

Legislation for everyday Occupational Therapy practice

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ABSTRACT

Occupational therapists practise in a progressively structured legal framework in which much of what was previously ethical obligation has become entrenched in legislation – hence the need for accessible information about such legislation. This paper reviews legislation relevant for day to day practice, from an occupational therapy perspective, regardless of client group, facility or practice area. It provides information about the relevant Acts in user friendly terms and outlines implications for practice.

The author reviews the Constitution of South Africa Act 108 of 1996, the Health Professions Act 56 of 1974 (as amended) and the National Health Act 61 of 2003 in detail, highlighting relevant provisions, and briefly mentions the Promotion of Access to Information Act 20 of 2000, and the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

This paper thus attempts to provide a context within which the occupational therapist can practise legally and professionally. As ethical principles are now firmly embedded within legislation this impacts on professional ethical training and practice, this paper aims at assisting the occupational therapist to gain sufficient understanding of the law to enable effective and ethically appropriate patient/client management.

Key words: South African legislation, health professional, ethics, occupational therapy practice.

Introduction

Citizens and health care practitioners are obliged by law to be familiar with relevant legislation. The move away from a paternalistic medical model to a social model of practice and greater professional autonomy has created the need to think critically and make ethical decisions based not only on sound core values and professional attitudes, but on knowledge of current legislation and policy, necessitating a substantial increase in knowledge and a need for opportunities to observe and practise effective clinical reasoning.

Changes in clinical reality² call for clinically sound decision-making when faced with ethical problems, creating a need for both independence and inter-dependence in practice. Rather than acting according to personal virtues entrenched in training, clinicians now have to act according to ethical principles which may compromise other norms or ethical principles³, and this within a progressively more structured legal framework of patients' rights and practitioner responsibilities. Simply put, being a virtuous professional is no longer sufficient and a recent Health Professions Council of South Africa (hereafter HPCSA) directive to all training centres (2009) requires all registered health professionals to be trained not only in ethics but also in human rights and medical law.

The occupational therapist practises mainly within the public and private health and education sectors. Consequently, the relevant legislation, policy and codes directly impact on the practice of the profession and need to be taken cognisance of. The occupational therapist must have insight into, and abide by, the provisions of law, while maintaining an ethical, moral and virtuous practice. All too often it is this understanding of the law which is sorely neglected by occupational therapists.

To understand the legislation it is necessary to briefly review the link between legislation and ethics. According to Dickens⁴, the law is the minimal ethic which describes what people must and must not do, whereas bio-ethics encompasses what health professionals aspire towards. The law is designed to prohibit certain behaviour and compel obedience, but what is legal may not be ethical, and vice versa.

The law may be a reflection of ethics held within a community or professional group, but not necessarily so. Prostitution, for example, is still criminalised in South Africa yet seems to be regarded by many as an acceptable means of income generation. But the law can act more proactively than some community-held beliefs would normally allow, such as legalising the termination of pregnancy. Dickens notes that there are times when contravening the law may be ethically justified, as in the case of euthanasia for the terminally ill. The law may concur with ethical principles⁴, such as non-maleficence, and it will of necessity determine the behaviour and attitude of the practitioner towards his/her patients/clients. One striking difference is that while the law can advance ethical values, it does not allow

for choice in determining the rightness or wrongfulness of action, whereas ethics begs the practitioner to choose how to act.

Pellegrino⁵ helps contextualise where the law and ethics fit in to practice. He describes a three-tiered system of obligations which can be applied to all health practitioners: *obedience to the law; observance of moral rights and fulfilment of moral duties; and the practice of virtue*. This idea is expanded by Beauchamp and Childress, who refer to ethics as a "focussed morality"⁶ encompassing both morality and ethical theory as reflected in professional ethical codes. It is imperative that health professionals have a client-centred approach, act with justice and impartiality and demonstrate a profound respect and compassion for the patient/client⁷. In this way, the continuity and standards of health professional practice would be safeguarded⁷.

Legislation promulgation since 1994 has shown a major shift of emphasis to a culture of recognition of human rights, prior to this time conduct towards patients was guided by ethical theory, universal ethical principles and the ethical rules of the statutory body (the South African Medical and Dental Council up to 1994, thereafter the Interim Medical and Dental Council, followed by the HPCSA) and Codes of Ethics of the medical and dental professions, and the Professional Associations for Occupational Therapists (SAOT, then OTASA and WFOT). Since the promulgation of the mentioned Acts, the rights of the patient/client and the responsibilities of the healthcare practitioners, have been firmly entrenched, making what was previously striven towards, around issues such as, for example, informed consent, legally binding.

For the sake of clarity, the legislation will be discussed in the context of general practice. It is important to note that ethics, legislation and human rights all exist within the context of an evolving multidimensional society and attain "significance" for practitioners by virtue of their professional integrity and clinical independence.

Legislation for practice

Experience shows that occupational therapists are not well informed about legislation affecting their practice, a situation exacerbated by the often obscure legal language used, and the publication of legislation in the inaccessible format of the Government Gazette. We also have to contend with our difficulty in interpreting such documents, the legal practitioners' differing interpretation of sections or even words of an Act and further interpretations and judgements of different courts of law.

An Act is legislation (a law) that has been passed by Parliament, signed by the relevant minister and published in the Government Gazette (promulgated). Acts are given a short and a long title and are written up in Section(S) and subsection(s) and grouped into chapters. [S2(b)] in the text would thus refer to Section 2 subsection (b) of the Act.



