THE HPCSA MUST PROVIDE CLEARER GUIDELINES ON SOCIAL MEDIA MARKETING FOR SOUTH AFRICAN HEALTH PROFESSIONALS

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DECLARATION

I, Neil Hopkins, declare that this research report is representative of my own work, compiled under academic supervision [1]. In it I have followed the required conventions in referencing the thoughts and ideas of others. This research report is being submitted for the Degree of Master of Science in Medicine (Bioethics and Health Law) at the Faculty of Health Sciences, School of Clinical Medicine, University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other tertiary institution.

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7th day of March 2023 in Cape Town

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I Neil Hopkins (Student number: 2339236) am a student registered for MSc (med) Bioethics and Health Law in the year 2022.

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Neil Hopkins

7th day of March 2023 in Cape Town

ABSTRACT

There is a longstanding debate around the ethics and legality of advertising for health professionals. Recently advertising has seen a transition from traditional marketing towards social media marketing. Unfortunately, inappropriate social media marketing can result in exploitation, which is why guidelines are necessary to protect consumers from deceptive content. The Health Professions Council of South Africa (HPCSA) has published a set of ethical guidelines on social media. However, this report highlights that there is limited information in the guidelines pertaining to social media marketing. There is also no reference to South African legislation that should be considered when using social media marketing. The purpose of this report is to emphasise that the HPCSA has an ethical and legal obligation to create clearer social media marketing guidelines for South African health professionals. This report proposes that the HPCSA must update their social media guidelines to make them clearer and to provide more information on social media marketing.

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DEFINITIONS

Health Professions Council of South Africa - “The Health Professions Council of South Africa is a statutory body, established in terms of the Health Professions Act and is committed to protecting the public and guiding the professions.” (1). The Health Professions Council of South Africa governs health professionals (For example: Doctors, Physiotherapists, Biokineticists, Podiatrists, Dietitians).

Allied Health Professions Council of South Africa - “The Allied Health Professions Council of South Africa is a statutory health body established in terms of the Allied Health Professions Act.” (2). The Allied Health Professions Council of South Africa governs allied health professionals (For example: Osteopaths, Chiropractors, Homeopaths, Naturopaths, Reflexologists).

ABBREVIATIONS: GENERAL

COI - Conflict-of-interest / Conflicts-of-interest

MTT - Ministerial Task Team

SA - South Africa/South African

SCT - Social Contract Theory

SM - Social media

SMM - Social media marketing

ABBREVIATIONS: INSTITUTIONS / ORGANISATIONS / STATUTORY BODIES

AAMSSA - Aesthetic and Anti-aging Medicine Society of South Africa (3)

AHPCSA - Allied Health Professions Council of South Africa (2)

AHPRA - Australian Health Practitioner Regulation Agency (4)

ARB - Advertising Regulatory Board (5)

CCSA - Competition Commission of South Africa (6)

FTC - Federal Trade Commission (7)

GMC - General Medical Council (8)

HPCSA - Health Professions Council of South Africa (1)

ABBREVIATIONS: LEGISLATION

CPA - Consumer Protection Act (9)

HPA - Health Professions Act (10)

HPAA - Health Professions Amendment Act (11)

MRSAA - Medicines and Related Substances Amendment Act (12)

NHA - National Health Act (13)

POPIA - Protection of Personal Information Act (14)

TERMINOLOGY

i) Health Professional [2]: For the purposes of this report the term "health professional" when used in a South African (SA) context will refer to individuals who are registered with the Health Professions Council of South Africa (HPCSA) (1) and governed by the Health Professions Act (HPA) (10).

ii) Marketing and advertising: For the purposes of this report the terms "marketing" and "advertising" can be used interchangeably.

iii) Social media (SM): Is an umbrella term that describes a variety of online platforms (15). The application and use of SM is diverse and includes, but is not limited to: blogs/microblogs, business networks, collaborative projects, enterprise/personal/ community social networks, online forums, photo/video/media sharing platforms, product reviews, social bookmarking, social gaming, and virtual worlds (16).

iv) Social media marketing (SMM): Is any form of direct or indirect marketing that uses SM as a means of creating awareness for a brand, business, product, or person (17). For the purposes of this report SMM includes the marketing of a person (health professional), a practice (the health professionals' practice/business), as well as products/devices (used in the health professionals' services). This includes the use of solicited testimonials/reviews from patients/peers [3].

v) Social media influencer: A term that is used to describe an individual who uses SM to build up an audience, over whom they have a sphere of influence (18).

vi) Council: Health Professions Council of South Africa (1).

vii) Booklet 16: Ethical guidelines for good practice in the health care professions Booklet 16: "Ethical Guidelines on Social Media" (19).

[2] HPCSA Booklet 11: ""Health care professional" means any person registered in terms of the applicable Act which governs the functioning of any of the Councils that form part of the Forum of Statutory Health Councils. This includes persons registered by the Health Professions Council of South Africa. The term also includes registered student health care practitioners." (20).

[3] Reviews/testimonials are mentioned in the HPCSA guidelines under the topic of "canvassing". Ascertaining if the review/testimonial is solicited or unsolicited becomes challenging.

HPCSA QUOTATIONS

Wherever possible direct quotations from the HPCSA guidelines have been used.

i) These may include the following errors: spelling, punctuation, formatting, as well as referencing. I have chosen not to correct these errors when using direct quotations. However, I have highlighted some of the significant errors in the footnotes.

ii) In this report I have underlined sections in some of the direct quotations to place emphasis on the section that is pertinent to the argument/discussion.

CHAPTER 1: INTRODUCTION

1.1 Background literature analysis and critique

There has been debate around the ethics and legality of advertising for health professionals dating as far back as the late 1800s (21,22). There are arguments in favour of advertising, because of increased competition, and against advertising, because it is perceived to be unprofessional and unethical (21–28). The Health Professions Council of South Africa (HPCSA) previously addressed advertising ethics for South African (SA) health professionals in a set of guidelines on "Making Professional Services Known" (29). However, these guidelines were repealed [4], following an unsuccessful exemption application (30) to the Competition Commission of South Africa (CCSA) (6). The CCSA found [5] that some of the HPCSA marketing guidelines may be overly restrictive (31) and in conflict with existing legislation (32).

Advertising has seen a transition from traditional marketing towards digital platforms and techniques (33). With social media marketing (SMM) being one of the digital forms of advertising that has recently flourished (17). SMM, like all advertising, is intended to influence purchasing decisions (34). In some industries SMM has been shown to be highly effective at influencing customer behaviour (35). Unfortunately, there is potential for exploitation which is why there are country specific guidelines designed to protect consumers from deceptive and misleading advertising (36–42) and SMM (43–45). In SA there are no specific SMM regulations; however there are industry guidelines for advertising (37,38,41,42) as well as legislation that protects the rights of citizens (46,47), and in particular the right to protection from deceptive or misleading advertising (9).

Despite the lack of published data on the benefit of SMM for health professionals, many have embraced social media (SM) platforms as a means of marketing themselves, or advertising their practices (26,48). The HPCSA has noted this trend,

[4] The guidelines on "Making Professional Services Known" were repealed, but not replaced.

[5] "The Commission noted that although the objectives of the HPCSA's Ethical Rules are valid, the application of the rules themselves could have a negative effect on competition in the health professions. In this regard, the Commission was of the view that the purpose and objectives of the HPCSA's Ethical Rules could be achieved by means that are not overly restrictive on competition, while complying with the objectives of the applicable rules for purposes of maintaining professional standards and the ordinary functioning of the health profession. In this regard the Commission is of the view that there may be less restrictive means to achieving the HPCSA's objectives." (31).

and acknowledges that SM has become a popular tool for the advertisement and promotion of goods and services (19). The increased use of SMM by health professionals is driven in part by an increase in competition, but also an increase in demand from patients (49). Patients as consumers are increasingly relying on online methods to find health professionals (49). However, the use of SM and SMM is not without risk for both patient and practitioner (24,50–65).

Research into the use of SM by SA health professionals has focussed on the ethical and legal obligations pertaining to privacy, patient-practitioner relationships, and professional reputation (52,56,57,60). There has been some empirical research on the use of SMM by health professionals in SA (48,66). However, there has been limited focus on the legal and ethical principles pertaining to SMM use by health professionals.

Analysis of both local (19,67) and international [6] (68–77) SM guidelines reveals that the focus is predominantly on the use of SM as a means for communication. The two exceptions would be the Australian Health Practitioner Regulation Agency (AHPRA) guidelines (75), and the Aesthetic and Anti-aging Medicine Society of South Africa (AAMSSA) guidelines (78). Both documents clarify the legal and ethical obligations for health professionals when using SMM.

The HPCSA is mandated under the Health Professions Act (HPA) (10) to regulate HPCSA registered health professionals. As part of this mandate, the HPCSA has two primary obligations: firstly, to protect the public, and secondly to guide registered health professionals (1). The first role involves the enforcement of guidelines, while the second role involves the creation of guidelines. To achieve this the HPCSA has established a set of ethical guidelines for SA health professionals (79), and sanctions if they do not comply (80). In this report I will focus on the obligation to provide guidance on SMM.

The HPCSA has published a set of “Ethical Guidelines on Social Media” (Booklet 16) (19). However, there is limited content in the booklet pertaining to SMM. Furthermore, there are three major shortcomings in Booklet 16: Firstly, the HPCSA uses the phrase “conflicts-of-interest” (COI) rather than SMM. Secondly, Booklet 16 needs to be read

[6] Only guidelines written in English were used in this analysis. This is a potential limitation as there may be guidelines in other languages that have not been included.

in conjunction with additional HPCSA guidelines (20,81–83) rather than being a stand-alone reference. This makes it the responsibility of the health professional to search for additional information that might pertain to SMM. This is no simple task and creates ambiguity. Best practice would be to contain all the relevant information in one document. Thirdly, there is no reference to SA legislation that should be considered when using SMM. This includes the Consumer Protection Act (CPA) (9) and Medicines and Related Substances Amendment Act (MRSAA) (12). Referencing additional HPCSA guidelines may be an adequate starting point, but guidelines are subordinate to legislation. The HPCSA guidelines are an expansion of the HPA, therefore additional legislation should be referenced to include information that is not contained in the HPA. I will argue that as a result of these shortcomings the HPCSA SM guidelines need to be clearer and must be updated to provide more information on SMM for SA health professionals.

1.2 Research question

Is the HPCSA obligated to provide clearer guidelines on SMM for SA health professionals?

1.3 Rationale for the study

Firstly, there is limited research focusing on the ethical guidelines pertaining to the use of SMM by health professionals in SA. Secondly, the current HPCSA ethical guidelines on SM (Booklet 16) published in 2019 lacks clarity on SMM.

1.4 Thesis statement

I argue that the HPCSA must provide clearer guidelines on SMM for SA health professionals.

1.5 Research aim

To defend the thesis that the HPCSA must provide clearer guidelines on SMM for SA health professionals.

1.6 Research objectives

- To illustrate that the current HPCSA SM guidelines for SA health professionals do not comprehensively address SMM.

- To demonstrate why clear SMM guidelines for SA health professionals are necessary.

- To argue that the HPCSA has an obligation to create clearer guidelines pertaining to SMM for SA health professionals.

1.7 Research design

1.7.1 Normative / ethico-legal study

This will be a normative / ethico-legal study using bioethical and philosophical research methods. The fundamental methods and standards of philosophical research will be applied (84). There will be no empirical component to this research project.

1.7.2 Research methods

Interpretation and critical analysis of literature will be used to answer the research question. Source material will consist of existing literature, ethical guidelines, and legislation. Reasonable steps will be taken to ensure that literature for consideration is ethically sound before inclusion into the analysis and discussion.

The analytical process will include the following: i) the definition and explanation of key concepts, ii) the identification and critique of possible counter arguments, iii) the analysis, evaluation and application of selected theoretical frameworks (including, but not limited to Social Contract Theory (SCT) and Deontology), and iv) the articulation of the most reasonable interpretation of significant concepts found in the literature pertaining to the topic (85).

1.7.3 Argumentative strategy

In this research report I will argue that the HPCSA has an ethical and legal obligation to provide clearer guidelines on SMM for SA health professionals.

Firstly, I will begin with a synopsis of the current HPCSA SM guidelines for SA health professionals. In doing so I will highlight several shortcomings. I will argue that in the current format more emphasis has been placed on SM as a tool for connecting and communicating, rather than as a means of marketing. I will argue that this is a shortcoming because health professionals are increasingly utilising SM as a means of marketing themselves and their practices.

Secondly, I will illustrate that the HPCSA is *the* statutory body responsible for producing regulations and administering laws [7] or policies that apply to health professionals [8] (86). By using the HPA (1) I will illustrate how the HPCSA should 1) create guidelines for professional conduct, 2) protect the public in matters relating to the provision of health services by health professionals, and 3) uphold and maintain ethical standards (10).

Thirdly, I will provide clarity on the ethical obligations of the HPCSA. Using the works of Rawls and Hobbes I will illustrate how SCT applies to health professionals and the HPCSA. In doing so I will clarify how the HPCSA has an obligation to create and maintain ethical guidelines for SA health professionals. I will argue that this obligation extends to the provision of clearer ethical guidance on SMM.

Fourthly, I will provide context on how the HPCSA is failing to provide ethical guidelines. In the process I will illustrate how the HPCSA has previously failed to fulfil basic functions, including the failure to provide guidelines on SM. As part of my argument, I will highlight how the current HPCSA marketing guidelines for health professionals are inadequate and need to be clearer.

