unprofessional conduct against any practitioner. This makes the need for an affidavit from the doctor somewhat superfluous. There is provision in Section 19 for circumstances under which a practitioner's name may be removed from the register. These circumstances could for example be unprofessional conduct or failure to notify the registrar of the address where a practitioner is practising. A medical practitioner who was registered in error or fraudulently can also have his/her name removed from the registered through provisions of this section. Removing a doctor's name from the register has negative implications,

not least of which is that he/she cannot continue in his/her career until restored on the register. Unprofessional conduct is one the most common reasons for suspension or removal from the register.⁵⁴

Chapter IV of the HPA provides for disciplinary procedure of the professional boards (MDB in this case) against erring medical practitioners. Section 51 which has most relevance for the purposes of this report has been discussed. The remainder of the sections in this chapter provide for the handling of inquiries on matters of unprofessional conduct. The HPCSA through the MDB has the authority to institute an inquiry into any complaint, charge, or allegation of alleged unprofessional conduct against any medical practitioner registered under the HPA. The manner in which investigations are conducted is detailed in section 41. Where necessary, search warrants may be issued by the court to search for evidence such as books, documents, or electronic data. There is further provision for the procedure to be followed at an inquiry by the professional board (section 42) which includes imposition of a penalty, suspension of operation of the penalty, and a reprimand. In terms of section 45, the professional body is also empowered to take cognisance of any offence for which a practitioner is convicted of in a court of law. If the offence is deemed by the professional board to amount to unprofessional conduct, the doctor will face an inquiry by the board. The MDB has the powers in terms of the HPA to examine the offence(s) for which the doctor has been accused and convicted of. The board then has to decide whether there is a case of unprofessional conduct for the doctor to answer. The various sections in this chapter have relevance to an impaired practitioner. Firstly, an impaired doctor may face an allegation of unprofessional conduct that may be a result of his/her impaired state²¹. An

isolated allegation of unprofessional conduct might in some instances be the first time the MDB becomes aware of a practitioner's impairment²¹. This would set off an investigation by the board for two potential charges namely, unprofessional conduct and impairment. Secondly, infringements of the law such as driving under the influence of alcohol or dealing in illicit drugs may result in the practitioner being criminally charged. If the practitioner is convicted, the court may direct that the court record should be made available to the HPCSA. These crimes are given only as examples here; a variety of law infringements and subsequent conviction may lead to investigation by the MDB. The HPCSA lists a number of transgressions for which disciplinary steps may be taken against a practitioner; criminal convictions is included on that list².

The right to appeal is provided for in section 20 of the HPA. If a practitioner is aggrieved by the outcome of the disciplinary proceedings by the council or professional board the decision can be appealed in the High Court. In the spirit of ensuring justice this clause is desirable. It enables the practitioner to have access to a court of law if he/she feels dissatisfied with the regulating authority⁵⁵.

The medical practitioner plays an important role in the realisation of healthcare delivery. Accordingly, medical practitioners should be cognisant of the legislation as it affects their profession. The writer has given an outline of the relevant sections of the HPA as they may relate to the issue of impairment. The next section will discuss the ethical rules of conduct of the HPCSA.

2.3 HPCSA Ethical Rules of Conduct

The ethical rules of conduct of the HPCSA² govern the professional practice and conduct of all health professionals that are registered in terms of the HPA. It is submitted that the purpose of these rules is to streamline professional standards of practice for the various health professions regulated by the Act. The ethical rules are drafted by the HPCSA in consultation with the professional boards and with the approval of the Minister of Health, in terms of section 49 read with sections 61 and 61A of the HPA. The rules specify conduct or omissions for which a practitioner may be investigated, and disciplinary proceedings instituted if necessary. The investigations and hearings are conducted by the relevant professional board as provided for in terms of Chapter IV of the HPA.² In cases which involve medical practitioners, the professional board responsible for handling such proceedings would be the MDB. The ethical rules do not constitute an exhaustive list of conduct; a professional board can decide to inquire about any complaint of unprofessional conduct that is brought to its attention. In such instances the board is guided by the same rules, ethical rulings, and guidelines as well as policy statements which the professional board makes from time to time.² The ethical rules of the HPCSA may not necessarily be legally binding in a civil or criminal matter tried before a court of law. However, it is argued that from the point of view of reasonableness, some aspects of these rules may be invoked in such proceedings to decide a dispute, grievance or to provide a remedy. For example, the courts of law may use the hypothetical reasonable expert principle to decide on matters of medical negligence.⁵⁶ The reasonable expert principle is an objective yardstick that considers a composite of a community's judgement of how a person should behave in a situation

that poses a danger to the public.⁵⁷ Impairment, especially arising from substance abuse disorder tends to cloud sound judgement and this can potentially lead to negligent clinical decisions. Further, deliberate actions such intoxication or dereliction of clinical duties, as often occurs in a substance abuse disorder are unlikely to pass muster of the reasonable clinician test.⁵⁸

The ethical rules of professional conduct can be roughly categorised by their intended focus in guiding the practitioner. These are competence and conduct, business practices and professional practice. This review will provide some examples of each category. Ethical rule 25 which is the focus of this report is intended to ensure that doctors are fit to practice without endangering their patients' lives. This is a core tenet in the practice of medicine and also for the regulatory body (HPCSA).² Impairment negatively affects competence even if a doctor is well trained in his/her field of practice. This consequently compromises the safety of patients who may sometimes be oblivious to the fact that the doctor is actually impaired. The writer is of the view that there is justification for this ethical rule; it promotes self-regulation and a spirit of look-out-for-one-another among medical colleagues. It is also argued that, refining this rule further may remove some of the barriers to reporting impairment. The business models used by practitioners to conduct private professional practice is another aspect that is guided by the rules of ethical conduct (rule 8). Advertising of a private practice is only allowed if it is not unprofessional or deceptive (rule 3). There are ethical rules that prohibit the manufacture of medicines and medical devices for commercial purposes (rule 23). Rule 23A gives guidance to practitioners who may have financial interests in hospitals or healthcare facilities. For example, there is an obligation to inform their patients about

financial interests in institutions where they may admit or treat patients. These rules have relevance in the context of impairment. The managing of business in the environment of a professional practice may potentially become an area of concern against an impaired practitioner. The prospects for transgression of these rules are real. More often than not, impairment especially that which is a result of substance abuse disorder, tends to be associated with poor judgement of issues by the affected person¹⁰. This may potentially lead to failure to comply with obligations spelt out in the ethical rules of conduct. For instance, a doctor impaired from a substance abuse disorder may indulge in deceptive advertising of his/her services in order to target particular kinds of patients. In doing this the doctor may have an ulterior motive to leverage his/her access to supplies of controlled drugs such as narcotics. Alternatively, the doctor may clandestinely promote preferential use of particular medicines even though it is not clinically appropriate or not the most cost-effective, again with similar ulterior motives⁵⁹. This will lead to an investigation and potential disciplinary measures by the MDB.