The Acts relevant for everyday practice can be classified into:

- those which guide and prescribe professional conduct, such as the Health Professions Act 56 of 1974⁸ (hereafter the Health Professions Act)
- those that have direct bearing on intervention, such as the National Health Act 61 of 2003⁹ (hereafter the National Health Act), and which also guide standards of training and practice; and
- those which require action from the health practitioner in specifically delineated areas, such as the Children's Act 38 of 2005¹⁰ (hereafter the Children's Act).

In this paper, the following Acts are discussed: the Constitution of the Republic of South Africa Act 108 of 1996¹¹ (hereafter the Constitution), particularly Chapter II, The Bill of Rights; the Health Professions Act⁸, with a brief look at relevant common law duties and the National Health Act⁹. Brief mention is made of relevant aspects of the Promotion of Access to Information Act 2 of 2000¹² (hereafter Access to Information Act) and the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000¹³ (hereafter the Promotion of Equality and Prevention of Unfair Discrimination Act).

The Constitution of the Republic of South Africa, Act 108 of 1996¹¹

The Constitution¹¹ is the supreme law of the country. Section 2 states that law or conduct inconsistent with it is invalid. The Constitution forms the yardstick against which common law, legislation, case law, regulations, policy, codes and conduct are measured. Of special significance is chapter 2, the Bill of Rights, which enshrines the rights of all the people in our country, inclusive of those of patients/clients, and affirms the values of human dignity, equality and freedom.

The significance of the Bill of Rights in terms of health professional practice is fourfold: first, it empowers persons to demand respect for these rights; second, it gives clear indications to the health practitioner in terms of patient/client management and service provision; third, it enables the practitioner to act more effectively as an advocate for the client/patient; and fourth, it helps the practitioner justify behaviour or action taken against discrimination or inadequate levels of care.

Many sections of the Bill of Rights can be read with a view to health professional practice. This paper addresses sections which have specific relevance for the practice of occupational therapy, such as those which deal with human dignity, the freedom and security of persons, privacy, labour relations, the environment, health care, food, water and social security, children, education and access to information. The Bill is discussed according to relevant sections and, where appropriate, cross-referenced to other legislation, regulations and codes.

Equality [Section 9(1) and (3)]

"Everyone is equal before the law and has the right to equal protection and benefit of the law" [S9(1)]. "The state may not unfairly discriminate directly or indirectly against anyone on grounds such as race, gender, pregnancy, marital status, ethnic and social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth" [S9(3)]. The most important of these, for the occupational therapist, is that of non-discrimination on the grounds of *disability*. This ensures the persons with disabilities the right to enjoy equal rights and freedoms and enables and enjoins the health practitioner to act as advocate for disability rights.

Human dignity [Section 10]

Persons' inherent dignity and the right to have their *dignity respected and protected* translates into respect and consideration for each client, privacy of intervention and an attitude of respect for the autonomy of the individual. This means that a client will be treated with respect during interventions, will never be ridiculed or embarrassed, will be encouraged to actively participate in decision making and that confidentiality will be maintained.

Freedom and security of the person [Section 12(2)]

Section 12(2), stipulates that everyone has the right to *bodily and psychological integrity*, including the right to security in and control over their body [S12(2)(b)(c)] and not to be subjected to medical or scientific experiments without their consent. In practice, this means that informed consent must be obtained from the patient/client/guardian before commencing any assessment procedure or other intervention, both direct and indirect, and is best done in writing.

Privacy [Section 14(d)]

The right *not to have the privacy of their communications infringed* is also significant and relates directly to the ethical principles⁶ of beneficence, respect for autonomy (in particular) and the professional duty of confidentiality, which are fundamental to all health practitioner practice.

Labour relations [Section 23(1)]

The right to *fair labour practices* is relevant to the profession in view of the discrimination which still exists in the employment of persons with disabilities, despite progressive labour legislation. There is the need to overcome such discrimination, foster fair practice and make adequate provision for the accommodation of disability in the workplace.

Environment [Section 24(a)]

Awareness of a person's right to *an environment that is not harmful to anyone's health or wellbeing* is most important, especially in situations where resources are severely limited. This will be relevant in terms of inappropriately restrictive environments and unacceptable levels of care which pose a definite threat to health and wellbeing. Maintaining a safe and healthy environment in which intervention may be done is crucial for all health care practitioners and in keeping with the universal principle of non-maleficence, it should be noted that limited resources may not be used as justification for unacceptable standards of care or unprofessional practice.

Health care, food, water, social security and emergency treatment [Section 27(1)]

The right of *access to health care services*, not to be confused with a right to health care services, requires the occupational therapist to make his/her services readily accessible, even if obliged to make concessions in respect of time and place, such as establishing outreach programmes or extending consultation hours. It is unfortunately true that frailty, poverty, poor access to roads and transport and remoteness, may hinder a person with a disability attending a service facility. Language and the way in which information is presented may likewise constitute barriers to access and these must be actively addressed by health care professionals.

Despite the National Building Regulations¹⁴ providing detailed specifications for accessible ramps, lifts, doors, toilet and parking facilities for disabled people in public buildings, and adequate notification of these facilities, services on the ground remain insufficient, especially in rural areas where elderly persons and those with disabilities collect their grants or pensions, or attend clinics. Even if the recommended structural requirements are met, very often lack of or unsuitable transport prevents people from reaching service points.

Occupational therapists have a responsibility, firstly, to provide adequately for their clients in their own practices, and secondly, to take an active part in compelling authorities to provide the best facilities for their welfare. Buildings need to be planned well, should have ease of access and the equipment used should be of the highest standard. As occupational therapists are trained to assess facilities and equipment and recommend adaptations, this responsibility should be accepted as a service to the community, regardless of where barriers to access occur.