Fifthly, I will provide a critical analysis of the HPCSA SM guidelines on COI. In doing so I will address the shortcomings of terminology and the lack of reference to legislation. I will also highlight the lack of clarity on fundamental concepts linked to endorsements and promotions.

[7] This is not achieved independently and relies on the Legislature and South African Police Service.
[8] The AHPCSA produces regulations for allied health professionals.

Finally, I will propose changes that must be made to the HPCSA SM guidelines. In this section I will emphasize why the guidelines must be updated. I will also establish that it is not possible to update them in isolation. Additional guidelines will also need to be updated. As part of my argument, I will illustrate why marketing related legislation must be referenced in the SM guidelines, and why the guidelines ought to use plain language. I will also highlight the need for clarity on the financial incentives that underpin SMM, as well as the interplay between health professionals and SM influencers. In doing so I will argue that the HPCSA must provide clarity on scenarios such as the "content-for-free-services", as well as scenarios where health professionals leverage their credentials for financial gain.

1.8 Ethics

The nature of this normative / ethico-legal study does not require ethical clearance. However, an ethics waiver will be required from the Human Research Ethics Committee of the University of the Witwatersrand.

1.9 Research outcomes

The first objective is to provide recommendations to the HPCSA on how to improve the SM guidelines, by including a section dedicated to the legislation and ethical principles pertaining to SMM. The second objective is to provide information for SA health professionals, patients and the public on the legislation and ethical principles pertaining to SMM. The third objective is to produce a high-quality argument that can result in research publications in peer-reviewed journals. The final objective is to present the findings of the report at the HPCSA conference, as well as any other relevant conferences that deal with medico-legal topics.

1.10 Limitations

Firstly, there are numerous guidelines for health professionals that deal with SM, but only the AHPRA and AAMSSA guidelines deal expressly with the topic of SMM. Secondly, only guidelines written in English were used in the analysis. Guidelines

written in another language may address the topic of SMM in a more comprehensive manner. Thirdly, there is limited empirical research on the use of SMM by health professionals in SA. Future empirical research on the topic will be helpful to determine the extent of SMM use by SA health professionals. Finally, due to the nature of normative research this research report will rely entirely on existing empirical evidence. No new data will be collected, and the research report will therefore be bound by the typical constraints of normative / ethico-legal work.

1.11 Overview of sections/chapters

Chapter 1: Introduction

Chapter 2: Current SM guidelines for HPCSA registered health professionals

Chapter 3: The legal obligations of the HPCSA to provide SMM guidelines

Chapter 4: The ethical obligations of the HPCSA to provide SMM guidelines

Chapter 5: The failure to provide guidelines

Chapter 6: Shortcomings of the HPCSA SM conflict-of-interest guidelines

Chapter 7: Recommendations for future SM guidelines for SA health professionals

Chapter 8: Conclusion

CHAPTER 2: CURRENT SM GUIDELINES FOR HPCSA REGISTERED HEALTH PROFESSIONALS

2.1 Introduction

This chapter provides an introduction to the SM guidelines for HPCSA registered health professionals. There are four parts to this section. Part one is an introduction to the use of SM by health professionals in SA and abroad. Part two describes the research into the use of SM by health professionals. Part three provides a synopsis of the current HPCSA SM guidelines. Part four is a brief outline of SMM guidelines for health professionals. The critique of the HPCSA SM guidelines pertaining to SMM will be discussed in Chapter 6 [9]. The recommendations for future guidelines will be discussed in Chapter 7 [10].

2.2 The use of SM by health professionals

The use of SM [11] by health professionals is growing (87), and has become a common feature of clinical practice (88). In some instances SM has become a necessity when engaging with patients (89). The HPCSA has recognised the expansion of SM [12] (19). In their view, health professionals may find SM beneficial to themselves and their practices (19). According to the HPCSA, SM allows health professionals to: i) communicate with the public and other health professionals, ii) keep updated on healthcare developments, and iii) build professional networks (19).

[9] Shortcomings of the HPCSA SM conflict of interest guidelines.
[10] Recommendations for future HPCSA guidelines on SMM.
[11] SM is an umbrella term and can be used to describe a variety of online platforms (15). As a result, the use and application of SM can be diverse (19). SM can include: blogs/microblogs, business networks, collaborative projects, enterprise/personal/ community social networks, online forums, photo/video/media sharing platforms, product reviews, social bookmarking, social gaming, and virtual worlds (50). As a result of the wide array of platforms and functions many health professionals may use SM, knowingly or unknowingly, on a daily basis.
[12] The HPCSA Booklet 16 defines SM as:
"3.1 Social media describes the online tools and electronic platforms that people use to share content such as opinions, information, photos, videos and audio.
3.2 Social media includes social networks (e.g. Facebook, Twitter, WhatsApp and LinkedIn), content-sharing platforms (e.g. YouTube and Instagram), personal and professional blogs (including email, SMS, electronic journals as well as those published anonymously), internet discussion forums, and the comment sections of websites." (19).

However, the use of SM is not without risk for both patient and practitioner (24,50–65). This is why health professionals must be cautious when using SM (19,57). Consequently, professional standards are needed for SM, irrespective of whether the SM content is accessible to the public or is limited to specific individuals (19,57). Health professionals should be cognisant of potential risks involved in the sharing of information via SM, even if the consequences are unintended (19,57). This is why SM guidelines have been published, to protect patients and practitioners (81). Unfortunately, many of the SM guidelines are dated, and have not kept up with the advances in SM technology (16). It is critical that SM guidelines are modified as technology advances, even though the underlying principles of professionalism remain the same (55).

2.3 Research on the use of SM by health professionals

SM has been researched in various cohorts of health professionals (48,54,58,61,62,64,66,88,90–97). Many of these studies focus on the conduct of the health professional, and the implications for the patient [13]. Research into the use of SM by SA health professionals has focussed on ethical and legal obligations pertaining to privacy, patient-practitioner relationships, and professional reputation (52,56,57,60). There has been some empirical research on the use of SMM by health professionals (48,66). However, I argue that there has been limited research focus on the legal and ethical principles pertaining to SMM use by health professionals.

Thorough research is required to develop effective SM guidelines (88). This research assists in reaching a consensus on how health professionals should behave online (88). For this to occur there needs to be an investigation of global and country-specific standards for online behaviour (88). Unfortunately, empirical studies are seldom referenced or used in the creation of SM guidelines (88). This includes the HPCSA SM guidelines which reference other guidelines (67–70), rather than empirical

[13] Although there is a wide body of literature focussing on various health professionals it does not imply that the same type of empirical research was conducted in the studies referenced, nor does it imply that the findings were the same. In this scenario it highlights that there is a repetitive theme: there is concern about the conduct of the health professionals, and the implications for patients.

evidence. As a result, a reappraisal of how SM guidelines are promulgated needs to occur in order to improve their ability to guide appropriate behaviour (88).

2.4 The HPCSA SM guidelines

The HPCSA published [14] their set of "Ethical Guidelines on Social Media" [15] (Booklet 16) in 2019 (19). However, there were numerous local (67,98) and international (68–70) SM guidelines available prior to this. The Allied Health Professions Council (AHPCSA) was the local forerunner, and published SM guidelines for allied health professionals as early as 2015 (98). However, the HPCSA SM guidelines are the first set specifically promulgated for HPCSA registered health professionals (19).

According to Booklet 16 [16], the SM guidelines were developed to help health professionals understand their obligations when using SM (19). The guidelines also form part of the standards of professional conduct against which complaints of professional misconduct are evaluated (19). In creating these guidelines the HPCSA relied on British (69,70), American (68) and local (67) guidelines. They were also created in consultation with relevant ethical experts [17] as well as the Committee for Human Rights, Ethics and Professional Practice of the HPCSA [18] (19).

2.5 SMM guidelines for health professionals

Analysis of both local (19,57,67,78,98) and international (55,68–77,89,99,100) SM guidelines reveals that the focus is predominantly on the use of SM as a means for communication not as a means of marketing. I argue that this is a shortcoming as many health professionals are embracing SM platforms as a means of marketing

[14] The controversy leading up to the publication of the HPCSA SM guidelines will be discussed in Chapter 4.
[15] HPCSA Booklet 16 covers the following topics:
"- Obligations for health professionals in relation to SM
- Patient confidentiality and privacy
- The practitioner-patient relationship
- The health professional's image
- Conflict-of-interest
- Precautionary measures when using SM" (19).
[16] Booklet 16 - Ethical Guidelines on Social Media: Preamble (19).
[17] Dr N Tsotsi, Ms Nerissa Naidoo, Prof DJ McQuoid-Mason, and Prof A Dhai (19).
[18] Dr S Balton, Prof D J. McQuoid-Mason, Dr N Tsotsi, Prof B Pillay, Prof N Gwele, Prof N Mekwa, Prof S Hanekom (19).

themselves, or advertising their practices (26,48). The increased use of SMM by health professionals is driven in part by increased competition, but also an increase in demand from patients (49). Patients as consumers are increasingly relying on online methods to find health professionals (49).

Traditional marketing has seen a transition towards digital platforms and techniques (33). SMM is one of the digital forms of marketing that has recently flourished (17). SMM, much like conventional marketing, is intended to influence purchasing decisions (34) and customer behaviour (35). Not all of this influence is positive (34), and I argue that there is a potential for consumers to be negatively influenced or mislead. As a result there are guidelines [19] designed to protect consumers from deceptive and misleading advertising (36–42) and SMM (43–45). In SA there are no specific SMM regulations, however there are industry guidelines for advertising (37,38,41,42) as well as legislation (46,47) and common law that protects the rights of citizens, and in particular the right to protection from deceptive or misleading advertising (9).

There are SM guidelines for health professionals that have a limited focus on SMM (19,70,74,87,98) but there are also SM guidelines that fail to address SMM at all (55,68,69,71,72,76,77,89,99,100). The AHPRA guidelines (75) are an exception on an international level, while the AAMSSA guidelines (78) are an exception in SA. I argue that both sets of guidelines provide clarity on the legal and ethical obligations for health professionals when using SMM.

The HPCSA believes that the expansion of the online market is one of the most important areas of business practice [20] (19). It also acknowledges that SM has become a popular tool for the advertisement and promotion of goods and services [21] (19). However, their guidelines do not use the term SMM, rather they deal with SMM related issues in the section titled “COI” (19). The COI [22] section has 6 sub-sections. I will provide analysis of the COI section in Chapter 6 [23].

[19] Country specific.
[20] This references “business practice” rather than medical/health practice. The shortcomings of this will be discussed in Chapter 6.
[21] This does not specify if the HPCSA is being specific to health professionals or the general use of SMM. The shortcomings of this will be discussed in Chapter 6.
[22] Booklet 16 - Ethical Guidelines on Social Media: Section 9 Conflicts-of-interest (19).
[23] Shortcomings of the HPCSA SM conflict-of-interest guidelines.

2.6 Conclusion

This chapter served as an introduction to the SM guidelines for HPCSA registered health professionals. Part one highlighted the use of SM by health professionals in SA and abroad. Part two described the research that has been published on the use of SM by health professionals. Part two also highlighted that there is a lack of empirical evidence and research on SMM for health professionals [24]. Part three gave a synopsis of the current HPCSA SM guidelines. Part four outlined the lack of SMM guidelines for health professionals. Part four also laid the foundation for Chapter 7 which provides recommendations on what should be included in SMM guidelines for SA health professionals.

[24] This report is a normative report. However, future research should be done to ascertain the use of SMM by health professionals in SA.

CHAPTER 3: THE LEGAL OBLIGATIONS OF THE HPCSA TO PROVIDE SMM GUIDELINES

3.1 Introduction

This chapter serves as an introduction to the HPCSA and outlines the legal obligations to provide guidelines. There are four parts to this chapter. Part one is dedicated to how the HPCSA was established, as well as the role it must fulfil as a statutory body. Part two and part three outline the function and mission of the HPCSA relating to the production and maintenance of ethical guidelines. Part four provides an argument as to why it is the mandate of the HPCSA to provide marketing guidelines.

3.2 The establishment of the HPCSA

The HPCSA was established [25] in 1974 as a statutory body to regulate health professionals and to protect the public (10). In SA, statutory bodies are responsible for producing regulations and administering laws or policies that apply to a specific area of society (86). In this context the HPCSA is responsible for producing regulations and administering laws [26] or policies that apply to health professionals [27] and medical researchers (10).

Statutory bodies are established by the Parliament of the Republic of South Africa (102). They are established in terms of an "Act", which is a piece of legislation signed into law by the President of the Republic of South Africa (102). An example of such legislation is the HPA (10), which is a primary source of law that has binding authority (103). Chapter 1 [28] of the HPA provides for the establishment of the HPCSA (10). In 2007 the HPA was amended to revise terminology and to advance certain outdated

[25] This occurred when the Medical, Dental and Pharmacy Act of 1928 (101) was repealed, and then replaced by the HPA (10). Prior to this the HPCSA was known as South African Medical and Dental Council (1).
[26] This is not achieved in isolation as the HPCSA needs to rely on, and work in conjunction with, the Legislature and South African Police Service.
[27] Health professionals not allied health professionals, who are governed by the AHPCSA and Allied Health Professions Act (104).
[28] Health Professions Act: Chapter 1, Section 2 (10).

requirements and procedures [29] (11). The HPA, including amendments [30], defines the scope of each profession, and establishes processes to be followed in achieving the statutory mandate of the HPCSA (1).