The third aspect addressed by the ethical rules of professional practice is related to etiquette and handling of documents. Of salience in this category is the professional reputation of colleagues (rule 12), professional confidentiality (rule13), signing of professional documents, certificates, and reports (rules 15 and 16) and performance of professional acts and exploitation (rules 21and 22). The professional reputation of colleagues is relevant in the context of impairment. One of the reasons for the reluctance doctors to report colleagues that are impaired, is the perceived fear of casting aspersions on colleagues.^{21,60} This is in spite of reassurance from the HPCSA that no legal liability will be suffered by a practitioner who reports a colleague on good

suspicion and without malice.² As long there is no intentionally hidden ill-will on the part of the person making a report or submission, apprehension about legal liability should be of minimal concern. However, it is submitted that in some instances it may be difficult for practitioners to be certain if their actions are in keeping with the ethical rules. There are factors such as seniority and solidarity in the profession that may influence ethical decisions. These issues will be amply vetted in chapter 5. Nevertheless, this ethical rule serves to preserve professional decorum among colleagues. For example, colleagues making unpleasant comments regarding a practitioner who is impaired would be viewed as unethical. The ethical rules that guide the completion, writing and signing of documents such as sick medical certificates and reports are also important in the setting of an impaired practitioner. Any practitioner is well advised to take due care when handling documents such as medical certificates and medical reports. Again, an impaired practitioner who may have poor judgement of issues can potentially commit grave errors when dealing with such documents; this can be construed by the MDB as professional misconduct or bringing the profession into disrepute. The rules on the performance of professional acts and exploitation inform that a medical practitioner should only perform such duties for which he/she is adequately trained (except in an emergency) and that a practitioner should not permit himself or herself to be exploited in any way. The writer is of the view that, for an impaired doctor and perhaps at the coalface of a demanding clinical situation, lack of appreciation of professional limitations or potential exploitation may become a reality. Because of impairment the doctor may fail to see that referral to another colleague is the ethical step to take.

The writer has provided an overview of the relevant ethical rules of the HPCSA that currently govern health professionals in South Africa. However, the list is not exhaustive; only those rules that may bear relevance to the issue of impairment have been discussed. Medical practitioners who are impaired may potentially transgress some of these ethical rules of conduct which may lead them to being investigated by the MDB in addition to the proceedings instituted by the Health Committee.

CHAPTER 3

THE PROCESS OF MANAGING IMPAIRED MEDICAL PRACTITIONERS BY THE HEALTH COMMITTEE OF THE HPCSA

3.1 Introduction

The management of impaired medical practitioners is a process legislatively provided for by section 51 of the HPA. The provision in section 51 authorises the Minister of Health to make regulations relating to the impairment of medical practitioners and these regulations are published in the government gazette.² The HPA (s15) mandates the HPCSA to form professional boards of which the MDB is the board responsible for regulating medical practitioners. The MDB is in turn responsible for establishing a Health Committee (HC). The HC is a standing committee consisting of seven members, whose primary function is to have oversight over the compliance and rehabilitation of impaired medical practitioners. In fulfilling these functions, the role of the HC is not to be punitive but rather to guide impaired practitioners while also protecting the public. This rehabilitative approach is of significance in the context of encouraging medical practitioners to report impairment; practitioners can disclose information on impairment about themselves or colleagues with the reassurance that there will be no sanctions against them^{2,61}. It is however just one aspect in reducing potential obstacles to reporting; there are other factors that may contribute to the reticence to report impairment. The HC is also responsible for among other functions, the formulating of policies and mechanisms that help enlist cooperation among doctors to prevent impairment.⁶² Further, in terms of section 51 of the HPA it is also the responsibility of

the HC to review and refine the regulations and processes for the management of impaired practitioners. This places the HC in a unique position to play an influential role in reducing barriers to reporting impairment. The HC can fulfil this responsibility by regular appraisal of policy and by espousing contributions from other stake holders³³.

3.2 The Process

A complaint of alleged impairment is reported to the Health Committee Secretariat of the MDB by a professional colleague, a student, an intern, or any member of the public.² Alternatively, the affected medical practitioner may on his/her own volition report his/her own impairment as stipulated in the ethical rules of professional conduct.⁶² The matter is reported to the HC and scheduled for consideration on the agenda of its next meeting. After a meeting of the HC, the medical practitioner is informed in writing of the complaint and is requested to undergo an assessment to determine the veracity of the allegation. The assessment is done by two specialists, one of each selected by the HC and the medical practitioner.⁶² The type of specialists selected to do the assessment depends on the alleged cause of the impairment. For example, psychiatrists will be used to assess alleged impairment due to mental illness. The specialist assessors are given reporting guidelines of the assessment by the HC and their reports are solely used to determine whether or not the practitioner is impaired.² If the HC determines that a case of impairment exists, the practitioner is declared impaired in terms of section 51 of the HPA. The HC will then inform the MDB to impose certain conditions on the registration of the practitioner and inform him/her. The conditions imposed depend on the circumstances of each case. For example, supervision may be imposed on the

practitioner while he/she continues to practice, or specific restrictions when prescribing medication may be put in place. Limiting the scope of practice or suspension of registration may also be instituted against the practitioner.² The HC monitors and enforces the restrictions. If the HC determines from the report that the condition suffered by the impaired medical practitioner can be ameliorated by a rehabilitation program, the practitioner is advised to undergo such rehabilitation.⁶³ Such a condition may for example be a substance use disorder (SUD). Reports are submitted by the team of the healthcare providers responsible for the rehabilitation program of the impaired doctor. The reports are submitted in a specified format and are initially submitted quarterly in the first twelve months. Thereafter, the reports are submitted biannually for one year and then annually for the duration of the rehabilitation⁶³. It is important to note that an impaired practitioner may continue to practice (save for the imposed restrictions) if he/she has not been suspended from the register. This can be mutually beneficial for the doctor and the patients. While the doctor continues to earn an income, the community is protected by the HC monitoring the doctor through supervision and applicable restrictions on his/her professional practice.

The HC after considering the findings in the assessors' reports may determine that there is no impairment and dismiss the case. The practitioner is informed accordingly and the case file closed. Although it is clearly established that the process is not intended to be punitive for the impaired doctor, it is not clear as to what degree of severity of impairment that should exist before reporting to the HC. Some of the criteria used to define impairment in terms of the ethical guidelines (attitude and judgement) are rather subjective; they depend on individual experiences and may not be so reliable in

providing a composite yardstick in assessing impairment.^{64,65} It may thus be a challenge to make a determination on borderline cases. An additional function of the HC is to provide mechanisms for early identification of impairment. In light of this the writer is of the view that, an innovatively designed questionnaire, predominantly employing objective parameters might serve as a better gauge to determine impairment. This would entail engaging experts to design questionnaire tools that objectively seek information as to whether the capacity to practice safely is compromised due for instance to alcohol addiction⁶⁶. The questionnaire should be robust enough to pre-empt potential bias from aspects such as demographics or culture. This approach would minimise mistakes when assessing suspected cases and may also identify borderline cases⁶⁷

An issue of vicarious liability transpires in the context of an impaired doctor who is supervised while performing professional duties. This situation arises when, in terms of the regulations the HC decides that the doctor can continue to practice but only under supervision in an institution. In that case, the hospital and supervising staff may be potentially liable for acts of negligence that might be committed by the medical practitioner who is under their control⁶⁸⁻⁷⁰. Even under supervision, there is no guarantee that an impaired doctor, especially one who is suffering from substance abuse disorder will not relapse and in the process perpetrate clinical negligence. It is submitted that apprehension about vicarious liability may deter some institutions and doctors from taking on supervisory responsibilities for impaired medical practitioners. In order to protect themselves against potential legal costs in such an eventuality, all

parties involved should ensure that they have adequate medical practitioner insurance cover.