The right to *emergency treatment* [S27(3)] may be interpreted as allowing and requiring health professionals to provide emergency treatment regardless (within reason) of basic training.



Children [Section 28(1)(c)]

Each child has a right not only to *basic nutrition and shelter but also to basic health care and social services*. Practitioners should familiarise themselves with relevant policy and procedures to assist the child and his/her care provider to better access and utilise the available services in the area in which the child lives. The right to protection from maltreatment, neglect, abuse and degradation should be read in conjunction with the Children's Act 38 of 2005¹⁰ which provides for the protection of infants and the prevention of neglect, ill-treatment and exploitation of children. It further relates to manner of care and establishment and management of care facilities.

Education [Section 32(1)(a)(b)]

The right to a *basic education for all*, including adults, is expanded upon by the National Education Policy Act 27 of 1996, in which Section 4 prohibits discrimination on any grounds and advocates equal access to educational institutions. Section 4(d) stipulates that no person may be denied the opportunity to receive an education to the maximum of their ability. This places a responsibility on occupational therapists to render assistance to clients, particularly children with disabilities (be it physical or mental), in order for them to be accommodated in mainstream or special schools. Occupational therapists should contribute to making mainstream education accessible through teacher training and adaptation to the environment and available equipment at school. The South African Schools Act 84 of 1996, Section 5, supports this by stipulating that public schools must admit learners and serve their educational requirements without discrimination of any kind. Occupational therapists practising in rural areas often experience great difficulty getting a disabled child admitted to a mainstream school due to overcrowding, lack of facilities for disabled children, uninformed staff and the stigma attached to disability.

The Education White Paper¹⁵, which defines and outlines *inclusive education*, expands extensively on the Acts mentioned above (discussed in more detail later in paper).

Access to information [Section 32(1)(a)(b)]

The right of access to *information* held by the state or another person is necessary for the exercise or protection of any rights, and signifies the client's right to their occupational therapy records and assessment reports. This interpretation is supported by the Promotion of the Access to Information Act, as well as by the National Health Act, and is discussed in more detail in the next section.

It is obvious from the above that each health care practitioner should be familiar, at the least, with the provision of the Bill of Rights.

The Health Professions Act 56 of 1974 (as amended)⁸

The second Act of importance to practitioners is the *Health Professions Act*⁸. No practitioner should be allowed to practise without a basic understanding of this Act, as it outlines the regulations for practitioners registered under the Act. The Health Professions Act, as activated in 1999, comprises five chapters and provides for the establishment of the HPCSA and, consequently, Professional Boards [S15].

The HSPCA and Professional Boards

Chapter I of the Act deals with the establishment, objectives, functions and powers of the HPCSA and addresses matters of procedure; the primary objectives of the establishment of the Professional Boards of the HPCSA being *to guide the professions and protect the public*¹⁶.

There are currently twelve independent Professional Boards, each making autonomous decisions in profession-specific matters. The South African Medical and Dental Council, the forerunner of the Interim National Medical and Dental Council (1992 to 1998) was, until 1992, completely dominated by the medical and dental professions¹⁷. Until 1999, all other professions were classified as supplementary to medicine, much to the indignation of those working in these disciplines. Prior to 1992 all decisions by the Professional Boards, other than those of Medicine and Dentistry, needed to be

ratified by the Council. This assumed hierarchy of health professions was compounded by Chapter III of the Act [S36, 37, 38], which contained descriptions of the scope of practice of the medical, dental and psychology professions. It is a definite sign of greater acknowledgement of the standing of different health professions that the revisions to the Health Professions Act no longer include these sections in the body of the Act, but rather as profession-specific regulations which include all professional groups, the coverage does however still seem to favour the medical, dental and psychology professions in the extent/detail of regulations included.

The HPCSA registers all health professional practitioners except for those registered under different Acts¹⁸ such as nurses, pharmacists, chiropractors, homeopaths and other allied health professionals. Occupational therapy students (including those who come to South Africa to do electives) and all practitioners are required to register in order to train or practise [S17(1)(2)(3)].

The Professional Board for Occupational Therapy was established¹⁹ in 1973 under the regulations published in 1974 (*Note 1*). Since 1992 Occupational therapists have been compelled to register with the Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics as it was called at that time, it is now named the Professional Board for Occupational Therapy, Medical Orthotics and Prosthetics and Arts Therapy. The Board, amongst other tasks determines requirements for registration. Other practitioners who register are occupational therapy assistants²⁰ and occupational therapy technicians²¹.

The Arts Therapy category makes provision for music, art, movement and drama therapists. Previously^{22,23}, practitioners of these professions registered as single medium therapists in occupational therapy and needed to work in close consultation with a registered occupational therapist. Whereas arts therapists are now accepted as independent practitioners, the occupational therapy assistants and technicians cannot establish practices of their own and must work under the supervision of a registered occupational therapist²⁴, such supervision being defined as 'the acceptance of liability for the acts of another practitioner'.

Medical Orthotists and Prosthetists and their assistants categories also register with the Board.

The functions of the Professional Boards in terms of Section 12B (1) (hereafter referred to as the Board) are:

- ❖ Registration and supervision of practitioners, compulsory registration serving as a licence to practise, without which a person may not be employed.
- ❖ Recognition of undergraduate, postgraduate and additional qualifications.
- ❖ Conducting examinations, granting certificates and appointing the examiners for foreign qualified practitioners.
- ❖ Conducting professional conduct enquiries, which may result in suspension pending further enquiry, a fine or erasure of his/her name from the register. Thus the Professional Board directly controls professional conduct and may prescribe rules accordingly. Of concern is that the Board has no control over the conduct of unregistered persons, unless such conduct is reported by a third party, thereby inadvertently "allowing" illegal practice.
- ❖ Approval of training schools and programmes according to minimum standards and competencies held by the Board, as determined by the Standards Generating Body, thereby determining standards of training and consequently practice.
- ❖ Compilation of regulations as the need arises, for example, continuing professional development, training and registration of auxiliary level practitioners and the arts therapies (music, drama, dance and art therapy).