3.3 The function of the HPCSA

There are 12 professional boards within the HPCSA (1). These boards represent the various health professions (1). The HPCSA together with these professional boards provide control over education, training and registration for professions registered under the HPA (1). Chapter 1 of the HPA deals with the establishment, objects, functions, and powers of the HPCSA [31] (10). Section 3 relates to the objects and functions of the HPCSA (10). There are 17 objects and functions in Section 3 (subsection a - q) (10). However, not all of these are relevant to this report. Sections 3c, 3j and 3m are the provisions that pertain to guidelines. Therefore, the primary focus of this section will be on these provisions.

Section 3c:

- "To determine strategic policy in accordance with national health policy as determined by the Minister, and to make decisions in terms thereof, with regard to the professional boards and the health professions, for matters such as finance, education, training, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, interprofessional matters and maintenance of professional competence." (10)

Section 3c highlights that the HPCSA is not merely required to create guidelines for professional conduct, they are also obligated to provide training and education. Furthermore, section 3c makes it the responsibility of the HPCSA to ensure that

[29] "To amend the Health Professions Act, 1974, so as to amend and insert certain definitions; to provide for the requirements for removal of members from office; to provide for the functions of registrar and staff; to provide for the investigation of members whose names have been removed from the register; to provide for inquiry by professional boards into charges of unprofessional conduct; to provide for the handling of cases relating to the death of a person undergoing a procedure of a therapeutic, diagnostic or palliative nature; to provide for regulations relating to professional boards, educational institutions and facilities; and to provide for matters connected therewith." (11).

[30] From here on when referencing the HPA it will include reference to the Health Professions Amendment Act without specifically naming it.

[31] As well as the professional boards.

professional competence is maintained. I argue that for professional competence to be maintained, the ethical guidelines and training would require regular updates. In my view this is especially the case when it comes to aspects that involve rapidly evolving technology, such as SM.

Section 3j:

- "To serve and protect the public in matters involving the rendering of health services by persons practising a health profession." (10)

I propose that section 3j is the most important of the three clauses as it talks to the core philosophy of the guidelines. It emphasizes that the guidelines transcend mere regulation of health professionals. Rather, they have a more critical role in terms of the protection of the public. This emphasises that the HPCSA cannot be apathetic when it comes to the creation and enforcement of ethical guidelines. The Council must serve and protect the public by creating a core set of guidelines that health professionals are obligated to follow.

Section 3m:

- "To uphold and maintain professional and ethical standards within the health professions." (10)

Section 3m requires the HPCSA to monitor and enforce ethical standards. By implication this means that the HPCSA needs to uphold and maintain the ethical guidelines. There are two parts to section 3m that need to be addressed, "upholding" and "maintaining". Firstly, "upholding" needs to be clarified. "Upholding" requires the HPCSA to be involved in the creation and enforcement of a set of guidelines. The HPCSA cannot create a set of ethical guidelines and then passively assume that there will be compliance. They need to create *and* enforce the ethical standards. Secondly, the word "maintain" can be misinterpreted [32]. It should not be assumed that the word "maintain" implies there is an obligation for the HPCSA to maintain the status quo. This argument is based on conjecture and assumes that the HPCSA has no obligation to update the guidelines. My argument is that if the guidelines are not updated, they

[32] Maintain in the English language can be used in dichotomous contexts. Such as "keeping in a specified state" or to "keep in continuance" (168). The first use indicates keeping the status quo, while the second use indicates the advancement to keep current.

become outdated, especially considering the rapid changes that occur in SM (105). The SM guidelines may also fall behind updates in legislation [33], and consequently become difficult to enforce [34].

3.4 The mission of the HPCSA

Part of the mission [35] of the HPCSA is to set and maintain contextually relevant standards for healthcare training and practice (1). To achieve its mission objectives, the HPCSA maintains a set of ethical guidelines for SA health professionals (79), and sanctions if they do not comply (80). The HPCSA in consultation with the professional boards, and with the approval of the Minister of Health establishes a set of ethical rules of conduct [36] (106). These rules are gazetted as a board notice [37], and expanded on by the HPCSA in their ethical booklets (79). These ethical guidelines ("Guidelines for Good Practice in the Health Care Professions") can be found on the HPCSA website [38] (1). There are 17 booklets that cover legal and ethical topics that are relevant to health professionals and medical researchers (1). Booklet 16 (19) provides guidelines on SM, however it is the responsibility of health professionals to familiarise themselves with all of the guidelines [39], as there are concepts in the other booklets that may apply to SM.

[33] For example: The commencement date of POPIA (14) was July 2020 and HPCSA Booklet 9 on Guidelines on the Keeping of Patient Health Records (107) was only updated September 2022.
[34] This is especially the case when new legislation is passed, or if there is conflict between two pieces of legislation.
[35] According to their website (1) the HPCSA "Mission" is:
"To regulate and guide registered healthcare professions and protect the public through:
- Setting contextually relevant standards for healthcare training and practice.
- Setting and maintaining standards for Ethical and Professional practice.
- Strengthening the maintenance of continuing competency programmes.
- Ensuring consistent compliance to all the set standards.
- Engaging the public and other stakeholders continually." (56).
[36] These guidelines do not exist independently as they need to be congruent with the Constitution, legislation, and case law.
[37] Board Notice 26, Government Gazette 36183 (2013) (106).
[38] Under the Core Operations dropdown menu, the guidelines can be found in the section on "Professional Practice: Scope of Practice and Ethics" (1).
[39] Booklet 16 sub-section 4.3: "These guidelines must be read in conjunction with the other HPCSA Ethical Guidelines Booklets and other applicable publications." (19).

3.5 Responsibility to provide marketing guidelines

There is a longstanding debate on the ethics and legality of advertising for health professionals dating back to the 1800s (21,22). There are arguments in favour of advertising, because of increased competition in the healthcare industry, and against advertising, because it is perceived to be unprofessional and unethical (21–28).

Harm to consumers from advertising is contentious (108), and detractors propose that concern over unprofessional conduct on SM is unfounded (109). In this argument it is purported that health professionals are able to self-regulate without the imposition of guidelines (109). Furthermore, it is claimed that the consumer needs to assume some responsibility (108). The "freedom-of-choice" argument in this context frames the patient as a consumer who is savvy enough to make their own choices [40]. However, it is important to acknowledge that patients are not simply consumers in the conventional sense. It has been established that patients can be easily influenced, and should be considered as a vulnerable population group worthy of protection (110). This ought to include protection from inappropriate marketing by health professionals (111).

An argument against having advertising guidelines is the potential harm that practitioners may face if they are restricted in marketing their practices. This argument is founded on the notion that a set of guidelines would be anticompetitive. However, this "harm-against-the-practitioner" argument would have to rely on the balancing of the rights of the practitioner and the rights of the patient. The SA Bill of Rights [41] enshrines the rights of all people in SA and affirms the democratic values of human dignity, equality and freedom (47). Health professionals have the right to "freedom of trade, occupation and profession" as well as "freedom of expression" (47). However, these rights need to be balanced in light of the patient's rights to "fair and responsible marketing" (9). Section 36 of the Bill of Rights (47), is known as the "limitation clause" (121). Section 36 establishes a test that limitations must meet (121). The two prescripts of this test are reasonableness and proportionality (121). If there is to be a restriction on a right it must be reasonable, and it must be proportional (121).

[40] There is literature that deals with the longstanding debate over the use of nomenclature in healthcare, and there are arguments for and against the terms "patient" and "customer/consumer" (112–120). However, the term "patient" has been shown to be the preferred term in the majority of health care settings (120).
[41] Chapter two of the SA Constitution (46) deals with the Bill of Rights (47).

In the context of marketing for health professionals the restriction of "laissez faire" marketing must be proportional to the importance of the aim served by the limitation, which is the protection of patients from unfair and irresponsible advertising. I argue that with any healthcare marketing the benefit-to-risk ratio is skewed in favour of the health professional. The patient carries most of the risk, while the health professional stands to benefit the most. Which is why it has been argued that when setting the standard of reasonableness it is better to err on the side of being over-protective toward the consumer (patient), rather than too permissive toward the advertiser (health professional) (108).

The HPCSA previously attempted to address marketing guidelines for HPCSA health professionals in a booklet titled "Making Professional Services Known" (29). However, these guidelines were repealed following the rejection of an exemption application (31) made by the HPCSA to the CCSA [42] (6). The CCSA found that the guidelines were anti-competitive (31) and in conflict with existing legislation (32). These guidelines included sub-sections that limited audience [43], the use of images [44], and imposed size limitations on marketing [45] (29). Despite the findings of the CCSA, similar AHPCSA guidelines remain unchallenged, and some of the rules that were found to be anti-competitive in the HPCSA guidelines, including limitations on audience and use of images, continue to be used in the AHPCSA guidelines (98). I argue that in the interest of consistency and clarity the CCSA should have reviewed both sets of guidelines [46].

The AHPCSA justifies the need for its guidelines in order to safeguard the fiduciary relationship between health professional and patient (98). In their opinion their guidelines protect the best interest of the patient (98). The AHPCSA also believes that marketing has the potential to erode trust between health professionals and society (98). In their words: "…trust between the practitioner and patient is critical for the ultimate wellbeing of any patient" (98). Health professionals ought to keep the interests

[42] The CCSA is a statutory body constituted in terms of the Competition Act (32) and is given the power to investigate, control and evaluate restrictive business practices in order to achieve equity and efficiency in the SA economy (6).
[43] "6.1 Health care professionals may communicate with their bone fide patients via practice notices, but such communications may not be distributed to the public at large." (29).
[44] "3.6 The use of photographs on notifications is not permissible." (29).
[45] "10.1 Signs and nameplates may not be larger than 1 m x 0.5 m…." (29).
[46] Both HPCSA and AHPCSA.

of the patient as paramount (beneficence) (122). They also have a moral obligation to refrain from causing unnecessary harm (non-maleficence) (122).

Unfortunately, SA does not have an HPCSA-equivalent statutory body for marketing. The closest equivalent is the Advertising Regulatory Board (ARB) [47] (123), which is created by the advertising industry rather than by government and legislation. Marketers in SA are allegedly "self-regulated" by the industry (123). They remain accountable to legislation (9), but can elect to follow an international advertising code (39). There are however, no legal or moral obligations to follow this code. It is for this reason that I argue that the HPCSA has a legal obligation to "self-regulate" health professionals who form a unique cohort within marketers in SA.

3.6 Conclusion

This chapter introduced the HPCSA and highlighted the legal obligation of the Council to provide guidelines. Part one established that the HPCSA is *the* statutory body responsible for producing regulations and administering laws [48] or policies that apply to health professionals [49] (86). Part two highlighted some of the functions relating to the ethical guidelines that the HPCSA ought to fulfil. The sub-sections in the HPA (10) that are pertinent to this report indicate that the HPCSA should 1) create guidelines for professional conduct, 2) protect the public in matters relating to the provision of health services by health professionals, and 3) uphold and maintain ethical standards (10). Part three illustrated that the mission of the HPCSA includes the "setting contextually relevant standards for healthcare training and practice" (1) as well as "setting and maintaining standards for ethical and professional practice" (1). Part four addressed the counter argument that it is not the responsibility of the HPCSA to provide guidelines on marketing.

[47] The Advertising Standards Authority of South Africa attempted to obtain statutory support (124), however it was eventually forced to stop trading (125).
[48] This is not achieved independently and relies on the Legislature and South African Police Service.
[49] The AHPCSA produces regulations for allied health professionals.

CHAPTER 4: THE ETHICAL OBLIGATIONS OF THE HPCSA TO PROVIDE SMM GUIDELINES

4.1 Introduction

This chapter provides clarity on the ethical obligations of the HPCSA to provide and maintain guidelines [50] for SA health professionals. There are seven parts to this section. Part one provides an introduction to SCT (Hobbes [51] and Rawls [52]). Part two clarifies how SCT applies to health professionals. Part three addresses the HPCSA and the "court of public opinion". Part four uses SCT to address the ethical obligations of the HPCSA to health professionals and society. Part five highlights the obligation to provide ethical guidance. Part six establishes the ethical obligation to update guidelines. Part seven highlights the obligation to provide ethical guidance on SMM.

4.2 Social Contract Theory

According to Thomas Hobbes, morality consists of precepts that we ought to follow to obtain the benefits of social living (126). In this context morality is concerned with mutual benefit (126). Hobbes called this agreement a "Social Contract" (126). According to Hobbes people must agree on a set of rules that govern their interactions (126). Collectively these rules form the Social Contract (126). Furthermore, Hobbes proposed that in order to flourish, society needs a peaceful, cooperative social order, which cannot be achieved without rules (126). He argued that society must follow certain rules, and concomitantly there must be ways to enforce these rules (126). Rawls proposed that citizens of a well-ordered society normally want these rules to be maintained (127). In essence SCT explains the need for morality (rules that make social living possible) and government (the means to enforce rules) (126). In the context of this paper, I argue that morality exists in the form of the relevant legislation and ethical guidelines, and the role of government is enforced by the HPCSA as a proxy.

[50] In this context guidelines refer to the general ethical guidelines.
[51] Thomas Hobbes, 17th Century British philosopher (126).
[52] John Rawls, 20th Century American philosopher (127).

4.3 Social Contact Theory and health professionals

There is a longstanding tacit agreement, or Social Contract, that exists between health professionals and society (128–130). Historically, health professionals were given the privilege of self-regulation when the modern health profession was established by medical licensing laws in the mid-19th century (129). The privilege of self-regulation was based on the understanding that the profession would assure the competence and regulation of health professionals (129). Health professionals in return would be devoted to altruistic service, demonstrate moral integrity, and address issues of societal concern in healthcare (129). Mutually reciprocal trust is fundamental for this relationship to succeed, as society must trust individual health professionals, and in return health professionals must believe society will meet their reasonable expectations (129,131–134). This is the foundation of the Social Contract between patient and health professional.