If a medical practitioner refuses or reneges to submit to an assessment, the matter is referred to the legal department of the HPCSA for a formal investigation in terms of section 51 of the HPA. In this instance, a notice is given in writing to the practitioner to appear for an examination within 30 days and if he/she does not comply his/her name is suspended from the register of medical practitioners². A few other important aspects in the process need mention. The initial assessment of the practitioner by the specialists takes place as close as possible to where the practitioner lives. The HPCSA has a pool of assessors in all the nine provinces of South Africa. This may be to the benefit of the impaired doctor who must also bear the costs of travel, assessment and rehabilitation if recommended. The matter of financial costs is worthy of attention in the overall issue of impairment. For example a doctor who is impaired from a substance abuse disorder is more often than not in financial difficulties as he/she continues to spend money to feed the addiction.¹⁰ By the time the HC eventually intervenes to assist the doctor, there may not be enough financial resources to pay for assessment and rehabilitation. In such cases the alternative option is to use state resources in public institutions, but these institutions do not cover expenses such as transport and other necessities at home. The concern about financial expenses is thus real and must be factored in as contributing to the reticence shown by some practitioners in reporting impairment. The duration of treatment and monitoring is not fixed, and costs do escalate. It is only when the HC has resolved that the practitioner is no longer impaired in terms of the HPA that the monitoring and any other conditions imposed on the registration are lifted.⁶³

The process involved in managing impaired medical practitioners as outlined above demonstrates a regulatory process with implications for the affected practitioner who inevitably, may have to change the daily routines of his/her profession in order to preserve a career. The same process also has implications for the HC. The personal dignity and confidentiality of the doctor must be preserved, while concerned entities must take cognisance of the principle of vicarious liability for the impaired doctors that they supervise.

CHAPTER 4

A CRITICAL ANALYSIS OF RELEVANT LEGISLATION GOVERNING IMPAIRED PRACTITIONERS IN SELECTED FOREIGN JURISDICTIONS

4.1 Introduction

This chapter will provide an analysis of pertinent legislation that governs the issue of impaired medical practitioners from a selection of foreign jurisdictions. The problem of impairment to practice among doctors is well recognised worldwide.⁷¹⁻⁷³ This problem is further compounded by the insidious attitude of many doctors who turn a blind eye rather than assist affected colleagues in seeking help.^{6,74} This does not only potentially endanger patients' lives but also undermines the trust that is traditionally placed in the medical profession by society. In light of this, many countries have over time devised legislation aimed at formulating policies that protect patients against impaired practitioners. The writer is of the view that there are aspects in the South African legislation as well the medical profession code of ethics, that may inadvertently encourage reluctance to report impairment. These aspects will be vetted in chapter 5 and will justify the argument that there are points from other jurisdictions that can be incorporated in our legislation. Further, section 39 of the South African Constitution⁷⁵ enjoins due consideration of international and foreign law in the interpretation and development of the law. This analysis will review the legislation on impairment from regulatory authorities in the United States of America (USA), the United Kingdom (UK) and Australia. These countries are selected because of their strong health care systems

as well their robust research contributing to the understanding of the complexities of impairment in medical practitioners.^{4,76,77}

4.2 An overview of the Management of Impaired Medical Practitioners in the USA

The management of impaired physicians (medical practitioners or doctors in the USA are commonly referred to as physicians) in the USA is a multi-pronged strategy fulfilled through three separate influential agencies. In principle these agencies work together, and they are, the American Medical Association (AMA), the State Medical Boards (SMB) and the Physician Health Programs (PHP). The AMA is a medical association for physicians based in the USA, whose role is to look after the professional interests of physicians practising in the various states. Membership of the AMA is not compulsory however, the association plays a very influential role in the health policy of the USA. For this reason most physicians who are members find it to be a useful institution in promoting and protecting their professional interests.⁷⁸ The writer is of the view that non-statutory organisations such as the AMA play a crucial role in nudging governments to make progressive legislation for healthcare. The AMA contributed to the drafting of the Physician Health Program Act¹⁴. The Act enables physicians to seek assistance voluntarily and also for institutions or colleagues to refer physicians that need help because of addiction or impairment. In essence, the AMA would be comparable to the South African Medical Association (SAMA) which is also a voluntary association of medical practitioners in South Africa.⁷⁹ There is however a salient difference which is of relevance for this report. The Council on Ethics and Judicial Affairs established within

the AMA is responsible for ethical matters regarding physicians' conduct.⁷⁸ The AMA's code of conduct obligates physicians to promote patients safety through ensuring that impaired colleagues receive appropriate treatment and assistance.⁸⁰ In contrast, the code of conduct⁸¹ of SAMA does not specifically stipulate that members of the association have an ethical or collegial duty towards fellow members that are impaired. Neither does the association have programs in place to assist impaired doctors. This can be construed as a glaring omission that SAMA should perhaps consider investigating.

The state medical boards in the USA constitute the second important agency in the management of impaired physicians. In the USA each state has its own licencing authority, known as the medical board that is responsible for the accreditation of physicians practising in a particular state.⁸² The medical board plays a comparable role to the HPCSA in South Africa, including conducting inquiries and instituting disciplinary actions against physicians who are found to be impaired and recalcitrant to professional assistance⁸³. In contrast to the HPCSA process, an impaired physician in the USA is usually only reported to the medical board when he/she fails to show cooperation with the Physician Health Program (PHP).