In brief, the main objective of the Board is the promotion of health for the people of South Africa.

Note 1: The current constitution of the Board is determined by Gov. Gazette No.24811 May 2, 2003, GNR 584. Its 10-person membership includes persons from previously disadvantaged groups, a person with a disability, assistant category representatives and one Arts therapist.



Training and registration of health professionals

Chapter II of the Act focuses on training and registration. It deals with the control of training and procedures for keeping registers. The regulations (GNR2288) for the accreditation of training were promulgated as early as 1976 and specified three years of training at an educational institution with an additional six months of fieldwork experience. Student registration with the South African Medical and Dental Council (now HPCSA) became compulsory for all supplementary health professions as described in the Board Notice 130 of 1994 (Gov. Gazette No. 16180 p63). Training for health professionals may not be offered by any person or educational institution without application to the Board for approval [S16 (1)(2)]. The Board prescribes conditions for training and requirements for registration [S16 (3)] and its approval is a prerequisite for registration with the Board. It may accredit qualifications attained in other countries, which would then entitle holders of such qualifications to register [S24].

Currently the Professional Board for Occupational Therapy and Medical Orthotics and Prosthetics and Arts Therapy does not recognise the training of occupational therapists from other countries. Foreign trained occupational therapists who wish to register with the HPCSA are required to undergo an examination as determined by the Board in terms of S25(1)(2)(3) (Persons who qualify outside South Africa).

Standards are maintained by regular evaluation of training programmes and facilities. This takes place, as a rule, every five years for each programme. The Board appoints evaluators who visit every training institution and clinical training facility. Should training not meet the minimal requirements, the Board may withdraw accreditation of the course. The trainees are then not allowed to register and consequently are prohibited from practising [S31 (1)(2)].

A section of the Act of significance to occupational therapists is that which refers to *compulsory community service* of one year after qualification, for a person registering for the first time as a health professional, [S24a(1)(2)], which was implemented from 2003. This service must be completed within a 2-year period and proof thereof is a requirement for registration as an "independent practitioner".

Another important section deals with *Continuing Professional Development* (CPD) and training as a prerequisite for continued registration. The Health Professions Council Notice 35, April 5, 2002 stipulates that all practitioners registered with the Board as of 1 April 2002 must comply with conditions of Continuing Professional Development (CPD) and outlines the applicable rules. These specify possible CPD activities and a minimum number of Continuing Education Units (CEU's), often referred to as points, to be acquired in a specified period of time in order to remain registered. An honour system was introduced as from 2007, requiring all practitioners to maintain minimum of 30 CEU's at all times, each CEU having a shelf life of 2 years. All practitioners have to attain 5 CEU's in ethics each year, as part of the 30 CEU's needed. The implementation of the CPD requirements was initially fraught with problems due to the administrative load it placed on the structures of the HPCSA. The system has been revised and a generic system of CEU accrual introduced for all practitioners. The current system requires each practitioner to keep an individual record of all their CPD activities. This should include all relevant documentation about the activity. A random audit of practitioners from each discipline is done twice a year. Non-compliance leads to severe penalties.

Each Board compiles regulations and rules applicable to each of the practitioner categories it registers; these are submitted to the Council for approval and then submitted to the Department of Health for review and eventual promulgation.

The scope of professions and practice

Section 33 makes provision for the *scope of professions* and the *scope of practice*. The scope of profession, indicates broad areas of practice applicable to a profession and specifies acts (actions/activities) pertaining to that profession [S31 (1)]. It prohibits persons not registered from performing acts that fall within the ambit of that profession [S34] thereby allowing for the prosecution of unregis-

tered (lay) persons who perform such acts. The *scope of practice* describes the profession in specific terms and pertains to tradition, training and the accepted roles of each professional discipline.²⁵ The scope of practice is controlled by the ethical rules²⁶ which state that a practitioner may perform only those professional acts for which they have adequate training and sufficient experience, except in an emergency.

The Occupational Therapy Scope of the Profession²⁷ reads as follows:

- 1) The following acts are hereby specified as acts which shall for the purposes of the Medical, Dental and Supplementary Health Services Professions Act, 1974 (Act 56 of 1974), be deemed to be acts pertaining to the profession of occupational therapy, namely those acts which have as their aim the evaluation, improvement of maintenance of the health, development, functional performance and self-assertion of those in whom these are impaired or at risk, through the prescription and guidance of the patient's or client's participation in normal activities, together with the application of appropriate techniques preceding or during participation in normal activities which facilitate such participation.
- 2) For the purposes of regulation 1 'normal activities' shall include those activities performed by healthy children and adults in the course of their play, work, social activities, recreation, domestic activities and personal care.

This scope is currently under review by the Professional Board.

Unprofessional Practice

One of the powers of the Council and Boards is that of *disciplining persons registered under the Act*. This is provided for in Chapter IV and allows Professional Boards to enquire into complaints, charges or allegations of improper or disgraceful conduct against an occupational therapist or any other person registered in terms of the Act [S4(1)(2)]. It also describes the manner in which such investigations may be instituted [S4 (a)]. The procedure to be followed is outlined in Section 42, which provides for formal, "court-like" proceedings, and is supported by the procedural guidelines given by Council and the Boards. Findings of unprofessional conduct may lead to a reprimand and caution, suspension from practice for a specified period, removal of the practitioner's name from the register, a fine, or even a compulsory period of professional service [S42(1)]. In the last few years, much attention has been given to defining and eliminating unprofessional practices, such as acceptance of perverse incentives (kickbacks) and inappropriate practice arrangements such as franchises²⁸, also the need for stricter control. The Council's policy on undesirable business practices was launched in 2003 and more recently a Council Standing Committee on Undesirable Business Practices and Professional Practice was established²⁹. Additional guidelines for the control of unprofessional practice are detailed in a booklet, dedicated to this topic, published by the HPCSA³⁰.