The privilege of "self-regulation" for health professionals in SA is conferred via legislation [53]. The previous chapter established that the role of the HPCSA is firstly to protect the public and secondly to regulate health professionals (10). Therefore, the Council plays a role in enforcing the Social Contract. Part of the legislated mandate of the HPCSA is to educate health professionals on their legal and moral obligations (10) I argue that this is achieved by publishing and enforcing guidelines. In the HPCSA guidelines [54] it states that health professionals have natural duties and moral obligations (81). Therefore, I argue that the HPCSA guidelines serve as a written representation of the Social Contract.

[53] The HPA (10) and Health Professions Amendment Act (11).

[54] Booklet 1 - General Ethical Guidelines for Health Care Professionals: "Being registered as a health care professional with the Health Professions Council of South Africa (HPCSA) confers on us the right and privilege to practise our professions. Correspondingly, practitioners have moral or ethical duties to others and society. These duties are generally in keeping with the principles of the South African Constitution and the obligations imposed on health care practitioners by law." (81).

4.4 The "court of public opinion" and the HPCSA

Hobbes proposed that society must follow certain rules, and there must be a way to enforce these rules (126). Most often enforcement of the rules involves the law, but it can also involve "the court of public opinion" (126). Unfortunately, public sentiment toward the Council has degenerated recently and it has become a popular target for journalists (135–140). This has raised the prominence and public awareness of the HPCSA in a less than favourable manner.

John Rawls proposed that authorities ought to act in good faith, and this good faith must be recognised by those who are subjected to their authority (127). In this context the HPCSA ought to act in good faith, and health professionals ought to recognise this good faith. However, I argue that health professionals have their reservations about the good faith of the Council. According to the results of a recent customer [55] satisfaction survey [56] the HPCSA alleges that health professionals are satisfied with the performance of the Council (141). They claim to have improved from 51% in 2016, to 60% in their most recent survey [57] (141). However, this is contradicted by an admission by the HPCSA that there have been numerous online complaints (142). Health professionals have allegedly used SM platforms to complain about the failure of the HPCSA to fulfil basic roles and responsibilities (142). This has prompted the Council to issue an apology via an e-bulletin in 2021 (142).

According to Rawls the coercive powers of government are necessary for the stability of social cooperation (127). Individuals need to share a common sense of justice if they are to adhere to the Social Contract (127). If individuals suspect that others are not doing their part, they may also be tempted not to do theirs (127). Public awareness of these "temptations" may eventually erode the Social Contract causing it to break down (127). Rawls proposed that in the absence of the authoritative interpretation and enforcement of the rules, it becomes easier to find excuses for breaking them (127). I

[55] In this context the term "customer" is used in reference to health professionals rather than other stakeholders, such as patients.

[56] The purpose of this survey was to determine the performance of the HPCSA compared to their previous survey in 2016 (141).

[57] The HPCSA did not disclose who the survey was sent to, nor did they clarify which aspects of their performance were included in the survey. A self-administered survey will inevitably have shortcomings as difficult questions can be avoided in the interest of self-preservation. Another potential shortcoming is that the survey may only be answered by individuals willing to sacrifice the time to complete it. As a result, this might not be an accurate reflection of the sentiments of all HPCSA registered health professionals.

argue that in this context the HPCSA should provide stability and a sense of justice. The council ought to uphold their side of the Social Contract to prevent it from eroding. Drawing on Rawls' theory; if there is a suspicion that the HPCSA is not honouring their duties and obligations there may be temptation for health professionals not to fulfil theirs.

4.5 The ethical obligations of the HPCSA

The previous chapter highlighted that the HPCSA has legal and institutional duties. According to Rawls "laws and commands are accepted as laws and commands only if it is generally believed that they can be obeyed and executed" (127). If this is in doubt then authorities presumably have an ulterior motive other than the organisation of conduct (127). According to Rawls it is an injustice when those in a position of authority fail to apply the appropriate rule, or otherwise fail to interpret it correctly (127).

The Bill of Rights [58] (47) serves as a Social Contract (143). All statutory bodies in SA have a moral obligation to enforce and uphold this contract. As a statutory body the HPCSA has a Social Contract with members of the public, as well as with registered health professionals. This is an important role as the privilege of self-regulation of health professionals, mentioned above, relies upon the effectiveness of the HPCSA to fulfil its statutory mandate (129). Members of the public need to trust that the HPCSA has the capacity and the competence to regulate health professionals. The need for trust also applies to the relationship between health professionals and the HPCSA. Because health professionals may cease to act in a professional way if they lose trust in the healthcare system (129).

4.6 The ethical obligation of the HPCSA to provide guidelines

In the previous chapter I highlighted that there is a legal imperative for the HPCSA to provide guidelines. However, there is also a moral imperative. Immanuel Kant referred to this as a categorical imperative (144). A categorical imperative according to Kant is a command or moral law that everyone *must* follow, irrespective of the circumstances

[58] Chapter 2 of the South African Constitution (46).

(34). As a hypothetical imperative the HPCSA should provide guidelines because they are required to do so by law. But as a categorical imperative the HPCSA ought to provide guidelines, as without guidelines the system of healthcare can become a free-for-all, and potentially ungovernable. In essence a categorical imperative can be viewed as an unconditional responsibility (144). Therefore, in the context of this report, the HPCSA has a categorical imperative, otherwise phrased as a moral responsibility (144), to provide health professionals with ethical guidelines.

In order to protect the public and guide health professionals the HPCSA ought to ensure that practitioners uphold and maintain ethical standards (10). The HPCSA also ought to ensure the investigation of complaints concerning health professionals and to ensure that disciplinary action is taken against those who fail to act accordingly (10). I argue that failure to produce and enforce ethical standards makes it impossible to fulfil the secondary role of investigation and punishment as there is no basis to determine alleged misconduct. Which is why guidelines need to be established as a foundation, before the secondary role of investigation and punishment can be considered. I argue that these guidelines form the bedrock of the Social Contract that exists between health professionals and the public.

4.7 The ethical obligation of the HPCSA to update guidelines

In the previous chapter I highlighted that the HPCSA has a legal responsibility to update [59] their guidelines (10). In this section I argue that this obligation extends to an ethical obligation as well. I will illustrate this by using the precept “ought implies can” (127). Firstly, based on the principle that “ought implies can”, the HPCSA has a moral obligation to update their guidelines only if it is possible for the council to do so. Secondly, “ought implies can” conveys the notion that the HPCSA enacts laws and gives orders in good faith (127).

It is not unprecedented for the HPCSA to change the guidelines it creates for health professionals. These changes range from contextual amendments to existing

[59] Section 3m: “To uphold and maintain professional and ethical standards within the health professions.” (10).

guidelines [60], to the complete removal of entire booklets [61]. I argue that it is possible for the HPCSA to update their guidelines, and in a relatively short timeframe. The update of the telemedicine [62] guidelines in reaction to the Covid-19 state of emergency serves as an example [63] (145). The telemedicine guidelines were amended [64] in line with the directive from the SA President to place SA citizens under a nationwide lockdown due to the Covid-19 pandemic [65]. The amendments to the telemedicine guidelines were implemented to change nomenclature and to allow health professionals to consult with patients who were not permitted to travel [66] (146). Whether these amendments were made in the best interest of the patient, or as a result from persistent pressure from health professionals is not apparent. However, what is apparent is that the Council was able to react in a short space of time to amend shortcomings that may have taken years to address if there were not significant pressure.

4.8 The ethical obligation of the HPCSA to update the guidelines on SMM

In the 2018/2019 annual report the HPCSA president [67] bemoaned the rise of de-professionalisation in healthcare (148). In his words de-professionalisation occurs when health professionals are reduced to traders, retailers and entrepreneurs (148). The HPCSA needs to realise that health professional entrepreneurialism is a worldwide reality, spurred by financial pressure (149). The changing economic climate and increase in "competition" has resulted in many health professionals becoming entrepreneurs (149). I argue that as entrepreneurs, these health professionals may

[60] Amendments to the telemedicine guidelines (83).
[61] Removal of the booklet on "Guidelines on making professional services known" (29).
[62] Telemedicine is defined in Booklet 10 as: "The practice of medicine using electronic communications, information technology or other electronic means between a healthcare practitioner in one location and a healthcare practitioner in another location for the purpose of facilitating, improving and enhancing clinical, educational and scientific healthcare and research, particularly to the under serviced areas in the Republic of South Africa." (83).
[63] The use of telemedicine is addressed in Booklet 10 "Guidelines for the practice of Telemedicine" (83).
[64] The HPCSA revised their stance on telemedicine twice in 2020. The first was to admonish health professionals who consulted new patients without a prior face-to-face relationship being established [64] (146). And the second was to permit initial consultations without a prior relationship existing [64] (150).
[65] Regulation R43107 published on 18th March 2020 (147).
[66] Limitations on travel and risk of spreading the Covid-19 virus warranted many remote consultations.
[67] At the time Dr Letlape was the president of the HPCSA (148).

find the online SM space is a valuable marketing platform for marketing their small business (medical practice).

Chapter two highlighted that SMM is being embraced by both health professionals (26,48) and patients (49). Despite this trend, the focus of many of the ethical guidelines is on the use of SM as a means for communication rather than as a means of marketing [68] (19,55,67–78,89,98–100). The HPCSA needs to realise that SMM is intended to influence purchasing decisions (34) and customer (patient) behaviour (35). Unfortunately, not all of this influence is positive (34), and I argue that there is a potential for consumers (patients) to be negatively influenced or mislead. Which is why there are country specific guidelines designed to protect consumers from deceptive and misleading advertising (36–42) and SMM (43–45).

It has been argued that deceptive advertising creates false beliefs which can be harmful (151). False beliefs created by deceptive advertising erode trust, requiring consumers to be constantly on guard against information that has been distorted (108). Borrowing from the Kantian principle of "universal law" (144), if all advertising and marketing were deceptive or misleading, then it would not be possible to trust the advertiser or marketer. I argue that if the advertiser or marketer is a health professional, then doubt would be cast on their trustworthiness in general, not just when it comes to advertising or marketing. This can potentially erode the Social Contract that exists between medical professionals and society (130). I propose that having a stronger moral code is one way of combatting the threat to the Social Contract. This can be achieved by creating a clearer set of guidelines for the modern health professional who wishes to use SMM.

I argue that even though the HPCSA believes that the expansion of the online market is one of the most important areas of business practice (19), it devotes little attention to the topic in its guidelines on SM. The HPCSA acknowledges that SM has become a popular tool for the advertisement and promotion of goods and services (19), yet I argue that it does not clarify how health professionals ought to navigate SMM. As a result of the lack of clarity, in the light of increased use, I propose that the HPCSA

[68] What is more concerning is that some of the SM guidelines fail to address SMM at all (55,68,69,71,72,76,77,89,99,100).

ought [69] to update [70] their SM and SMM guidelines [71]. I argue that this will allow the HPCSA to honour their moral obligations, while protecting health professionals from breaking their Social Contract with members of the public (patients).

4.9 Conclusion

This chapter provided clarity on the ethical obligations of the HPCSA to provide and maintain guidelines for SA health professionals. Part one provided an introduction to SCT by drawing on the works from Hobbes and Rawls. Part two clarified how SCT applies to health professionals. It also highlighted that mutually reciprocal trust is fundamental for the Social Contract to succeed. Part three addressed the "court of public opinion" and the recent damage that has been done to the public image of the HPCSA. This section also highlighted that if there is suspicion that the HPCSA is not fulfilling their side of the Social Contract it may tempt others not to fulfil theirs. Part four used SCT to address the ethical obligations of the HPCSA to health professionals and society. This section highlighted that HPCSA has a Social Contract with members of the public, as well as with registered health professionals. The privilege of self-regulation of health professionals, relies upon the effectiveness of the HPCSA to fulfil its statutory mandate as well as the moral obligations of the Social Contract. Part five highlighted that the HPCSA has a moral obligation to provide ethical guidance. In part five it was established that there is a categorical imperative for the HPCSA to provide guidelines. As without guidelines the system of healthcare can become a free-for-all, and potentially ungovernable. Part six established that this obligation extends beyond provision, but also includes the maintenance of the guidelines. "Maintenance" in this context includes the moral obligation to update guidelines. The update of the telemedicine guidelines served as an example of how the HPCSA was able to update their guidelines in a short space of time, based on situational requirements. Part seven highlighted that the moral obligation to update the guidelines extends to the provision of clearer ethical guidance on SMM. This section established that the HPCSA ought

[69] In this context "ought" is used in a moral sense with emphasis, rather than in the layperson sense, which may have weaker connotations.
[70] Even though these guidelines were published in 2019 (19).
[71] This will be discussed in Chapter 7.

to provide clarity on how health professionals can use SMM in a manner that is not detrimental to the Social Contract.

CHAPTER 5: THE FAILURE TO PROVIDE GUIDELINES

5.1 Introduction

This chapter highlights some of the recent shortcomings of the HPCSA along with scenarios where the council has failed to provide guidelines. There are three parts to this section. Part one addresses the alleged failure of the HPCSA to fulfil basic functions. Part two focusses on the previous failure of the HPCSA to provide guidelines on SM. Part three critiques the current HPCSA marketing guidelines.