Physician Health Programs are found in each state and constitute the third component in the management strategy for impaired physicians in the USA.¹⁴ The Federation of State Physician Health Programs (FSPHP) brings together the various PHP centres in all the states. The federation drafts policy and guidelines that are agreed upon and followed by the PHPs in the country. The PHPs function as resource centres specially designed to assist doctors suspected of being impaired or suffering from potentially

impairing illnesses such as substance use disorder (SUD). The PHPs operate by entering into a confidential agreement with the individual doctor to participate in a treatment and rehabilitation program and without the involvement of the state medical board. As a matter of formality, the PHP notifies the state medical board about physicians who are on the program and their progress¹⁴. Normally the medical board does not institute disciplinary proceedings if the physician fulfils his/her obligation during the treatment program. The primary purpose of these resource centres in the USA is early intervention to ensure the safety of patients while at the same time offering confidential assistance to physicians suspected of being impaired.⁸⁴ Doctors may refer themselves to these centres voluntarily or on advice by colleagues. Institutions employing physicians can also refer impaired physicians to these centres. With such a modus operandi, PHPs in essence act as diversion programs for impaired physicians to maintain their accreditation as long as they follow the prescribed program. The process has two advantages. Firstly, it provides an incentive for doctors and institutions to seek assistance confidentially and without the apprehension about disciplinary proceedings. Secondly, potential harm to patients is averted by early intervention. The Federation of State Medical Boards of the USA (FSMB) has also highly endorsed the important role that PHPs play in protecting the public and encourages all medical boards to work with them.⁸³ The FSMB is an umbrella body that brings together all state medical boards in the USA. While endorsing PHPs, the FSMB also advises that appropriate boundaries should be maintained between the AMA, the PHP and, the medical boards to avoid conflict of interests and dual roles.⁸³ It is submitted that such a process is likely to imbue confidence for physicians who may contemplate using the resource.

The fundamental approach in physician health programs is early identification. To achieve this, an important distinction must be made between “impairment” and “illness” *ab initio*. Accordingly, the presence of a disease in a physician should not be equated to impairment. For example, addiction to alcohol is potentially impairing but not all addicted physician are impaired to practice.^{14,83} However, addiction can lead to impairment which is a functional categorisation, implying that the physician affected by addiction is not able to perform specific duties with the necessary skill and safety. This critical distinction in effect enables early identification of those doctors who are identified as having “an illness” for early and confidential assistance.⁸³ This may entail a differential approach to the problem. The physician who is impaired would be advised to defer professional practice until he/she has participated in a program (PHP). On the other hand, a physician suffering from a potentially impairing illness or condition would be allowed to continue to practice with a caveat compelling him to participate in a PHP. This approach contrasts with the process used by the HPCSA in managing impaired practitioners in South Africa. Based on the phrasing used in the legislation (HPA) to define impairment,³ the HPCSA seemingly approaches impairment from a perspective of capacity to perform professional duties . In defining impairment as a physical or mental condition that renders a doctor incapable of executing professional duties with reasonable skill, the distinction between illness and impairment alluded to above is obscured. A doctor who is for example addicted to a substance such as alcohol but is still competent may be overlooked and is likely progress to impairment. In addition to its major responsibility of managing impaired doctors, the Health Committee is also mandated to fulfil other duties that are stated as “the prevention or alleviation of

circumstances which may lead to impairment” and “early identification of impairment”.⁶³ However, the process currently followed by Health Committee seems to cater more for practitioners that are suspected to be impaired already. This approach can be construed as a missed opportunity for early identification of practitioners who suffer from potentially impairing conditions. The writer is of the view that strategies to reduce barriers to reporting impairment should also embrace preventative measures.

Some authors have argued that PHP efforts to assist physicians to adhere to the treatment programs are coercive.⁶⁰ Further, in some states they have questioned the collaborative relationship between the medical board and the PHP as lacking transparency. The PHPs must refer physicians on the program to designated treatment centres. The PHPs are sometimes the only source of clients for business at treatment centres. The treatment centres also sponsor most PHP meetings of a regional or national concern^{60,85}. Because of this, the significantly close financial ties between the two entities may be viewed as of conflict of interests. The counter argument to the assertion that doctors are coerced into treatment programs is that doctors have a social contract with society. In exchange for them to practice their profession with autonomy, they have a duty to show professionalism and ensure the safety of patients. The social contract is the agreement between the physicians and the government (represented by the licencing authorities), which secures a benefit for the public – the right to safe medical practice.⁸⁴ PHPs in part fulfil the broader context of the social contract. Secondly, doctors are a socially privileged fraternity with the wherewithal for teamwork and self-care and are unlikely to be merely coerced into PHPs. There are also governance structures in place to foreclose the assertion of lack of transparency and

conflict of interest⁸⁴. PHPs are answerable to the boards of directors of entities that sponsor their operations. These include medical societies, medical schools, medical boards, and hospitals that have robust systems for accountability.⁸⁴

4.3 An overview of selected legislation on Impaired Medical Practitioners in the UK

The General Medical Council (GMC) is the statutory body responsible for the accreditation of medical practitioners in the UK as well as regulatory functions affecting the medical profession including medical education in the UK.⁸⁶ The GMC was established in terms of the Medical Act.⁸⁶ In terms of section 35 of the said Act, the concept of “fitness to practice” is central to the policy of the management of impaired medical practitioners. The ethical guidance published by the GMC⁸⁷ is based on this concept and there are aspects about the doctor’s physical and mental health included in the ethical guidance. According to the policy, a doctor’s fitness to practice becomes “impaired” if the GMC investigates and concludes that there is transgression of the ethical guidance. Poor physical or mental health, for example arising from severe depression or SUD will lead to a practitioner’s fitness to practice being declared as impaired. Unprofessional conduct and substandard professional competence are other categories where the fitness to practice as a doctor may be found to be impaired. The procedures to assess fitness to practice are usually triggered by a concern about a doctor’s behaviour, health or professional performance.⁸⁸ The concern can be raised by a medical colleague, the doctor’s employer or a member of the public. A medical practitioner may also self-report his or her concerns about fitness to practice. The

matter is investigated by the GMC's Investigations Committee to determine the veracity of the complaint.⁸⁹ The Investigation Committee is provided for by section 35C of the Medical Act. After the investigations are concluded, the matter is referred to the Medical Practitioners Tribunal Service (MPTS). The MPTS conducts hearings for doctors whose fitness to practice medicine has been brought into question. The MPTS was also established in terms of the Medical Act 1983 and although it is funded by the GMC it acts independently and reports to Parliament.⁹⁰ The impaired practitioner may suffer sanctions (s.35D and s.35E) from the MPTS which include restriction on registration, suspension or revocation of accreditation.⁸⁸ The doctor has a right of appeal through courts of law, in terms of section 40 if he/she is not satisfied with the ruling made by the MPTS.⁹¹

The GMC procedure differs noticeably from the HPCSA procedure. The focus of attention for the GMC and MPTS seems to concentrate on establishing whether a practitioner's "fitness to practice" is intact or not. In contrast, the HPCSA through its Health Committee principally endeavours to protect the public while at the same time helping the impaired doctor to preserve his/her career. The Health Committee is mandated to specifically manage cases involving impaired doctors. This contrasts with the role of the Investigating Committee of the GMC which involves the investigation of all issues related to fitness to practice. The writer is of the view that the process followed by the HPCSA is of more benefit for the medical practitioner. This is because the HPCSA process affords the practitioner an opportunity to protect his/her career by utilising established internal mechanisms. For example, a recommendation of rehabilitation for a substance abuse disorder is likely to be of more benefit in the long

term for the individual. In such cases reports that are regularly submitted during the rehabilitation program help the committee track progress. This approach is more supportive to the impaired doctor as it is likely to provide the feeling that the authority is acting in one's interests to preserve a career. On the other hand, the principal role for the GMC and MPTS is only to decide on the "fitness to practice". This approach seems to be solely focused on the interests of the patient and does not seem to offer suggestions such as rehabilitation. The responsibility to reclaim the fitness to practice is entirely for the medical practitioner to deal with. The GMC and MPTS do not play an active role in the rehabilitation process of the doctor. The writer is of the view that an empathic approach should be encouraged to accompany an impaired doctor through their ordeal. This is because more often than not, especially where a substance abuse disorder is the cause of impairment, there is loss of insight due to the mental effects of addiction. Without the support and compassion from the regulating body it becomes an uphill task to succeed with the rehabilitation programs. In the UK there are private agencies that are available to assist with rehabilitation for alcohol and substance addiction.⁹² The doctor is apparently left to his/her own devices when dealing with these agencies.