Section 45 deals with registered persons who have been convicted of an *offence by a court of law*, either before or after registration. Boards may impose other penalties if the offence is deemed to constitute unprofessional conduct.

Section 49 allows the Council, in consultation with the Boards, to make *rules specifying professional acts and omissions in respect of which Boards may take disciplinary steps*. Contravening these rules constitutes improper or disgraceful conduct or unprofessional practice arrangements. Although known as Ethical Rules, they have legal power, are enforceable by law and apply equally to all practitioners registered under the Act. They are currently described by regulation²⁶, and contained in booklet no.2 published by the HPCSA for easy access by practitioners. The regulations comprise 28 rules dealing with a variety of client and practice management issues. The main underlying principles are:

- ❖ The practitioner may not promote him/herself, or glorify his/her personal attributes or achievements to the detriment of other practitioners.
- ❖ Patients may not be induced to seek out a particular therapist through underhand methods or misleading advertisements.



- ❖ The practitioner cannot exploit or mislead the patient.
- ❖ The practitioner cannot receive benefits for services not rendered (kickbacks) and may not participate in undesirable business practices.
- ❖ The practitioner must show respect for fellow health professionals.
- ❖ The practitioner must maintain clinical and professional autonomy and independence, taking ultimate responsibility for every clinical intervention.
- ❖ His/her professional integrity must be above question.

These rules deal mainly with ethics around practice and inter-professional relationships, with limited attention to conduct towards the patient. Ethical Principles are not specifically addressed and several ethical duties not mentioned, the most significant being that there is no reference to obtaining informed consent. These aspects are dealt with in detail in the Code of Conduct of the HPCSA as contained in booklets 1, 14 and 15.

In summary, only rule 11 (Impeding a patient) and rule 13 (Confidentiality) refer directly to the *practitioner-patient relationship*; whereas eight other rules refer to the *relationship between practitioners* and include rule 3 (Advertising, canvassing and touting), 4 (Information on professional stationery), 5 (Naming a practice), 6 (Itinerant practice), 8 (Partnerships and juristic persons), 9 (Covering), 10 (Supersession), 12 (Professional reputation of colleagues), 25 (Reporting of impairment or of unprofessional, illegal or unethical conduct).

A further seven rules describe *limitations of practice*, such as rules 19 (Secret remedies), 21 (Performance of professional acts), 22 (Exploitation), 24 (Financial interest in hospitals), 25 (Reporting of impairment), 26 (Research development, chemical, biological and nuclear capabilities).

The rules as promulgated in 2006 are essentially similar in content and context as those promulgated in 1994, except for rule 25 and 27 which merit some discussion.

Rule 25 Reporting of Impairment refers to students, interns and practitioners and stipulates that they are obliged to report impairment (as defined by the Act) in another student, intern or practitioner to the relevant Board. It also requires the impaired student, intern or practitioner to report him/herself to the Board should she/he be aware of or have been publicly informed of such impairment, or have been seriously advised by a colleague to obtain help in view of an alleged or established impairment. The rule does not seem to allow for interim remedial action by a training centre or employing body but requires what constitutes immediate reporting. This rule has implications for the training of students and the supervision of practitioners, and has been expanded upon by a Government Notice³¹ which describes an interactive remedial rather than punitive approach. It outlines the establishment and function of a health committee for the examination of the person concerned and makes provision for supervision or suspension of clinical practice.

The seriousness of the issue of impairment is underscored by a recent decision by the HPCSA, as published in the HPCSA Bulletin Jan (2005)²⁹, to undertake the management of practitioners facing such challenges as an overarching Council function. A Health Committee of Council has been established which is responsible for developing policies and procedures, enlisting co-operation and support for the prevention or alleviation of circumstances which may lead to impairment in students and practitioners, and overseeing the implementation of treatment programmes for impaired individuals. It is very important that all employers, training centres, registered students and practitioners take note of these provisions.

Rule 27 allows for Dual Registration which enables registration with two different boards or councils. Practice of more than one profession may, however, not be "combined" at any time and CPD requirements and registration payments are as stipulated by each profession. Clients need to be made aware of the profession within which a practitioner is practicing at any one time.

Additional Professions Specific Regulations have been promulgated which cover acts and omissions in the performance of professional acts for each health professional discipline provided for

in the act (Note 2). These regulations apply to the student, qualified occupational therapist and occupational therapy auxiliary/technician categories of practitioners.

- ❖ They restrict the practitioner to the scope and practice of the profession and to practicing only that for which they are adequately trained or experienced.
- ❖ They also describe the occupational therapist-medical practitioner relationship as one of *communication* and *co-operation*, a major move away from previous requirements, prior to 1992, where an occupational therapist could only treat a patient on referral from a medical practitioner.
- ❖ The performance of professional acts by occupational therapy auxiliaries or technicians should be within the scope of practice of occupational therapy and under the supervision of a registered occupational therapist. This means the registered occupational therapist is responsible for the quality of care and service provided, and that s/he takes vicarious liability for the acts of auxiliary staff. Such staff are accountable to the occupational therapist for delegated tasks and referrals. It further specifies that practitioners in these categories may not establish a practice of their own.
- ❖ Students have to perform professional acts under the supervision of a registered occupational therapist, which implies vicarious liability on the part of the supervisor for the acts of students.
- ❖ All occupational therapy and auxiliary practitioners who wish to be employed by a body other than central, regional or local authorities must obtain permission from the Board and submit a contract of employment for review.