5.2 Failure to fulfil basic functions

In 2015 the Minister of Health [72] established [73] a Ministerial Task Team (MTT), from the Department of Health (152). The MTT was established to investigate [74] allegations of mismanagement, administrative irregularities, and poor governance at the HPCSA (153). This MTT was formulated in response to an increase in the number of complaints made by health professionals, professional associations, as well as academic training institutions against the HPCSA (153). These complaints included accusations of poor communication, along with the failure to provide guidance in resolving challenges affecting health professionals (153). Upon investigating the complaints the MTT found that the HPCSA administration processes were a shambles, the executives were incompetent, and the organisation was riddled with corruption (153). The MTT concluded that the HPCSA was structurally unsuited to carry out its core functions (153).

The HPCSA claims to have improved since the publication of the MTT report (141). However, in a recent judgement [75] against the HPCSA, Judge Nelisa Mali [76] questioned whether the HPCSA is fit for purpose. This matter was related to a series of

[72] Dr Aaron Motsoaledi.
[73] In accordance with the Health Professions Amendment Act (11) Section 6(g)(5).
[74] The MTT only had the power to investigate and report back to the Minister of Health (11), and therefore its findings were not binding. However, the recommendations of the MTT report and section 6.1i of the Health Professions Amendment Act left the Minister of Health in a position to dissolve the council according to Section 6.3a (11).
[75] Kholina v Health Professions Councils of South Africa and Others (2021).
[76] North Gauteng High Court Judge.

administrative blunders, where the HPCSA failed to fulfil a legally mandated role [77] (154). In this case Judge Mali found that the HPCSA unfairly prejudiced health professionals due to their tardiness (154). Judge Mali further held that the HPCSA has legal obligations, and should not shrug accountability, or assign responsibility to third parties (154).

5.3 Failure to provide ethical guidelines on SM

The HPCSA did not always have a set of SM guidelines. They only published their SM guidelines in 2019 (19), five years after a controversial hearing related to SM. The investigation and subsequent hearing ensued after a complaint of alleged unprofessional conduct on SM. The complaint was made by a health professional (dietitian) against a fellow health professional (medical practitioner). This complaint ultimately led to a highly publicised HPCSA hearing [78] involving a local scientist and health professional, Professor [79] Tim Noakes [80]. Professor Noakes faced a charge of unprofessional conduct for a Tweet [81] that he posted in 2014. The complaint resulted in a 26-day multimillion-Rand hearing into the professional conduct of Professor Noakes (155,156).

There was significant public and professional interest in the Noakes case because of the complexities surrounding the use of SM as a communication tool. This case highlighted that there needs to be a balance between professional obligations (what is in the best interest of the patient/public) and the right to freedom of speech (health professionals may have differing treatment paradigms and beliefs). It also raised a moral dilemma about the content of information posted by health professionals on SM, and the potential blurring between what is true scientific information and what is

[77] In this case the HPCSA failed to assist a foreign qualified health professional who sought registration with the Council. This health professional's request was not unreasonable as one of the mandates of the HPCSA is to facilitate training, education, and registration of health professionals (10).
[78] Referred to by some as a "trial" (156).
[79] Emeritus.
[80] Professor Noakes is no longer registered with the HPCSA. At the time he was a Sport Physician working in Cape Town. HPCSA practitioner number MP 0173479.
[81] Tweet: a short 280-character message posted on the social media platform called Twitter. At the time of the Noakes tweet the character limit was set at 144. The crux of this case hinged on whether the tweet i) constituted medical advice without prior patient-practitioner relationship and ii) whether the content of the tweet was out of scope of practice. Professor Noakes was found not guilty on both counts.

disinformation or false. At the time the HPCSA did not have an independent set of SM guidelines (60). I argue that this hamstrung the entire process as SM was unchartered territory for both the Council and the health professional they were investigating. Following the hearing the HPCSA was compelled to publish their booklet on SM (19).

I argue that in this scenario the HPCSA was heavy-handed in their response, which resulted in unnecessary public controversy. I argue that the administrative mismanagement of the hearing could have been prevented if there were clear and independent [82] SM guidelines. Even outspoken critics of Professor Noakes have lamented the handling of the matter, calling the hearing a waste of time and money (157,158). According to critics the alleged Tweet was possibly irresponsible, but not unethical according to the rules at the time, making the process wasteful and misguided (157,158). I argue that this cost the HPCSA, and by implication registered health professionals, millions of Rand in unnecessary expenditure. Furthermore, I argue that the HPCSA was slow to react to the dynamic online environment. Other local (67,98) and international (68–70) SM guidelines were available long before the HPCSA published their SM guidelines. I propose that the HPCSA should have been proactive in creating guidelines rather than reacting when they realised that their existing guidelines (20,82) were insufficient.

The HPCSA claims that it is “impossible to develop a complete set of specific ethical prescriptions applicable to all conceivable real-life situations” (81). They assert that “health care professionals may have to work out for themselves what course of action can best be defended ethically” (81). The Council claims that scenarios not covered in the guidelines can be resolved using “ethical reasoning” (81). The folly of this logic is evident from the Noakes saga where no SM guidelines existed. I argue that this is the current predicament facing all SA health professionals when it comes to SMM. Where there is a distinct absence of guidance on SMM, requiring many health professionals to navigate the rapidly evolving online environment for themselves without the compass provided by the Council.

[82] Stand-alone booklet devoted to SM rather than generic guidelines being extrapolated to incorporate SM.

5.4 Failure to provide adequate guidelines on marketing for health professionals

The focus of this report is on the SM guidelines, however the HPCSA cannot amend the SM guidelines without addressing the marketing guidelines in Booklet 2. I will address the shortcomings of the marketing guidelines in the section below as these shortcomings pertain to the recommendations that I will make in Chapter 7 [83].

Following the removal of the "Making Professional Services Known" booklet the HPCSA became reliant on the advertising guidelines in Booklet 2 and the information found in Booklet 11 on perverse incentives [84]. Unfortunately, the remaining guidelines are not specific about what is considered to be "acceptable" advertising (159). There is no clarification on what is deemed to be "unprofessional, untruthful, deceptive or misleading" [85] (82). This has resulted in other professional associations creating their own guidelines [86] (78,160). These independent guidelines are created by the professional associations to assist in the absence of clarity from the HPCSA (159). However, these independent guidelines have the caveat that health professionals should contact the HPCSA for clarification on a case-by-case basis (159,160). I argue that dealing with queries on a case-by-case basis is a poor allocation of resources for three reasons. Firstly, I argue that other health professionals may be facing the same dilemma and would benefit from the information. If information is provided on a case-by-case basis it will inevitably be shared via private correspondence. Secondly, I argue that if the HPCSA created clear guidelines they would not need to devote resources to deal with case-by-case queries. Thirdly, I argue that if the HPCSA had clear guidelines there would be fewer queries and ethical dilemmas. Health professionals should not have to feel that there is a "fine line between what is permissible and what is not" (159).

[83] Chapter 7: Recommendations for future HPCSA guidelines on SMM.
[84] I will describe the shortcomings of these guidelines in Chapter 6.
[85] HPCSA Booklet 2 - Rule 3 Advertising and canvassing or touting. 3. (1) "A practitioner shall be allowed to advertise his or her services or permit, sanction or acquiesce to such advertisement: Provided that the advertisement is not unprofessional, untruthful, deceptive or misleading or causes consumers unwarranted anxiety that they may be suffering from any health condition." (82).
[86] According to section 3 of the HPA this should be the responsibility of the HPCSA (10).

5.5 Conclusion

This chapter provided context on how the HPCSA is failing to provide ethical guidelines. Part one illustrated how the MTT reported that the HPCSA was failing to fulfil basic functions. It also highlighted that there are concerns relating to the ability of the Council to fulfil legally mandated roles. Part two built on this by highlighting where the Council failed to provide guidelines on SM. Part three provided critique on the current HPCSA marketing guidelines for health professionals. In part three I argued that the marketing guidelines are inadequate and need to be clearer.

CHAPTER 6: SHORTCOMINGS OF THE HPCSA SM CONFLICT-OF-INTEREST GUIDELINES

6.1 Introduction

This chapter provides critique of the COI section in the HPCSA SM guidelines [87]. There are seven parts to this chapter. Part one addresses the failure to provide an adequate section on SMM. Part two to part seven provides critique of sub-sections 9.1 to 9.6 within the COI section.

6.2 Failure to provide adequate guidelines on SMM for health professionals

In Booklet 16 there is limited information on SMM [88]. There is also no mention of, nor reference to, SA legislation such as the CPA (9) or MRSAA [89] (12) that should be considered when using SMM. There is a section termed "COI" that attempts to address SMM. However, this section needs to be read in conjunction with a separate set of guidelines [90] rather than being a stand-alone reference (19,20,82). This makes it the responsibility of the health professional to search for additional information that might pertain to SMM. I argue that this is a missed opportunity as section 3c [91] of the HPA highlights that the HPCSA is also obligated to provide education (10). Therefore, guidelines need not be purely about managing professional conduct, they can also provide an opportunity for education.

[87] HPCSA Booklet 16 - Ethical Guidelines on Social Media (19).
[88] It is referred to as COI.
[89] The MRSAA is referenced briefly (albeit incorrectly) in Booklet 11 (20).
[90] Booklet 2 (82) and Booklet 11 (20).
[91] Section 3c: "To determine strategic policy in accordance with national health policy as determined by the Minister, and to make decisions in terms thereof, with regard to the professional boards and the health professions, for matters such as finance, education, training, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, interprofessional matters and maintenance of professional competence." (10).

I will outline the shortcomings of the section on COI [92] below:

6.3 COI sub-section 9.1

> "Social media is also a popular tool for the advertisement and promotion of goods and services, with the growing online market being one of the most emphasised in business practice." (19).

I argue that this is a statement of "fact", rather than a guideline and thus serves little in the way of guidance or education. Furthermore, I argue that this statement is generic as it applies to general "business practice" rather than to the practices of health professionals. As I outlined in Chapter 2, there is limited data to support this statement as there is limited empirical research on the subject of SMM for health professionals. Consequently sub-section 9.1 falls into the same trap as other SM guidelines which are not based on empirical evidence (88).

6.4 COI sub-section 9.2

> "When using social media, even if via personal or anonymous blogs, health care practitioners must comply with the HPCSA rules on advertising practice, (including not engaging in active or passive touting [93] and canvassing [94] or allowing others to do so on their behalf), and must make sure that they declaring their financial interests in hospitals)" (19).

In addition, this sub-section refers health professionals to Booklet 2 [95] (82) and Booklet 11 [96] (20) to obtain "additional information" [97].

I argue that sub-section 9.2 is flawed for two reasons:

Firstly, I argue that it lacks reference to legislation. Encouraging health professionals to comply with the HPCSA rules on advertising practice is only one part of the bigger picture. Health professionals also need to comply with the CPA (9) when it comes to

[92] Sub-section 9.2 to sub-section 9.6 (19).
[93] Touting is raised in sub-section 9.3 (19).
[94] Canvassing is raised in sub-section 9.4 (19).
[95] Ethical and Professional Rules of the Health Professions Council of South Africa (82).
[96] Guidelines on Overservicing, Perverse Incentives and Related Matters (20).
[97] "(see Booklet 2 Ethical and Professional Rules of the Health Professions Council of South Africa and Booklet 11 Guidelines on Overservicing, Perverse Incentives and Related Matters)" (19).

the content and nature of marketing [98], the Protection of Personal Information Act (POPIA) (14) when it comes to consent to marketing [99], and the MRSAA (12) when it comes to the marketing of medicine [100] or medical devices [101]. I argue that these Acts are not referenced adequately [102] (19). I argue that this serves as another example of a missed education opportunity. The HPCSA ought to provide guidance on SMM. This would indirectly assist with protecting patients and health professionals as they would have a better understanding of their legal obligations.

Secondly, I argue that sub-section 9.2 lacks adequate clarity on SMM. Rather than dealing with the concepts as they pertain to SMM, sub-section 9.2 refers health professionals to additional booklets (20,82). I will expand on my argument as to why this cross-referencing is problematic in the sections below:

6.4.1 The shortcomings of cross-referencing Booklet 2

Health professionals need to refer to Booklet 2 (82) for additional information on advertising and canvassing or touting [103], which is limited to sub-sections 3.1 [104] and 3.2 [105]. I argue that this is an adequate starting point, but it is hamstrung by the definitions of canvassing and touting, which will be described below in sub-section 9.3 (touting) and 9.4 (canvassing).

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[98] CPA - Chapter 2: Fundamental Consumer Rights (9). Chapter 2 applies to SM as it addresses fundamental rights such as: the right to disclosure and information, the right to fair and responsible marketing, and the fair and honest dealing (9).

[99] POPIA - Chapter 8: Direct Marketing, Directories, and Automated Decision Making (14). This section applies to health professionals using SM as a means of direct marketing to followers or those who intend on using followers SM profiles as a directory (14).

[100] MRSAA - section 14 (12). This is applicable to health professionals as: i) Schedule 2 and above Medicines may not be advertised to the public, ii) prices of Schedule 2 and above medications may not be listed on SM, and iii) trade names may not be mentioned on SM (78).

[101] MRSAA - section 17 (12). This is applicable to health professionals as: Class C and D Medical Devices may not be advertised to the public (78). Class D Devices include all injectables (78). Injectables are therefore not allowed to be advertised or mentioned by trade name on SM (78).

[102] Section 5 on obligations mentions: "Just as with all aspects of professional behaviour, health practitioners should be aware of their obligations under the HPCSA Ethical and Professional Rules, the Professional Board's scope of practice and other relevant legislation, such as the Promotion of Access to Justice Act 3 of 2000, the Protection of Personal Information Act 4 of 2013, and the common law." (19).

[103] Section 3: Advertising and canvassing or touting (82).