The functional independence of the MPTS that is provided for by the legislation is also noteworthy. The reporting and investigation of fitness to practice is conducted by a separate entity (the GMC) while the adjudication is the responsibility of the MPTS, answerable only to parliament. This is probably an aspect South Africa could learn from.

4.4 An overview of pertinent legislation on Impaired Medical Practitioners in Australia

Mandatory reporting of impairment is the policy followed in Australia and this policy has been in effect since 2010.⁹³ The Medical Board of Australia (MBA) is responsible for the registration of medical practitioners in Australia and one of its regulatory functions is the investigation of complaints against practitioners.⁹⁴ In fulfilling this responsibility the MBA is supported by boards in each state and territory, to which it has delegated the powers of registration of doctors and notification of complaints.⁹⁴ The MBA is legislatively supported by the Australian Health Practitioner Regulation Agency (AHPRA), which is responsible for the accreditation of health practitioners that fall under the National Scheme.⁹⁵ This agency was established through section 25 of the Health Practitioner Regulation National Law Act (National Law).⁹⁶ Section 31 of the National Law provides for the formation of national boards in each state and territory. The legislation effectively brought the various health professions in Australia under one umbrella to facilitate among other things, the notification of impairment in health professionals.⁹⁷ In terms of section 141 all health practitioners are required to notify the AHPRA if they have reasonable suspicion that a particular health practitioner might have notifiable conduct. “Notifiable conduct” is the term purposely used to encapsulate all forms professional concerns for health practitioners in Australia.⁹⁵ If there is reasonable suspicion that a medical practitioner who is treating a colleague is impaired, that medical practitioner is obliged to notify AHPRA (s141B). The legislation is silent on the specifics of ‘reasonable suspicion’ and there are no standard rules to judge this notion. However, the Oxford English Dictionary⁹⁸ defines suspicion as “a thought that something is possible, likely or

true". The same source defines reasonable as "having sound judgement; fair and sensible". In a situation where a doctor suspects a case of impairment, the test would be what a reasonable doctor in the same circumstances acting without passion or prejudice would do. Observing this principle would ensure that unnecessary or malicious notifications are avoided. In this respect, section 237 of the National Law provides for the protection of the reporting doctor, from civil or criminal liability if a matter is notified on grounds of reasonable suspicion. The MBA publishes the guidelines on the procedure to follow when reporting notifiable conduct.⁹⁹ Notifiable conduct may include practising while intoxicated by drugs or alcohol, substance abuse disorder and mental illness as well as any physical illness that puts patients' lives in danger.⁹⁹ Health practitioners have mandatory reporting obligations, however a member of the public may also make a notification to the AHPRA, which receives the notification on behalf of the MBA.¹⁰⁰ It is noteworthy that the legislation empowers the public to make notifications as this protects patients from potential harm provided the reporting is done without bias and is not frivolous. After a notification, the MBA investigates the matter, and this may also involve an assessment of the medical practitioner's health (if the notification is not from the treating doctor). If the board finds that the doctor is impaired, it can accept an undertaking from the practitioner or impose restrictions on the registration of the practitioner.¹⁰⁰ Alternatively, the MBA can refer the matter to a health panel or a tribunal. The doctor also has the right to appeal to courts of law if he/she is not satisfied with decisions taken.¹⁰¹

The process in Australia has some similarities with the HPCSA process. The AHPRA regulatory function is in essence like that of the HPCSA. However, although the

obligation to notify impairment is comparable to that stipulated by the HPCSA, in Australia there is no obligation for medical practitioners to self-report if they are impaired. Nevertheless, they may notify AHPRA voluntarily. On the other hand, the HPCSA rules are not specific as to whether a doctor treating a colleague is obligated to report if there is suspicion of impairment. The HPCSA ethical rules (rule 13) prohibit practitioners from disclosing information about patients without their consent except in terms of a statutory provision.⁶³ This is in consonance with the Bill of Rights (s 10) of the Constitution of South Africa which entitles everyone to the protection of their dignity. The National Health Act (NHA) also provides (s14) that patients' information may not be disclosed unless a patient has agreed to the disclosure in writing or there is a court order that requires such disclosure. Practitioners may find themselves in legal peril if they fail to ensure that information about patients is kept confidential¹⁰². However, the right to dignity in a matter such as confidentiality is not absolute, and the Bill of Rights (s36) provides for the limitation of personal rights after due consideration of all relevant factors. It is submitted that there may be clinical situations where a treating practitioner may have doubts whether or not to report a colleague under his/her care if there is suspicion of impairment. The right to confidentiality not being absolute, it is an ethico-legal dilemma when a doctor is confronted with the question of providing information about patients without their consent. Legislation such as the NHA (s7) may provide legal comfort in general but, this does not necessarily dispose of the ethical nuances altogether. This is because many cases are likely to be unique in their circumstances. This dilemma is bound to intensify the complexities involved in the reluctance of doctors to report impairment. In Australia, the legislation requiring mandatory reporting of

practitioners by their treating doctor was not unexpectedly, a contentious issue. Bismarck et al¹⁷ in a qualitative study found that not many doctors were actually reporting the doctor-patients as required by the legislation. The reticence was intensified by the obligation to report past notifiable conduct (a requirement in terms of the legislation) that placed patients at risk. Medical practitioners were not at ease reporting notifiable conduct where treatment and progress were on a promising path¹⁷. The writer is of the view that perhaps a deficiency in the legislation is the requirement to report even when a practitioner is already participating in a treatment program. If a practitioner is participating in a treatment program, he/she should rather be continually monitored by the treating doctor rather than mandatorily be reported for potential disciplinary proceedings. Participation in the treatment program should be a mitigating factor and could be used as an incentive to encourage practitioners to voluntarily go for treatment. This would be akin to the situation in the USA. The apprehension about disciplinary hearings is likely to draw doctors away from seeking help. The treating doctors may also become restrained in reporting cases.