The National Health Act 61 of 2003⁹

This Act is all-embracing and provides a framework for a structured, uniform health system in South Africa. The objectives of the Act are to establish a *national health system*, to set out the *rights and duties* of health care users, providers, health workers and health establishments, and to establish national and provincial *health authorities*. The Act also supports and augments other legislation that provides for the establishment of the District Health Service.

This Act aims to protect and promote the rights of the people of South Africa to include access to health care services, an environment that is not harmful to health or wellbeing, basic nutrition and health care services for children and vulnerable groups. Interestingly, the Act actually addresses the *rights* of health care providers, however minimal these may be, the emphasis usually being on the *user* of the health service (S12, 15, 16). Occupational therapists are classified under this Act as health care providers by virtue of their compulsory registration with the HPCSA.

Chapter 2 of the Act, which deals with rights and duties of users and health care personnel, is of particular significance, as it reflects an important change from the Health Act 63 of 1977 (as amended). It clearly supports the provisions of the Patients' Rights Charter³² which include rights in terms of:

- ❖ a healthy and safe environment
- ❖ participation in decision making
- ❖ access to health care, which includes timely emergency care, treatment and rehabilitation, provision for special needs, counselling and palliative care
- ❖ treatment by a named health care provider, confidentiality and privacy, informed consent, refusal of treatment, a second opinion, continuity of care and lodging complaints against a practitioner
- ❖ choice in terms of health service provider and facility, and the receipt of health information in a language understood by the patient
- ❖ courteous, empathetic and tolerant health care workers

Note 2: Department of Health Gov. Gazette No. 15907 Annexure 6, August 12, 1994, R1379. Applies to occupational therapists, occupational therapy assistants, occupational therapy technicians and students in occupational therapy. The category of single medium therapist has changed to that of Arts Therapist with their own regulations according to Board Notice 535 of 1984 as amended by Board Notice 55 of 1997.



The National Health Act 61 [S5-20] and the Mental Health Care Act 17 of 2002, (hereafter Mental Health Care Act) both deal with matters such as the provision of information, obtaining informed consent, patient/client participation in decisions, provision of discharge reports and maintained confidentiality. Although certain of these duties have been briefly referred to they need to be considered further and expanded upon in view of their significance for day-to-day health professional practice.

Provision of information

Section 6 stipulates that the user should have *full knowledge* which is an important component of informed consent and refers to material and substantial information provided to the patient/client to facilitate informed consent. This section requires the health care provider to inform the user of his/her health status, diagnostic procedures, treatment options, benefits, risks, costs and consequences associated with each option; also the right to refusal and the implications thereof.

In notes on the landmark case of *Castell v De Greef*³³, as analysed by Van Oosten³³, provides an extensive list of topics to be covered, such as the nature of disease, proposed intervention, available alternatives, gravity of proposed intervention, potential adverse consequences, degree of risk, urgency and/or danger, as well as frequency of complications. He also includes knowledge of expertise of practitioner, professional as well as technical resources and specialisation available at the facility, as needing to be disclosed to the patient.

Informed consent

Related to the provision of information is the *Consent of the User* [S7]. The occupational therapist rarely deals with life-and-death issues. Consent issues thus centre on assessment or intervention of a remedial or rehabilitative nature. Essentially, the health care provider must take all reasonable steps to ensure that informed consent is obtained before any service is provided; this means that the user must receive and understand information, as outlined above, and make a decision for themselves or for someone for whom they are mandated or for whom the law requires them to make a decision.

The issue of informed consent was extensively dealt with in two previous publications^{34,35} by the author and will thus not be discussed in any detail.

Closely related to informed consent is the right to *participate in decisions* [S8] around health care, which is specifically mentioned in the Act. This section is easily endorsed by occupational therapists as it reflects a client-centred approach. It simply states that any user has the right to participate in decisions affecting his/her health or treatment, and to be informed and involved to the extent of his/her capacity, even if the user lacks the ability to give informed consent, as may be the case with a person with an intellectual impairment. The Children's Act makes it very clear that the child needs to be involved in decision making as far as possible, to the extent to which the child is able to understand.

Discharge reports

The provision of *discharge reports* [S10] is now a requirement. Health care providers (Note 3) must provide such reports verbally for an outpatient and in writing for an inpatient. Similar provisions are contained in Section 16 of the Mental Health Care Act 17 of 2002, which specifies that the head of a health establishment should, on a prescribed form, issue a discharge report. The occupational therapist should ensure adequate input into the report. As the provision similarly applies to private practice, a user of this service also has the right to a discharge report.

The discharge report should include information on:

- ❖ the nature of the health service rendered;
- ❖ the prognosis for the user; and
- ❖ the need for follow-up treatment.

Note 3: Persons providing health services in terms of any law including the Health Professions Act 56 of 1974 and this applies to occupational therapists; National Health Act 61 of 2003

An apparent omission is that the report does not provide for information on functional performance or recommendations for appropriate employment and accommodation in the workplace. From an occupational therapy perspective, the report would need to indicate skills attained and performance in the areas of personal management, work and productivity, and leisure.

Although prescribed for Health Departments at national, provincial and district level, the duty to *disseminate information* [S12] should also be a guideline for occupational therapists, particularly in endorsing rights of users and ensuring that clients receive relevant information about rehabilitation services. To be effective, this must be accepted as a responsibility by all health care providers.