[104] Advertising and canvassing or touting 3.1: "A practitioner shall be allowed to advertise his or her services or permit, sanction or acquiesce to such advertisement: Provided that the advertisement is not unprofessional, untruthful, deceptive or misleading or causes consumers unwarranted anxiety that they may be suffering from any health condition." (82).

[105] Advertising and canvassing or touting 3.2: "A practitioner shall not canvass or tout or allow canvassing or touting to be done for patients on his or her behalf." (82).

6.4.2 The shortcomings of cross-referencing Booklet 11

Booklet 11 deals with overservicing, perverse incentives and related matters (20). It also makes reference to legislation on marketing medicine and medical devices (12), with some of the definitions based on the MRSAA [106] (20). However, I argue that there are three major shortcomings:

Firstly, Rule 3 in Booklet 11 [107] is not a copy and paste job from Booklet 2. Booklet 11 is more comprehensive. However, I argue that rather than providing clarity, this elaboration on advertising in Booklet 11 creates legal uncertainty (103) and potential confusion for health professionals as to which definition is to be used (Booklet 2 or Booklet 11).

Secondly, I argue that the definition [108] of advertising in Booklet 11 is flawed in that it references "any health establishment" [109] and "the practice of a particular health care practitioner" (20). If this definition is to be followed to the letter, health professionals would not be able to advertise themselves or their practices. Health professionals who use adverts are marketing themselves or their practices (health establishment) with the purpose of notifying or attracting prospective patients. These prospective patients will pay money for the services rendered which indirectly implies that the whole

[106] Booklet 11 incorrectly references the MRSAA as the "Medicine and Substance Related Act" (20).

[107] "Advertising rule 3: Health care practitioners shall not advertise or endorse or encourage the use of any health establishment or orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance or health related product or health related service in a manner that unfairly promotes the practice of a particular health care practitioner or a health care facility for the purpose of financial gain or other valuable consideration." (20).

[108] Booklet 11 defines advertising as:
"Advertise in relation to any health establishment or orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance or health related product or health related service, means any written, pictorial, visual or other descriptive matter or verbal statement or reference in respect thereof:
2.1.1 Appearing in any newspaper, magazine, pamphlet or other publication; or
2.1.2 Distributed to members of the public; or
2.1.3 Brought to the notice of members of the public in any manner whatsoever,
That is intended to promote the sale of that orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance or health related product or to attract patients to any particular health establishment or health related service." (20).

[109] Booklet 11: ""Health establishment" means an institution, facility, building or place where persons receive treatment, diagnostic or therapeutic interventions or other allopathic or complementing health services and it includes facilities such as a clinic, mobile clinic, hospital, community health centre, maternity home or unattached delivery suite, convalescent home, consulting room, dispensary of health related treatment or aids and appliances, first aid station, orthopaedic workshop, dental laboratory or workshop, ambulance, unattached operating theatre, sanatorium, laboratory, pharmacy, occupational health clinic, radiological clinic, and health spa or hydro." (20).

purpose of the health professional advertising is for financial gain. Thus, any advert made by a health professional would be in contravention of ethical Rule 3.

Finally, I argue that health professionals are required to trawl through the entire booklet to find fragments of information pertaining to SM and SMM. Rather than address SMM directly in the section on COI, the HPCSA shifts the responsibility to older guidelines [110]. Consequently, I argue that the reference to Booklet 11 in the HPCSA SM guidelines is a mealy-mouthed attempt to address SMM indirectly. Rather than having unnecessary sub-sections like 9.1 and 9.6, the HPCSA could easily add in sub-sections that address the concepts covered in Booklet 11 and how they pertain to SMM. I argue that the Noakes case serves as an example of what happens when the HPCSA assumes that generic guidelines are sufficient.

6.5 COI sub-section 9.3

> "Touting involves drawing attention to one's professional goods or services by offering guarantees or benefits that fall outside one's scope of practice. An example is advertising free Wi-Fi services to patients while waiting for their consultations." (19)

I argue that the use of "touting" and the definition provided by the HPCSA is flawed for four main reasons:

Firstly, I argue that the term is outdated. Historically it has been reserved for "professionals" [111] (161). However, it has been abandoned in modern guidelines (162). Reference to touting in contemporary academic texts is difficult to find, however there are references dating as far back as the 1890's (163,164). Historically touting was seen as a context where a health professional desired to lure a patient away from a competitor (164).

[110] They do this in referencing Booklet 11 as it addresses the concept of advertising in two sections (20). Firstly, in the "Defining concepts" section and secondly when addressing Rule 3 from Booklet 2 (82).
[111] Lawyers, Architects, Engineers, Health Professionals, etc.

Secondly, I argue that the term is not recognised internationally [112]. None of the international SM guidelines reviewed in this report use the term touting (55,68–77,89,99,100). From extensive searching it appears that the term has previously been used internationally (163,165,166) but now remains an anomaly, unique to the SA guidelines (19,82,98,167).

Thirdly, I argue that the HPCSA has made an error with their definitions. This is evident when you look at the verb "tout" and the "verb" canvass. The verb, "canvass", is seen as means of soliciting or drumming up support (168). While the dictionary definition of the verb "tout" is to advertise boastfully or praise extravagantly (168). This is not the same meaning that the HPCSA assigns to canvassing or touting. Touting in HPCSA terms is to lure, while canvassing is to brag or boast (19,82). Words and their associated definitions matter because the scope and effect of legal principles are embodied in words in which they are framed (169). As a result, the HPCSA ought not to create their own definition of words, particularly if they are not congruent with the dictionary, international norms, or historic meaning.

Finally, I argue that the definitions are not consistent. The definition changes between Booklet 2 and Booklet 16 (19,82). Sub-section 9.3 makes an attempt to simplify the definition [113] of "touting" found in Booklet 2 (19,82). This can lead to confusion as the shorter definition in Booklet 16 may not convey as much meaning as the longer definition in Booklet 2 (19,82).

6.6 COI sub-section 9.4

> "Canvassing involves the promotion of one's professional goods and services by drawing attention to one's personal qualities, superior knowledge, quality of service, professional guarantees, or best practice. An example of canvassing is a health care practitioner declaring on social media or posting patient reviews that state he or she is 'the best health care practitioner in the country'." (19)

[112] Consequently, SA health professionals cannot look at international guidelines as a reference point if they need further clarification. By implication, it also means that the HPCSA has not remained current with its guidelines by using outdated terms that have been abandoned internationally (162).

[113] "Touting means conduct which draws attention, either verbally or by means of printed or electronic media, to one's offers, guarantees or material benefits that do not fall in the categories of professional services or items, but are linked to the rendering of a professional service or designed to entice the public to the professional practice." (82).

I argue that this definition and the use of the word “canvassing” is flawed for five main reasons:

Firstly, I argue the term is outdated. Historically canvassing by health professionals was associated with door-to-door sales (163,165,166). Much like a politician who canvasses door-to-door for votes (170). Canvassing was previously held to encompass direct approaches to individual patients, as well as the unsolicited distribution of advertising material, which included advertising in the press or via other media (162). The General Medical Council (GMC) (8) realised that their guidelines on advertising were too strict [114] and subsequently removed the term canvassing (162).

Secondly, I argue that canvassing is not a term that is widely used. It is a term that is unique [115] to SA guidelines (19,82,98,167). The term appears in Booklet 2 and Booklet 16, and is used by the HPCSA when referring to advertising (19,82). It is not a term that is used in any of the international SM guidelines reviewed in this report (55,68–77,89,99,100).

Thirdly, I argue that the concept of canvassing is not easily understood. It appears that the HPCSA has incorrectly incorporated activities considered to be “touting” into their definition of “canvassing”, and in the process created their own definition. Furthermore, the definition assigned by the HPCSA has also changed over time which can result in confusion. Booklet 16 (19) differs from the definition [116] provided in Booklet 2 (82) as well as the 2012 definition [117] found in the Government Gazette (172).

Fourthly, I argue that the HPCSA does not have an accurate understanding of SM. Self-promotion is a central tenet of SM. The whole drive on SM and the purpose of SMM is about self-promotion. For example, the use of photos and images draws attention to the personal qualities of the health professional. If sub-section 9.4 had to

[114] In the United Kingdom the requirement that advertisements made by health professionals should be of a non-promotional nature was rejected on the grounds that it is difficult to define, and is unjustified when patients are not considered to be in a vulnerable state (171).
[115] Albeit historically used by the GMC (8) in their ethical guidelines (162,171).
[116] “Canvassing means conduct which draws attention, either verbally or by means of printed or electronic media, to one’s personal qualities, superior knowledge, quality of service, professional guarantees or best practice.” (82).
[117] “Canvassing means conduct which involves direct contact with prospective clients verbally or by, inter alia, distributing letters, pamphlets, circulars or other means of communication including printed or electronic communication, in which attention is drawn to one’s personal qualities, superior knowledge, quality of service, professional guarantees or best practice in order to secure the prospective clients’ custom.” (172).

be adhered to then health professionals would have to refrain from publishing photos of themselves, which is an unnecessary marketing restriction (31).

Finally, I argue that the HPCSA is trying to regulate SM in a manner that might not be possible. Sub-section 9.4 fails to distinguish between solicited or unsolicited reviews. In this sub-section reviews are conceptualised as practitioner driven, where the practitioner actively seeks and publishes favourable reviews. What sub-section 9.4 fails to address is the patient driven reviews which could be favourable, or unfavourable, and published without the knowledge or consent of the health professional. On certain platforms [118] reviews can only be edited or removed by the individual who made the review. Thus, health professionals could be held accountable to sub-section 9.4 even though the location and content of the review is not within their control.

6.7 COI sub-section 9.5

> "Health practitioners may not advertise, endorse or encourage the use of any hospital, medicine or health-related product on social media in a manner that unfairly promotes the practice of a particular health practitioner or establishment for the purposes of financial gain or other valuable consideration." (19)

I argue that sub-section 9.5 is flawed for two main reasons:

Firstly, I argue that this sub-section could be considered an oxymoron. The whole point of marketing is to entice customers and therefore the fundamental purpose is financial gain (34). Health professionals will be promoting themselves and/or their practices on SM and therefore in breach of this sub-section.

Secondly, I argue that sub-section 9.5 does not adequately address the term "endorse" or "promote". Unlike sub-section 9.2 this sub-section does not refer to Booklet 11. The "Defining Concepts" section of Booklet 11 attempts to clarify the term "endorse" with the following definition (20):

[118] For example, Google will not allow the owner of a business to delete a review made by a customer. The review can be reported to Google, who in turn will determine if it should be removed (173).

> "Endorse means any action whereby a person or body attaches approval to or sanctions any health establishment or orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance or other health related product or health related service with a view to encouraging or promoting the preferential use or preferential sale thereof for the purpose of financial gain or other valuable consideration." (20)

The term endorse does not appear in the HPCSA SM guidelines other than in sub-section 9.5. However, it is possible to argue that the HPCSA makes an attempt to address the topic of endorsements indirectly when they mention that canvassing and touting cannot be done on the behalf of a health professional (82). However, this is found in section 3 of Booklet 2 which is also not referenced in sub-section 9.5. The terms "endorse" and "promote" also need to be read in conjunction with Rule 7 on "commission" in Booklet 11. Rule 7 appears in section 3.9 and deals with accepting commission [119] and paying commission [120] (20).

I argue that there is insufficient guidance on endorsements, promotions, or the payment of "commission" in the current SM guidelines. Endorsements and promotions are prevalent on SM (174), which makes the clarification of the terms "endorse" and "promote" critical. Especially when dealing with SM influencers [121] and health professionals who are considered to be SM influencers.

Certain SMM tactics have been used to deliberately influence, and in some cases mislead, consumers (45,174–178). Endorsements and promotions made by SM influencers are an example (176). These are common on SM with SM influencers endorsing products, people and places (179). Endorsements made by SM influencers are subjective, almost always positive, and constitute a potential COI (176). It is for this reason that some countries have established SMM guidelines and legislation

[119] 3.9.1 Accepting commission: "Accepting commission: Health care practitioners shall not accept commission or any financial gain or other valuable consideration from any person or body or service in return for the purchase, sale or supply of any goods, substances or materials used by the health care professional in his or her practice." (20).

[120] 3.9.2 Paying commission: "Paying commission: Health care practitioners shall not pay commission or render any financial gain or other valuable consideration to any person for recommending patients." (20).

[121] The term SM influencer is used to describe an individual who uses SM to build up an audience, over whom they have a sphere of influence (18). Health professionals have followed the influencer trend and become influencers themselves or used influencers to market their practice (28,61).

pertaining to transparency and the declaration of any SM post that constitutes a COI (43–45,180–182). For example, the United States of America Federal Trade Commission (FTC) (7) and the FTC Act [122] (183) requires that disclosures are prominently displayed so that they are noticeable to consumers (43–45,181,182). SA legislation requires that consumers are fully informed when it comes to marketing [123] (9), and that patients are fully informed when it comes to medical treatments [124] (13). There are also guidelines that require health professionals to disclose possible COI [125] (79). I argue that patients cannot be fully informed if health professionals, and influencers as a proxy, use misleading SMM tactics such as endorsements and promotions that fail to disclose potential COI.

6.8 COI sub-section 9.6

> "A failure to follow these guidelines when using social media will undermine public trust in the health profession." (19)

I argue that this is a declaration rather than a guideline and thus serves little in the way of education on COI for health professionals. It is also not exclusive to the COI section. For example, if health professionals were to breach patient-practitioner confidentiality [126] on SM it would also undermine public trust. Sub-section 9.6 applies to all of Booklet 16 and therefore belongs in the preamble. The concept of trust applies to all of the HPCSA guidelines which is why it is discussed in Booklet 1 [127] (81).