The Health Committee of the HPCSA is the final arbiter in the matter before a doctor resorts to courts of law for remedy if he/she is not satisfied with the decisions taken. In contrast, the MBA can escalate a matter to a separate health panel or a tribunal before the courts of law are involved. It is submitted that, although escalation of a matter to another agency may cause more anguish for the affected doctor, it may be financially less exerting than the procedural necessity of immediately resorting to courts of law as is the case in South Africa.

In this Chapter the writer has provided an analysis of aspects of legislation governing the management of impaired doctors from three jurisdictions namely, the USA, UK, and Australia. The salient similarities to and differences from the HPCSA policy have been pointed out. The comparison has provided an opportunity to assess whether a possibility exists to further develop the current legislation in South Africa as enjoined by section 39 of the Constitution. The writer is of the view that aspects such as delineating “functional impairment” and “potentially impairing illness” *per se* may be innovatively adopted by the HPCSA in the process of managing impaired doctors. The inclusion of doctors’ professional organisations is also a potential opportunity to reduce barriers to reporting impairment. These aspects and others will form part of the discussion in the next chapter.

CHAPTER 5

SALIENT BARRIERS TO REPORTING IMPAIRMENT OF MEDICAL PRACTITIONERS

5.1 Introduction

In this chapter, factors that are considered to be of significance in preventing doctors from reporting impairment will be discussed. Reporting impairment is an ethical obligation⁶². The discussion will analyse both the psycho-social barriers and the difficulties with some aspects of the regulations. The focus will be on barriers related to impairment caused by alcohol, substance abuse disorders and mental illness as these are of most concern⁸. The writer acknowledges that impairment of doctors can also be caused by physical illness and where relevant this aspect will be considered. The discussion will examine aspects such as denial, stigmatisation, dynamics related to family and co-workers as well as psychiatric co-morbidities and lack of knowledge. Particular difficulties with aspects of the regulations will also be explored. Suggestions to improve reporting will be provided and the discussion will be concluded with analysis of ethical aspects related to impairment of medical practitioners.

The preceding chapters have provided context to the matter of reporting impairment of medical practitioners and demonstrated that it is an issue of importance for the profession. The privilege to practice medicine comes with the responsibility of self-regulation¹⁰³. The failure of medical practitioners to monitor themselves and their colleagues undermines the integrity of the profession; impaired and incompetent doctors may endanger the lives of patients¹⁰⁴. In light of this, it behoves the profession to be alert to the issue of impairment and take responsible action.

5.2 Denial

Denial is one of the most common barriers that inhibit reporting impairment among doctors. There is evidence to show that some doctors harbour a sense of invulnerability to certain diseases such as alcoholism or substance abuse disorder (SUD)¹⁰⁵. This feeling might be fortified by the personality traits of independence, self-confidence and prowess that are commonly associated with academic or professional success. The aura of success and being self-sufficient obscures awareness that substance abuse can lead to addiction, loss of autonomy and ultimately impairment^{105,106}. There is a tendency to rationalise excessive consumption of alcohol or prescription drugs such as opioids. As a result, denial may present in different guises of rationalisation such as self-medication for pain, stress related to work or relationship issues³⁴. The apparent justification of consumption and the underestimation of quantities consumed intensify the denial that a problem exists, thereby forming a barrier to report oneself or to request assistance from colleagues¹⁰⁷. Medical practitioners generally organise their routines around helping others and may not readily complain or acknowledge their personal health needs. They may thus be averse to the proposition of being in the sick role (patient-doctor) or asking for help³⁴. This frame of mind encourages self-prescribing and gives a false sense that a problem such as depression or anxiety is being self-managed. Thus, denial is a psychological survival tool to cope with difficulties experienced by the affected doctor. Dhali et al¹⁰⁷ observes that, impaired practitioners do not recognise the problem they have or they recognise the problem but they do not think they need help. Further, they may recognise that they have a problem and realise that they need help but, they do not take any further steps to remedy the situation.

5.3 Stigmatisation

The decision to self-report or report a colleague suspected of being impaired is often fraught with feelings of uncertainty, for fear of stigmatisation. Stigmatisation is a major concern for many doctors confronted with impairment and is a barrier that should be taken seriously³⁴. The impaired practitioner may feel fearful to self-report impairment for reasons of being labelled as weak, unreliable, and not trustworthy. The feeling of failure to be in control may be overwhelming and become a deterrence to seeking help.

Further it is generally difficult for society to associate doctors with addiction or lack of control of their personal problems. This is because of the perception that the medical profession personifies nobility, self-reliance and competence²¹. A negative experience by a colleague who previously sought assistance may also reinforce the apprehension about the potential of being disgraced if impairment is reported³⁴. The doctor may also feel that he/she will not get benefit from healthcare teams that would be looking after him/her. Instead, the doctor-patient may fear that he/she will be neglected or derided during his/her treatment. This apprehension may become a reality in instances where healthcare givers fail to show their professionalism¹⁰⁸. These factors individually or collectively contribute to create uneasiness that an impaired doctor is likely to be disgraced, thereby frustrating efforts to report.

5.4 Barriers related to family and co-workers

The dynamics in family relationships also play a role. A medical practitioner might feel hesitant to self-report impairment for the reasons that the family and relatives will become aware of it. The doctor would then be blamed for causing embarrassment to

the family and for potential loss of financial support. However, the Health Committee of the HPCSA reassures confidentiality when handling matters of impaired medical practitioners⁶³. Further, practitioners might also be apprehensive that self-reporting impairment is an expression of failure in their profession, for which they would be blamed and heavily sanctioned. They might believe that they would face disciplinary proceedings and may lose their accreditation with negative financial consequences¹⁰⁹. This misconception is most probably related to lack of information on the issue of impairment in South Africa. There is tellingly a dearth of information in local academic circles on the subject of impairment; a best effort literature search is unlikely to retrieve a published article on this subject beyond 2006¹⁰⁷. Information from the HPCSA is available on the council's website and includes processes followed in managing suspected impaired practitioners. However, online services are not consistently available for many medical practitioners, especially those in rural areas¹¹⁰. It is submitted that more needs to be done to improve the infrastructure for online platforms. This will enable medical practitioners to easily access relevant information. Colleagues and co-workers also contribute to the silence on impairment. Many times, colleagues are reluctant to intervene in a doctor's private life even though they suspect that there is a problem. This "conspiracy of silence" is often catalysed by the change in the behaviour of the subject who may show mood swings or a withdrawn demeanour^{34,109}. Such behaviour may inadvertently stifle an offer to help when it is most needed. The problem may be more delicate if the impaired practitioner is a senior colleague, a mentor or doctor with an impeccable career record. The junior colleagues may be fearful of potential retaliation that might negatively affect progress in their

carriers. On the other hand, colleagues and co-workers may want to spare a senior doctor the embarrassment and stigma of being reported to the council¹⁰⁹. The reluctance to report because of seniority considerations or to protect a reputation is a disservice to the impaired individual. There is also foreboding that because most impaired doctors are under pressure, anxious and perhaps with poor judgment, they may become desperate fearing their problem will be revealed publicly. There is evidence to suggest that the desperation may in some instances lead to self-harm including the potential for suicide³⁴. When colleagues consider the potential and consequences of self-harm they may get discouraged to report. A lack of trust in the system and the perception that there will be no benefit in reporting is also a contributing factor to the silence. The perception might be based on the experience of other doctors which a potential reporter may have heard about⁹³.