Confidentiality and access to information

Confidentiality [S14] is provided for in a separate section of this Act where it relates to confidentiality about health status, treatment or stay in a health care establishment. It is described as a recognition of the patient's right to expect the practitioner not to pass on any personal or confidential information acquired in the course of his/her professional duties, unless agreed by the patient³⁶. Where there exists a good and overriding reason to make a disclosure, such as probable and serious harm to an identifiable third party, serious threat to public health, a public health emergency or any overriding and ethically justified legal requirement, this may be done only with the patient's consent³⁷.

Similar provisions on disclosure are made in Section 13 of the Mental Health Care Act 17 of 2002³⁸ and in Sections 30 and 61 of the Promotion of Access to Information Act 20 of 2000 [S30;S61]. The section of the Mental Health Care Act is somewhat broader than Section 14 of the National Health Act, as it specifies confidentiality of any information, which a mental health care user is entitled to keep confidential in terms of any other law. Section 13(s2) does, however, provide for disclosure by the head of a national or provincial department or health establishment if failure to do so would seriously prejudice the health of the mental health care user or of other people. It further makes provision for the non-disclosure or temporary denial of mental health care users to information contained in their health records if such disclosure could seriously prejudice the user or cause the user to behave in a manner which would seriously prejudice him or her or the health of other people. Therapeutic privilege is at issue here and although appropriate in limited cases, it is open to abuse, paternalistic in nature and can be harmful³⁹.

From a bio-ethical perspective, confidentiality is somewhat of a misnomer as it may be breached⁴⁰ in cases where the practitioner is ordered to give information by a court of law, Act of parliament or where there is a moral or legal obligation to make a disclosure to a person or agency who has the right or duty to receive such information. Examples would be where a third party is at real risk⁴⁰ or a practitioner discloses as part of his own defence. According to the 1994 version of the Ethical Rules, practitioners could make a disclosure only under protest but this is no longer a requirement. Confidentiality around issues of HIV/AIDS or possible infection of third parties pose particular difficulties as it seems to shift the practitioner's primary duty to the welfare of the person who is in real danger of being affected rather than the patient in the practitioner's care⁴¹.

The provisions of the section on access of *health records* [S15] seem to contradict Section 14 as it allows for disclosure of *personal information* of a user. This may be done by a health care provider or health worker with access to personal records, to *any other person*, health establishment or health care provider for any legitimate purpose within the ordinary scope of his duties, where such disclosure is in the interest of the health care user. Personal information relates to sex, gender, race, age, physical and mental health, wellbeing, disability, religion, conscience, belief, culture, language and birth. The Promotion of Access to Information Act 20 of 2000¹² expands on this list and clarifies what is meant by the term personal information, also that it refers to information of an identifiable individual. The list below shows that it is extensive and inclusive of:

- ❖ education, criminal or employment history, and information about financial transactions



- ❖ identity number, or personal identification, address, fingerprints or blood type
- ❖ personal opinions, views or preferences
- ❖ correspondence of a private nature
- ❖ views of another about the individual
- ❖ opinions of another about grant proposals, awards or prizes
- ❖ the name of the individual where it appears in their personal information or where disclosure of the name could reveal information about the individual.

The section on *further access of health records* [S16] allows health care providers access to the health records of users for purposes of treatment authorisation, study, teaching or research, with the permission of the user, the head of the health establishment and the relevant ethics committee. Should such research, study or teaching not reveal the identity of the user, authorisation is, however, not required. In practice this means that a disturbingly large number of people could legitimately have access to user information, which could compromise the basic ethical principle of respect for autonomy.

How the *integrity of health records* may be protected is described in Section 17 of the Act. Access to records should be properly authorised and records may not be copied, changed, destroyed or transmitted without the necessary authority. As this “authority” could be vested in a health worker who may provide information to “anyone” with an ostensible reason for access, the concept of consent and confidentiality becomes somewhat farcical. In this regard we may consider the virtual “open door” policy described in Sections 15 and 16.

In terms of patients’ rights, section 18 makes provision for the *lodging of complaints* by a user about the manner in which they have been treated in a health establishment, ensuring that such complaints are investigated. It is necessary for occupational therapists to display prominently the procedure for lodging complaints, which must be communicated to patients/clients on a regular basis, and complaints must be investigated and referred where necessary.

The *duties of users* are covered in Section 19 which states that a user must adhere to the rules of a health establishment where he receives treatment or makes use of services, must give the health care provider accurate information about his health and must cooperate with health care personnel, treating them with respect and dignity. Should a user refuse to accept recommended treatment, he is required to sign a discharge certificate or release of liability.

The rights of health care personnel are rarely, if ever, referred to. Section 20 is unique in that it *refers to such rights* and states that personnel may not be discriminated against on the basis of their own health status. It further provides for the head of a health establishment to impose conditions of service (in accordance with guidelines determined by the Minister) that may be rendered by a health care personnel on the basis of their health status.

It is important for health establishments [S20(3)] to minimise injury not only to the persons and property of health care personnel, but also in respect of the transmission of disease. In some cases, however, severely limited resources make these provisions difficult to implement. Another provision that is also not easily applied is that a health care provider may refuse to treat a user who is physically or verbally abusive or who sexually harasses him/her. We need only consider a hospital casualty department on a Saturday evening, users who abuse substances, or persons in states of psychological distress or with mental illness, to realise the virtual impossibility of complying with this provision. It could even be viewed as diametrically opposed to the principles of beneficence and non-maleficence.

It is clear from the above that the National Health Act provides explicit instructions for day to day practice and endorses the Patients’ Rights Charter and the Bill of Rights throughout, making it a critical piece of legislation for practitioners to be familiar with.