6.9 Conclusion

This chapter provided a critical analysis of the HPCSA SM guidelines pertaining to marketing/advertising. In this chapter I addressed the shortcomings of the definitions for canvassing and touting. In my argument I proposed that the terms are outdated, not widely used internationally, not used in other SM guidelines, and are fundamentally flawed as the HPCSA definitions conflict with basic dictionary definitions. Furthermore,

[122] Section 5: Unfair or Deceptive Acts or Practices (183).
[123] CPA Chapter 2 - Part D: Right to disclosure and information (9).
[124] NHA Chapter 2 - Section 6: User to have full knowledge (13).
[125] HPCSA Booklet 1 - Subsection 5.8 Potential Conflicts of Interest (20).
[126] Section 6: Patient Confidentiality and Privacy (19).
[127] HPCSA Booklet 1 - General Ethical Guidelines for the Healthcare Professions (81).

I critiqued the lack of reference to legislation and concomitant reliance on, and cross referencing to, additional booklets rather than addressing the concepts in the SM guidelines. In doing so I highlighted the lack of clarity on fundamental concepts linked to endorsements and promotions. I argue that based on these shortcomings the HPCSA must update their SM guidelines. Recommendations on how to advance or improve section 9 of the HPCSA SM guidelines will be dealt with in Chapter 7 [128].

CHAPTER 7: RECOMMENDATIONS FOR FUTURE HPCSA GUIDELINES ON SMM

7.1 Introduction

This chapter provides insight into the changes that need to be made to the HPCSA SM guidelines. There are seven parts to this chapter. Part one illustrates that the guidelines on SM need to be updated. Part two briefly establishes that it is not possible to update the SM guidelines in isolation. Part three highlights that further empirical research is needed. Part four emphasizes the need for additional marketing related legislation to be included in the SM guidelines. Part five illustrates the importance of language and terminology in the SM guidelines. Part six highlights the need for clarification on the term COI while using SMM. Part seven illustrates that the term "perverse incentives" requires clarification as it pertains to SMM.

7.2 The need for guidelines on SM to be updated

The speed at which social media has advanced has been exponential, especially since the pandemic [129] (105). Yet the 2019 SM guidelines [130] have not been updated or advanced. Even though the underlying principles of professionalism remain the same, SM guidelines should be modified with time (55). Unfortunately, if guidelines are not updated, they will not keep up with the advances in SM technology (16). Guidelines are helpful in dynamic environments, particularly if a knowledge gap is identified (55). In these scenarios the guidelines ought to fill that gap (55). According to Brown et al the SM guidelines for health professionals have done little to improve the uncertainty

[128] Recommendations for future HPCSA guidelines on SMM.
[129] COVID-19 Pandemic forced more people to become isolated and thus more reliant on digital means (SM) for communication (105).
[130] Which are based on guidelines dating back as far as 2010 (Incorrectly referenced as a 2012 document) (68).

of health professionals online, and consequently need to be refined (88). The guidelines should be used to avoid errors or to assist in reflection and remedial action (55). In the context of SM, the guidelines should be designed to help users recognise ethical challenges that arise online (55). These SM guidelines should include key questions with discussion, rather than proclamations (55). The guidelines ought to advise, explore, and mentor (55).

Despite SM becoming an increasingly common feature of clinical practice, many health professionals have different views and practices regarding appropriate SM conduct (88). The SM guidelines should guide online behaviour rather than letting individual health professionals make mistakes that impact public trust (55). Additional guidance would assist health professionals on a homogenous approach to ethically challenging SM situations (88). Best practices for online behaviour are evolving all the time, and despite this evolution they ought to maintain and enhance public trust in health professionals (55).

I argue that the HPCSA has an obligation to update their current SM guidelines in order to make them clearer for SA health professionals. The current HPCSA SM guidelines state that they were developed to help health professionals understand their obligations when using SM (19). However, I propose that there should be shared responsibility rather than just a unilateral taxonomy of obligations for health professionals. The HPCSA has an ethical and legal obligation to teach SA health professionals how to navigate SMM in an ethically and legally appropriate manner. It is important to state that my argument is for clearer guidelines, not necessarily stricter guidelines. The two are not synonymous. Clearer guidelines honour the “respect for persons” principle (autonomy) (122) by providing the health professionals with clear information. By educating the health professional they will be better informed when making SMM decisions. I propose that the SMM guidelines ought to include guidance on ethical and legal obligations (9,46,47) as well as the potential consequences of using unacceptable SMM (80,106,184).

7.3 The need for collateral change

I argue that it is not possible to update the SM guidelines in isolation. The SM guidelines will need to be updated in conjunction with the guidelines on marketing in

Booklet 2 [131] and perverse incentives in Booklet 11 [132] (20,82). The scope of this report however is limited to the SM guidelines (19) [133] and the need for a clearer section on SMM. In this chapter I make recommendations on guidelines for SMM, however some of these recommendations can be extrapolated to Booklet 2 and Booklet 11.

7.4 The need for additional research

I argue that more empirical research is needed on SMM to better inform the guidelines for health professionals. In Chapter 2 I highlighted that there is limited empirical research into the use of SMM by health professionals, with only two studies that have focussed on SMM in SA (48,66). There has been research into the general use of SM by SA health professionals, but it has focussed primarily on the ethical and legal obligations pertaining to privacy, patient-practitioner relationships and professional reputation (52,56,57,60).

It has been argued that more empirical research is necessary to develop effective guidelines (88). Research into SM guidelines should determine what to include and how the guidelines should be enforced (88). Firstly, consensus needs to be reached on how health professionals ought to behave online (88). To reach this consensus it will require an expanded investigation of global and country-specific standards for SM (88). Secondly, a reappraisal of how guidelines are promulgated needs to occur, as the current ethical guidelines may not be effective in guiding appropriate online behaviour (88). Furthermore, in order to change online behaviour it will require active engagement, rather than the passive diffusion of guidelines (88).

7.5 The need for reference to legislation related to marketing

I argue that there is a need for additional [134] reference to legislation in the SM guidelines, along with an explanation of how it applies to health professionals wanting to use SMM. There are local guidelines (78) as well as international guidelines

[131] Last updated in 2016 (82).
[132] Last updated in 2016 (20).
[133] Last updated in 2019 (19).
[134] There is reference to the HPA (10), Promotion of Access to Justice Act (185), POPIA (14), NHA (13), as well as the Constitution (46).

(75,186) which highlight significant concerns pertaining to legislation that ought to be considered by health professionals when using SMM. I argue that these considerations are notably absent from the HPCSA guidelines on SM (19). The section on COI does not mention the CPA (9), nor the MRSAA (12). This section also does not address the relevant aspects of the POPIA (14).

Firstly, the CPA ought to be referenced as it pertains to the right to: i) equality; ii) privacy; iii) disclosure and information; iv) fair and responsible marketing; v) fair and honest dealing; vi) fair, just and reasonable terms and conditions; as well as vii) fair value, good quality and safety (9). These rights ought to be considered by health professionals who wish to use SMM.

Secondly, the MRSAA ought to be referenced as it is relevant to health professionals wanting to use SMM to market products or services. The MRSAA General Regulations (187) state that certain schedules of medicine may not be advertised to the public (187). The use of trade names [135] or reference to prices is also not permitted (78). Furthermore, certain classes of device cannot be advertised to the public (187). All injectables [136] are included in this category (78).

Finally, the SM guidelines also ought to provide more detail on the POPIA and how it applies to SMM. The POPIA should be considered by all health professionals wishing to use SMM as it relates to cybersecurity as well as the use of third-party platforms (all SM platforms are hosted/managed/owned by a third-party, most of which are not SA based [137], and most will capture, process and store information for their own purposes). The POPIA is also applicable to images [138] of patients that are shared on SM by health professionals for marketing purposes [139]. The SM platforms are a third-party in the processing, storing, sharing of the image, and thus would require health

[135] For example: Dermapen® (188).
[136] For example: Botox® (Botulinum toxin) (189).
[137] Section 72 (Transfers of personal information outside Republic) of the POPIA states: "A responsible party in the Republic may not transfer personal information about a data subject to a third party who is in a foreign country unless - (b) the data subject consents to the transfer" (14).
[138] Section 1 (Definitions) of the POPIA states: "Record:' means any recorded information - (v) photograph, film, negative, tape or other device in which one or more visual images are embodied so as to be capable, with or without the aid of some other equipment, of being reproduced" (14).
[139] This would require additional consent above the requirements stipulated in the National Health Act (13) and other related legislation.

professionals to obtain consent before using the third-party platforms for certain types of SMM posts [140].

7.6 The need for plain language

I argue that the HPCSA needs to address the use of language and terminology in their SM guidelines. One of the most appealing factors about the AAMSA SM guidelines (78) is that they use contemporary language and terms that make the ethical concepts more relatable and understandable. I argue that this is lacking in the HPCSA SM guidelines. I will elaborate using three examples: i) the use of COI as a heading, ii) the perpetual reliance on "canvassing and touting", and iii) the use of the term "unprofessional".

7.6.1 COI

I argue that the entire sub-section in Booklet 16 titled: COI, should be renamed. The use of the term COI in this current context is vague. The section ought to be titled "Social Media Marketing and Related Matters". Within this there can be a sub-section that deals with COI. In section 7.7 (below) I will discuss matters relating to COI in more detail.

7.6.2 "Canvassing" and "touting"

While addressing terminology the HPCSA must consider the removal of outdated terms such as canvassing and touting [141]. These terms are an anomaly, unique to the SA guidelines (7,33,50,58) with no contemporary sources referencing the terms (3,29,30,32,36–45). My recommendation for future SMM guidelines would be to omit both terms.

7.6.3 "Unprofessional"

In the definitions for advertising the guidelines state that marketing cannot be "unprofessional". However, they do not provide clarity on a definition of

[140] For example: the use of images of patients in "before" and "after" photos.
[141] The GMC chose to abandon the terms in the 90's (162), yet 30 years later the use of the terms persists in the HPCSA guidelines.

"unprofessional". Furthermore, the guidelines do not elaborate on who determines whether an advert is "professional" or "unprofessional".

There is no end to the need for professionalism and beneficence; it is perennial (55). However, the concept of professionalism has evolved over time (162,190). Something that may have been regarded as unprofessional previously (163,165,166) may be more tolerated in modern professional standards (162). The GMC realised this as a problem when their guidelines were challenged, and ultimately omitted terms that relate to "professionalism" (162). Unfortunately, the HPCSA section on advertising in Booklet 2 does not provide clarity on what constitutes an "unprofessional" advert (82). Yet there are significant consequences [142] for using "unprofessional" advertising as health professionals can face financial penalties (80). I argue this is something that will need to either be clarified or omitted from the SMM guidelines.

7.7 The need for clarification on COI

I argue that the phrase COI needs to be clarified in the context of SMM. With SMM there are unique perverse incentives and financial interests that need to be considered. Firstly, there is the financial incentive that underpins SMM, where producers of content (health professionals) attempt to drive viewers of content (patients) to their own practice/health establishment. Secondly, there is the interplay between health professionals and SM influencers.

7.7.1 The financial incentive that underpins SMM

Health professionals are allowed to market themselves (82); however their marketing ought to align with the CPA (9). The CPA requires that consumers are fully informed when it comes to marketing [143] (9). This also applies to health professionals who ought to declare if there is a potential COI. COI and the obligation to inform patients is addressed in Booklet 11 [144] (20). Section 9.2 of the HPCSA SM guidelines references Booklet 11, and urges health professionals to declare their financial interests in

[142] Fine of R2500.00 – R10000.00 (80).
[143] CPA Chapter 2 - Part D: Right to disclosure and information (9).
[144] This booklet also addresses overservicing and perverse incentives (20).

hospitals [145] [146] (19). However, I argue that this clause only portrays "financial interest" in a very binary way, especially when considering the diversity (16) and rapid expansion (105) of SM. Booklet 11 also urges health professionals to disclose any COI prior to referring a patient to a health establishment where the health professional has a financial interest [147] (20). However, this is not mentioned in the SM guidelines. Health professionals may own other business entities that may potentially interact with the patient for financial gain. This includes health establishments (independent brand owned by the health professional) that are not considered to be hospitals or clinics. I argue that the guidelines ought to include a clause requiring health professionals to declare this type of COI when using SMM.

7.7.2 The interplay between health professionals and SM influencers

With the rise in SM influencer endorsements more needs to be done in order to curtail deceptive SMM practices (192). In the financial sector significant fines can be imposed on SM influencers who fail to adequately declare COI [148]. I argue that the HPCSA SM guidelines should address the use of SM influencers in a similar manner to the declaration of interest in hospitals (clause 9.2 in Booklet 16), where there ought to be a declaration of any COI relating to SMM. This ought to include disclosure on paid for reviews [149] by SM influencers. This is not an unreasonable expectation as it is already a recommendation [150] made by several international advertising authorities (43,44,193,194). In the advertising code produced by the ARB there are

[145] When using social media, even if via personal or anonymous blogs, health care practitioners must comply with the HPCSA rules on advertising practice, (including not engaging in active or passive touting and canvassing or allowing others to do so on their behalf), and must make sure that they declaring their financial interests in hospitals (see Booklet 2 Ethical and Professional Rules of the Health Professions Council of South Africa and Booklet 11 Guidelines on Overservicing, Perverse Incentives and Related Matters) (19).
[146] Rule 23A "Financial interest in hospitals": "A practitioner may have a direct or indirect financial interest or shares in a hospital or any other health care institution: Provided that - (e) such practitioner does not participate in the advertising or promotion of the hospital or health care institution, or in any other activity that amounts to such advertising or promotion;" (20).
[147] HPCSA Booklet 11 - 3.5 Referrals rule 24: "3.5.1 Self-referrals - Health care practitioners may only refer their clients or patients to any health establishment in which such health care practitioner or a close family member or business associate has a financial interest or a potential conflict of interest if such interest has been declared to and approved by the HPCSA and on condition that such interest is discussed, and agreement reached with the patient prior to the referral for the patient's consent." (20).
[148] SM influencer and celebrity, Kim Kardashian, was fined $1.26 million by the Securities and Exchange Commission after she failed to disclose that she was paid $250,000 to publish an Instagram post on a cryptocurrency (191).
[149] Including reviews for services that are provided for free, in exchange for a review.
[150] Albeit not enforced by SM platforms.

recommendations [151] for advertisers when using SMM. I argue that a similar set of recommendations ought to feature in the HPCSA SM guidelines. The HPCSA does attempt to address endorsements [152] in Booklet 11; however I argue that this interpretation is limited in that it focuses on the obligations [153] of the health professional and not the vicarious obligations relating to content produced by SM influencers [154].