The feeling that one is a whistle blower is also a source of social discomfort for medical practitioners that might be persuaded to report. Practitioners may perceive this as betrayal of the medical community and as a result continue to reassure themselves that someone else should, and will take care of the problem, ultimately taking no action^{34,107}. This perception is strengthened by an apprehension of potential legal liability in case their allegations are challenged in a court of law. The unease about potential legal liability may linger on despite reassurance by the HPCSA that no legal action would be incurred by a medical practitioner who reports a colleague in good faith. However, it is submitted that since each case might be unique in its circumstances, practitioners may not always be sure whether there are potential legal ramifications for reporting, reassurances from the HPCSA notwithstanding. The writer is of the view that inclusion

of panel discussions on this subject, as part of professional development programs for doctors will serve to increase confidence.

5.5 Psychiatric co-morbidities and lack of knowledge

A section of impaired doctors who suffer from SUD may also have concomitant psychiatric morbidities such as depression or severe anxiety¹¹¹. The abuse of prescription drugs or alcohol might be a coping mechanism through self-medication to relieve psychiatric symptoms. The affected medical practitioner may feel that he/she will not cope with the embarrassment of coming forward and self-report. A lack of skills in recognising impairment among colleagues is another barrier limiting reporting. Impairment in some cases is probably foreshadowed during training to become a doctor. However, the training programs seem to lack depth on issues related to impairment. They tend to concentrate more on the ethics of patient-doctor interaction and do not impart enough skills specific to handling situations related to impairment of doctors⁷. As a result, many doctors may not be well informed and have limited practical skills to deal with a colleague who is impaired^{6,109}. This lack of competence in dealing with a unique problem encourages the reluctance to get involved, despite what the regulations stipulate. The writer is of the opinion that more needs to be done to sensitise doctors in training on the matter of impairment.

5.6 Problems with the regulations and ethical rules

There are aspects that are seemingly problematic with regard to the regulations relating to the impairment of medical practitioners¹¹². Regulation 22 specifies measures that the

Health Committee (HC) can take against an impaired doctor. This includes imposing restrictions on the registration or clinical activities of a practitioner. This aspect is problematic as most practitioners would interpret it as a threat to their autonomy and would be reluctant to report themselves or their colleagues if they are impaired. The loss of autonomy may potentially threaten their income and choice in the field of practice. It is accepted that the intent of the regulations is to protect patients and help the impaired doctor. However, while enforcing these precepts is desirable, the potential for limiting one's autonomy would be an unpalatable fact to many practitioners¹¹³. This is likely to discourage most practitioners from self-reporting when they are impaired. This apprehension also augments the fear of stigmatisation discussed above; colleagues and members of the public are likely to speculate on the change in the professional circumstances of the affected individual.

In terms of regulation 21, the HC committee selects the health examiners with due regard to the purported cause of the impairment. Regulation 22 provides for an array of decisions that the HC has at its disposal which also include treatment and rehabilitation. The cause of impairment might be a mental or physical illness and the assessors are likely to be fellow medical practitioners. Because of this, the writer is of the view that a doctor-patient relationship exists between the assessors and the impaired doctor¹¹⁴. The shift in the power dynamics means that a trusting relationship between the patient (the impaired doctor) and the health assessors is imperative¹¹⁵. However, there is no clause in the regulations to provide for the impaired doctor to exercise his/her autonomy in the decisions taken. This is important if treatment and rehabilitation are envisaged,

otherwise the recommendations made may be viewed as medical paternalism and coercion.

There are also aspects of the ethical rules of conduct for medical practitioners that can be interpreted as barriers to reporting. Ethical rule 25(b) obligates a practitioner to report him/herself if he/she suspects that he/she is impaired or has been publicly informed or advised to do so by a colleague. The writer submits that the phrase, “publicly informed” as stated in Rule 25 is vague as the circumstances in which a doctor is publicly informed are not specified. Doctors can also be reluctant to report themselves for fear of potential self-incrimination. The Constitution of the Republic of South Africa (s35) protects individuals from divulging information that may incriminate them in a criminal matter. Some cases of substance abuse disorder involve the use of scheduled drugs that are available in clinical practice. The scheduled drugs commonly used in clinical practice include morphine, pethidine, fentanyl and ketamine. A doctor may gain access to these drugs illegally by pilfering from hospital stocks or by not administering the drugs prescribed for patients. An investigation might be instituted if the doctor self-reports that he/she is impaired. During the investigation the doctor may unwittingly disclose certain information which may potentially incriminate him/her. It can be argued that the practitioner could engage legal representation during such an investigation to advise against divulging potentially self-incriminating information. However, the costs involved in hiring legal representation and the laborious nature of such a criminal investigation are likely to coerce the doctor to remain silent and not report about his/her impairment.

Another barrier to reporting is that the ethical rules are silent on the duration of impairment before reporting can be considered. There is no clarity on whether temporary incidents of impairment are reportable or only perpetual impairment should be reported. The lack of criteria causes uncertainty and promotes hesitancy to report.

5.7 Suggestions to prevent impairment and to improve reporting

The issue of impaired medical practitioners invites a conflict between protecting patients from potential harm and the medical practitioners themselves. In light of this, the long-term strategy should ideally be to prevent impairment. It is submitted that the HC is uniquely placed to achieve this through its mandate. One of the duties of the HC is to create mechanisms for the early identification and prevention of impairment¹¹². The second strategy would entail attempts to refine the regulations relating to impaired medical practitioners in order to minimise barriers that may prevent doctors from reporting impairment.

It is suggested that the HPCSA should consider adopting some aspects of the management processes in other jurisdictions. The writer reiterates that, this resonates with section 39 of the Constitution which encourages due consideration of international and foreign law in an open democracy. The process followed by the USA is of particular interest here. Medical organisations for physicians in the USA play a role in preventing and managing impairment in their members. The American Medical Association (AMA) is one such example. The writer urges that the HPCSA should consider inviting medical organisations of doctors such as the South African Medical Association (SAMA) to be

part of the process in preventing and managing impairment. SAMA is a voluntary professional association of which many medical practitioners in South Africa are members⁷⁹. It is submitted that there may be other less known professional organisation for doctors, but this report will use SAMA as an example. The writer suggests that SAMA with support from the HPCSA should facilitate the establishment of support centres that can serve as first ports of call for medical practitioners who are in need of help. Doctors who have been identified by colleagues or employers as in need of intervention for potentially impairing problems would be encouraged to use these centres. They will also not be reported to the Medical Board (MB) if they have voluntarily accepted to make use of the intervention services and adhere to the programs set up to help them. It is envisaged that non-engagement with the MB at least initially, will hopefully reduce the hesitancy to come forward and report. The writer is of the view that many doctors perceive dealing with the MB as rather onerous. The participation of SAMA will expectedly provide a confidential buffer and will help to relieve such trepidation. The writer is of the view that SAMA as an organisation is perceived by many doctors as acting in the best interest of doctors and promoting a sense of solidarity. The sense of belonging and camaraderie is bound to at least loosen the anxiety associated with impairment. The writer does not hesitate to suggest that other similar associations of doctors can also be invited to participate in such a program. The HC with its authority is well placed to recommend a system similar to the one outlined above and in so doing will facilitate in the early identification and management of impaired medical practitioners. There is evidence to suggest that such programs have benefitted physicians in the USA^{4,116}.