The promotion of Access To Information Act Act 20 of 2000¹²

This act will be touched on briefly, as relevant to health professional practice. It enables people to realise their constitutional right to access information, held by the state or another person, which may be required for the exercise or protection of any rights or matters related to it. It also aims to educate the public and to facilitate participation in decision-making through transparency of processes [S9].

When reviewing the Act, what seems a simple matter becomes bewilderingly complex, but the basic premise is that a person, within reason, has the right to access his own personal information held by other bodies. This right can be limited only if it is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom (as is stated in the Constitution).

The Act clearly differentiates access of information from a public body as opposed to that from a private body. A *public body* is defined as being any department or state (national/provincial/district) or any other official or institution performing a duty in terms of the constitution or any other law; whereas a *private body* would include a person (in a professional capacity), a partnership or any juristic person, both formerly and currently existing.

Any person or their representative may request access to records of a private or public body. The conditions, requirements and procedures to be followed are outlined in the Act, and a fee may be charged for such information.

There are justifiable limitations of access to records used in criminal or civil proceedings; the mandatory protection being the privacy of a third party [S34] and records of the South African Revenue Services [S35]. There are also limitations on access to commercial information; certain confidential information of a third party [S37]; concerning the safety of individuals and property [S38]; and research information of a third party or public body [S43]. An evaluation of the National Health Act and the Promotion of Access to Information Act makes it seem more difficult to access your own information than for others to access your personal information, which is clearly problematic.

It is necessary for the profession [S14] to compile a manual on the function and index of records held in a public body like a hospital. The occupational therapist generally contributes to such records, and must compile records that are accessible. The practitioner must know who and where the information officers are [S10(2)(b)] in order to direct clients to them. Should a person requesting information not be able to make a written request due to illiteracy or some disability, it may be done orally [S17(3)(a)]. Further, if a person requesting information is not able to read, view or listen to a record in the form in which it is held, the information officer must take reasonable steps to make access possible at no extra charge [S29(5)(b)].

Section 30 deals with requests for access to records held by health practitioners; defined as an individual registered in an occupation involved in the provision of care or treatment for the physical and mental health or for the wellbeing of individuals (thus including occupational therapists).

The first provision of Section 30 is that, should the information officer consider that the release of any part of the record could cause serious harm to the physical or mental health or wellbeing of the requester, he would consult with a health practitioner. Should the health practitioner be of the same opinion, the information officer will only give access to the record if adequate provision is made for counselling to avoid or to alleviate such harm. The counsellor will then be given access to the record.

The requirements for *private bodies*, including practitioners in private practice, are similar in terms of access, such as the compiling of a manual, voluntary disclosure, automatic availability of records and the formation which the request is made [S18(1), S53(1)]. The difference is that private bodies are not required to have an information officer. Access to health records may thus be requested by the individual concerned or another “relevant person” on his behalf. The requesters should be informed within 30 days if their request has been granted. The stipulation of providing information that could cause serious harm only after adequate provision is made for counselling, also applies here. Every third party to whom the record relates should be informed of the request made and given the opportunity to make representations and refuse or give consent [S71,72,73]. Procedures are also in place to make appeals to the public body and/or the courts [S74 -78].



This means that the occupational therapist in private practice or employed by a private institution must comply with these provisions and make justifiable access to records possible. Confidentiality issues may arise in the case of teachers and family members wanting access to records (particularly family of persons with mental illness or of a child with learning or behavioural problems).

It is also apparent that access to information seems to make maintaining confidentiality very difficult. The possible protractedness of the process, the forms to be completed and the third parties to be consulted are all impediments for the man in the street.

When considering provisions for access to information, it would seem that the provisions of the National Health Act, in terms of the extent of the personal information that may be provided and the use of such, are much less stringent than the provisions of the Promotion of Access to Information Act.

*The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000*¹³ needs brief mention as it aims to eradicate unfair discrimination and promote equality in respect of race, gender and disability, highlighting the fact that a person may not be discriminated against on the basis of disability.

Conclusions

In conclusion, it should be clear from the various Acts discussed that respect the rights of patients/clients are of paramount importance and entrenched in legislation. In keeping with the provisions of the Bill of Rights; the National Health Act, the Mental Health Care Act, the Promotion of Access to Information Act as well as the Promotion of Equality and Prevention of Unfair Discrimination Act all place much emphasis on the respect for and acknowledgement of the individuals rights and autonomy, understanding of the implications for practice at different stages of intervention and as relevant to different procedures thus becomes essential.

The Acts discussed have furthermore heralded an era of autonomy for different health care disciplines such as occupational therapy and a need to exercise sound clinical reasoning and autonomy. The acceptance of the patient/client as an important partner in the health care process and acknowledgement of the individuals ability, not only to participate in, but to make valid decisions about their lives, health and care is now central to every intervention, thus further diminishing the medical paternalism that formed the cornerstone of health care in the past.

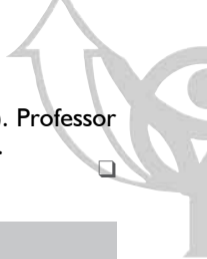
It is clear that the health professional has a seemingly unending list of responsibilities and obligations and very few rights. Additionally, many of these responsibilities were previously ethical obligations but are now entrenched in law and require the practitioner to take cognisance of all legal stipulations whilst providing quality care and having an empathetic client-centred approach. The only way, I believe, that a practitioner can adequately fulfil all these seemingly overwhelming obligations is through unquestionable professional integrity and sincerely embracing the ethical principle that the patient/client's needs take precedence above all else.

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