7.8 The need for clarification on "perverse incentives"

I argue that the term "perverse incentives" needs to be clarified in the context of SMM. There are various ways that health professionals can exploit patients for their own SMM agenda. One such tactic is to offer discounted fees in exchange for social media content [155]. I argue that the content-for-free-services falls into a gap where the

[151] ARB: Code of Advertising Practice Appendix K:
3. Declaration of advertising:
"3.1. To ensure full transparency advertisers are required to disclose if content is part of a Social Media Advertising campaign as opposed to purely Organic Social Media." (38).
"3.2. In the case of Social Media Advertising on Social Media platforms such as 'Promoted' tweets on Twitter or 'Sponsored' posts on Facebook, these are often obviously identifiable as such through its positioning and the inherent conventions that each Social Media platform has for displaying advertising which quickly becomes recognisable to users (i.e. hereinafter referred to as "Social Media identifiers"). Provided that the material is clearly identifiable to the average user of the Social Media platform as advertising or Paid Advertising, the marketer is not required to further disclose the paid nature of these advertisements as they are commonly understood. However, where Paid Advertising may reasonably appear to the consumer to be the unsolicited opinion of the influencer or platform, then the material must be clearly identified as Paid Advertising through the use of supported Social Media identifiers." (38).
"3.3. Marketers should pay particular attention to ensuring that paid social media advertising is obviously identifiable as such. A clear Social Media identifier must be included within the content of the tweet or post, in order to ensure that consumers reasonably understand this to be a Paid Advertising as opposed to an Organic Social Media endorsement." (38).
"3.3.1. Recognised Social Media identifiers include:
3.3.1.1. "#AD"
3.3.1.2. "#Advertisement"
3.3.1.3. "#Sponsored"" (38).
[152] "Endorse means any action whereby a person or body attaches approval to or sanctions any health establishment or orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance or other health related product or health related service with a view to encouraging or promoting the preferential use or preferential sale thereof for the purpose of financial gain or other valuable consideration." (20).
[153] Advertising Rule 3: "Health care practitioners shall not advertise or endorse or encourage the use of any health establishment or orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance or health related product or health related service in a manner that unfairly promotes the practice of a particular health care practitioner or a health care facility for the purpose of financial gain or other valuable consideration." (20).
[154] The HPCSA guidelines make an attempt to address this when they state that "canvassing" and "touting" cannot be done on the practitioners behalf (19,20,82).
[155] An international example of this is Dr Joseph Cipriano (American based Chiropractor) who offers a $100 discount to patients who "consent" to their treatment being filmed and published on Dr Cipriano's YouTube

guidelines are not explicit enough. The patient does not always provide the content with the intention of eliciting patient referrals, and therefore does not constitute "canvassing" on behalf of the health professional. In this scenario the health professional takes advantage of the goodwill of the patient to obtain promotional material that can be leveraged for marketing purposes.

Offering free/discounted services to patients is not covered in section 7 of Booklet 2, which is related to fees and commission (82). Booklet 2 does mention that health professionals should not pay commission, or other material consideration, in exchange for the referral of patients [156] (2). However, in the content-for-free-services scenario the patient is not actively endorsing the health professional. They are consenting to the creation and sharing of media [157] of their "successful" [158] outcome/case, to be used by the health professional to entice prospective patients. Booklet 11 deals with "improper financial gain" and other forms of compensation, payment, reward or benefit [159] (20). When analysing "improper financial gain" there are two caveats that state that the behaviour needs to be illegal and/or contrary to the ethical guidelines (20). Firstly, creating/using media of a patient's treatment is not illegal provided that there is consent [160] from the patient (14,19). Secondly, there is no guidance on the ethical implications of using this media as marketing material for the financial gain of the health professional. Practitioners are advised in Booklet 16 that they "should avoid"

channel (195). The Cipriano-discount albeit international is concerning as it is highly probable that SA patients are offered similar discounts by their SA based health professionals in exchange for the "rights" to their treatment media.

[156] HPCSA Booklet 2 - Fees and Commission Section 7.2: "A practitioner shall not pay commission or offer any material consideration, (monetary or otherwise) to any person for recommending patients." (82).

[157] Photographs/Videos rather than written testimonials (which could be construed as "canvassing").

[158] It is improbable that unsuccessful cases will be used by health professionals, therefore creating a choreographed narrative of "excellence/success".

[159] HPCSA Booklet 11 - Defining concepts Section 2.9: ""Improper financial gain or other valuable consideration" means money, or any other form of compensation, payment, reward or benefit which is not legally due or which is given on the understanding, whether express, implied or tacit, that the recipient will engage or refrain from engaging in certain behaviour in a manner which is either:
2.9.1 Illegal; and/or
2.9.2 Contrary to ethical or professional rules; and/or
2.9.3 Which, in the opinion of a the HPCSA, may adversely affect the interests of a patient or group of patients,
In order to procure some direct or indirect advantage, benefit, reward or payment for the person offering or giving the said money, compensation, payment, reward or benefit, and "perverse incentive" has the same meaning." (20).

[160] Preferably written.

taking photographs during treatment [161] (19). Firstly, this is provided as advice (should avoid), rather than a directive (must not). Secondly, it is framed in favour of the health professional's "image" rather than the best interest of the patient.

I argue that the HPCSA guidelines ought to address these advanced types of perverse incentive that are unique to SMM. If the guidelines are not explicit enough, then there is the potential for the loophole to be exploited. There are also significant consequences for paying kickbacks or receiving perverse incentives as the HPCSA can impose penalties [162]. Health professionals are vulnerable to unnecessary fines if the guidelines are not transparent.

Clarification is also needed on the potential role that some health professionals play as SM influencers. Internationally there have been reports of health professionals leveraging their credentials for financial gain (196). Booklet 16 only advises against marketing hospitals, medicines or health-related products for the purposes of financial gain [163] (19). There is no mention of marketing other businesses, services or non-health related products that may benefit from using the credentials of the health professional to enhance trust and credibility. I argue that health professionals who are SM influencers ought to declare if there are perverse incentives relating to SM content they produce on behalf of others. In this scenario health professionals ought to follow the same SM influencer recommendations mentioned above (43,44,193,194).

7.9 Conclusion

This chapter highlighted the changes that need to be made to the HPCSA SM guidelines. Part one illustrated why the guidelines on SM need to be updated. Part two established that it is not possible to update the SM guidelines in isolation. In this section I highlighted that additional guidelines will also need to be updated to provide standardised ethical guidance. Part three highlighted that further empirical research is

[161] HPCSA Booklet 16 - Health Professionals Image: "8.4 Social media activities health practitioners should avoid for example include: 8.4.1 Taking photographs during surgery and other forms of care or treatment;" (19).
[162] Fine of R20000.00 (80).
[163] HPCSA Booklet 16 - Conflict of Interest: 9.5 "Health practitioners may not advertise, endorse or encourage the use of any hospital, medicine or health-related product on social media in a manner that unfairly promotes the practice of a particular health practitioner or establishment for the purposes of financial gain or other valuable consideration." (19).

needed. Part four emphasised that additional marketing related legislation needs to be included in the SM guidelines. In this section I argued that the SM guidelines ought to reference, and provide clarity on, the CPA, the MRSAA, and the POPIA, as they all pertain to SMM. Part five illustrated the importance of language and terminology in the SM guidelines. In this section I argued that the guidelines ought to use plain language. I proposed that the heading COI ought to be replaced with “Social Media Marketing and Related Matters”. I also argued that the terms “canvassing” and “touting” ought to be abandoned. At the same time, I highlighted that the term “unprofessional” needs to be clarified or omitted. Part six highlighted the need for clarification on the term COI while using SMM. In this section I argued that the HPCSA needs to provide clarity on the financial incentives that underpin SMM. I also argued that clarity is needed on the interplay between health professionals and SM influencers. Part seven illustrated that the term “perverse incentives” relating to SMM requires clarification. In this section I argued that the HPCSA needs to provide clarity on scenarios such as the “content-for-free-services”, as well as scenarios where health professionals leverage their credentials for financial gain.

CHAPTER 8: CONCLUSION

8.1 Conclusion

The aim of this research report was to defend the thesis that the HPCSA must provide clearer guidelines on SMM for SA health professionals. The first objective was to illustrate that the current HPCSA SM guidelines do not comprehensively address SMM. The second objective was to demonstrate why clear SMM guidelines are necessary. The third objective was to argue that the HPCSA has an obligation to create clearer guidelines pertaining to SMM.

Chapter 2 highlighted the use of SM by health professionals in SA and abroad. It also highlighted that even though there has been research on the use of SM by health professionals there is a lack of empirical evidence on the use of SMM. Based on this I argued that more empirical research is necessary to assist in the creation of guidelines. This chapter also gave a synopsis of the current HPCSA SM guidelines and outlined how there is a lack of SMM guidance for health professionals.

Chapter 3 provided an introduction to the HPCSA and the legal obligation of the Council to provide SMM guidelines. This chapter established that the HPCSA is *the* statutory body responsible for producing regulations and administering policies that apply to SA health professionals. It also highlighted that the HPCSA should 1) create guidelines for professional conduct, 2) protect the public in matters relating to the provision of health services by health professionals, and 3) uphold and maintain ethical standards. This chapter also illustrated that the mission of the HPCSA includes setting and maintaining contextually relevant ethical standards for training and practice. In this chapter I addressed the anti-competitive argument against the promulgation of HPCSA guidelines on marketing and argued that it is the responsibility of the HPCSA to provide guidelines on SMM.

Using SCT, Chapter 4 emphasised the ethical obligations of the HPCSA to provide and maintain ethical guidelines. This chapter clarified how SCT applies to the HPCSA and highlighted that mutually reciprocal trust is fundamental for the Social Contract to succeed. In this chapter I addressed the “court of public opinion” and the recent damage that has been done to the public image of the HPCSA. In doing so I argued that if there is suspicion that the HPCSA is not fulfilling their side of the Social Contract it may tempt others not to fulfil theirs. The privilege of self-regulation of health

professionals relies upon the effectiveness of the HPCSA to fulfil its statutory mandate as well as the moral obligations of the Social Contract. As part of this moral obligation, I argued that the HPCSA must provide ethical guidelines, as without them the system of healthcare can become a free-for-all, and potentially ungovernable. I established that this obligation extends beyond provision, but also includes the maintenance of the guidelines. “Maintenance” in this context included the moral obligation to update guidelines. I argued that these updates extend to the provision of clearer guidelines on SMM. This section established that the HPCSA ought to provide clarity on how health professionals can use SMM in a manner that is not detrimental to the Social Contract.

Chapter 5 provided context on how the HPCSA has failed to fulfil basic functions, including the provision of guidelines. In this section I highlighted that there are still concerns relating to the ability of the Council to fulfil legally mandated roles. I argued that the epitome of this failure is when the Council failed to provide guidelines on SM. I also provided critique on the current HPCSA marketing guidelines for health professionals. In this section I argued that the marketing guidelines are inadequate and need to be clearer.

In Chapter 6 I provided a critical analysis of the HPCSA SM guidelines pertaining to marketing/advertising. In this section I addressed the shortcomings of definitions and critiqued the lack of reference to legislation. I also highlighted the problematic reliance on cross referencing to additional booklets rather than addressing important concepts in the SM guidelines. Based on the shortcomings I argued that the HPCSA must update their SM guidelines, with emphasis placed on the COI section.

In Chapter 7 I highlighted the changes that need to be made to the HPCSA SM guidelines. Firstly, I provided an argument as to why the guidelines on SM need to be updated and established that it is not possible to do so in isolation. Secondly, I highlighted that further empirical research is needed to assist the HPCSA in the creation and promulgation of SM guidelines. Thirdly, I argued that additional marketing related legislation needs to be included in the SM guidelines. Fourthly, I proposed that the guidelines ought to use plain language. In doing so I highlighted that the HPCSA needs to provide clarity on the financial incentives that underpin SMM at the same time as addressing the interplay between health professionals and SM influencers.

Finally, I argued that the HPCSA needs to provide clarity on scenarios such as the “content-for-free-services”, as well as scenarios where health professionals leverage their credentials for financial gain.

This report has highlighted that the current HPCSA SM guidelines do not comprehensively address SMM. The report also highlights why guidelines are important to protect patients from exploitation, and to maintain the Social Contract between the health professional and patient. This report indicates how the ethical and legal obligation to provide clear SMM guidelines rests with the HPCSA. Therefore, the conclusion reached in this report is that the HPCSA must provide clearer guidelines on SMM for SA health professionals.

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