A review of the regulations should also be considered in such a way that there is a distinction between “impairment” and “potentially impairing illness”. A diagnosis of a disease does not necessarily equate to automatic impairment. The current regulations are critiqued for not recognising that impairment is part of a continuum where an illness predates impairment, often by a long period of time. For example, addiction to opioids is an illness that can lead to impairment after a period of time that may be variable from one person to another. By not providing for these aspects (“impairment” and “potentially impairing illness”) in the regulations, a window of opportunity is glaringly missed to assist a doctor who is addicted but not yet impaired. The writer submits that impairment should be viewed as a functional classification which implies that the medical practitioner’s illness has reached a point where he/she cannot practice with reasonable skill and safety. Assistance should be available and offered before an individual reaches the stage of impairment.

Evidence suggests that in some instances impairment could be foreshadowed at medical school¹⁹. Since early prevention is a proposed strategy, it is suggested that candidates entering medical school could be offered psychometric testing on a voluntary basis. It has to be emphasised though, that the suggested testing would not be a pre-requisite to entry to medical school. Making the screening compulsory would be an infringement on individual rights. Nevertheless, some students and parents may view the exercise as useful and take up the offer. Those candidates showing traits and attitudes towards alcohol or substance abuse may be offered counselling and flagged for closer follow up during their training. The early identification and sensitising these candidates may prevent future problems. Othman et al¹¹⁷ found that using the

Substance Abuse Subtle Screening Inventory A2 (SASSI-A2) – a psychometric testing tool, could be a useful and objective tool for testing potential chemical dependency in students at higher institutions of learning.

The HPCSA is mandated by the HPA (s3) to play an oversight role in the training of medical practitioners. This implies that the council is well positioned to have influence on the curriculum development of the training institutions. The council should be encouraged to challenge medical schools to increase the depth of information and sensitisation of students regarding the issue of impairment. The writer is of the view that more needs to be done in this area to embolden future doctors in preventing and reporting impairment. By instilling ethos of fellowship and collegiality during training, the future doctors will be more prepared to confront the issue of impairment, perhaps more confidently than currently.

5.8 Ethical aspects relating to impairment of medical practitioners

The Hippocrates oath¹¹⁸ enunciates the fiduciary relationship between a medical practitioner and his/her patients. It is on this basis that the safety of patients is an enduring responsibility for medical practitioners and a hallmark of ethical medical practice. Therefore, doctors must take the issue of impairment seriously and act accordingly to prevent potential harm to patients. In the endeavour to fulfil that duty colleagues or regulating authorities should also be mindful of the rights of the impaired doctor. These two competing interests call for a rational approach through application of ethical principles. Beauchamp and Childress¹¹⁹ assert that issues in medical ethics are

best approached using the four principles namely, respect for autonomy, beneficence, non-maleficence and justice. The principle of beneficence obligates practitioners to ensure that they prevent harm to their patients (One ought to prevent harm or evil). The maxim *primum non nocere* (Above all, do no harm) has appeared in many medical writings¹²⁰ and is also of relevance here. A medical practitioner has a duty to prevent potential harm to his/her patients through measures such as introspection or confiding in a colleague if there is a possibility that he/she might be impaired. Within the same principle of beneficence colleagues also have a duty to take steps and halt the professional activities of a doctor who is impaired (One ought to remove harm or evil). In general, the ethical rules of conduct as drafted by the HPCSA are also in tandem with the principle of beneficence. However, while the principle of beneficence is desirable in managing patients, it is necessary to remain alert to the interests of the impaired doctor. The impaired doctor is also in effect a patient and his/her interests should be protected and offered appropriate assistance. The principle of beneficence is similarly desirable for the impaired doctor when undergoing treatment and rehabilitation.

Juxtaposed to the principle of beneficence is the concept of non-maleficence. Non-maleficence requires desisting from actions that cause harm (One ought not to inflict evil or harm)¹¹⁹. This has a bearing in the context of reporting impaired medical practitioners. Practitioners who knowingly continue to practice whilst aware of their impairment are not acting ethically as they may potentially inflict harm to patients. Further, an impaired practitioner who for example pilfers scheduled drugs in the zeal to feed an addiction problem deprives his/her patients of a therapeutic benefit. Such a practitioner in essence inflicts harm to patients. Colleagues who fail to report or to

assist an impaired colleague and allow him/her to continue with clinical duties allow potential harm to be visited on patients and are not acting ethically. The authorities in drafting legislation and ethical rules should also show circumspection. Failure to do so may result in unintended consequences that may for example, promote reluctance in reporting impairment. For example, some aspects of Rule 25 of the ethical rules of the HPCSA might be counterproductive. Although the rule is meant to protect patients and help affected doctor, it may inadvertently discourage doctors to come forward for assistance. This may result in potential harm to patients. The writer is of the view that extant evaluation of the relevant aspects of the regulations serves to identify potential weaknesses in them. By rectifying those deficiencies potential harm to patients is prevented.

Another concept in principlism is respect for autonomy and is also pertinent to this discussion¹¹⁹. Respect for autonomy entails personal rule of self, given adequate understanding while remaining free from interference by others that limit or prevent choice¹²⁰. This principle presupposes mental capacities to understand and make decisions. Respect for autonomy should prompt the HC to show circumspection when advising the impaired doctor to go for treatment or rehabilitation. This also applies to the healthcare teams that conduct the treatment or rehabilitation. The doctor should be accorded the respect to his/her autonomy by being allowed access to all the information on the matter and also to express his/her thoughts. This would also be in accordance with section 8 of the NHA regarding participation in decisions. It is acknowledged that, in some instances this may engender controversy because of conflict in the principles.

However, a solution can be reached by considering the specific aspects and weighting the demands of the conflicting principles¹²⁰.

In this chapter the writer has explored the salient reasons that may prevent medical practitioners from reporting impairment of themselves or of their colleagues.

Suggestions have been provided to improve reporting and they include a review of the rules. The writer believes that there is an ethical obligation on medical practitioners to deal with their patients professionally and in the process strengthen the public trust in them. Further, it is recognised that competing interests are bound to occur in the process of reporting and managing impaired practitioners. However, such competing interests can be assuaged by carefully applying the four principles of principlism.

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