



THE PERCEPTIONS OF DURBAN PHYSICIANS IN THE HANDLING OF IMPAIRED DOCTORS

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By

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DEDICATION

Dedicated to Patricia, Gracia and Daniel. You all stood solidly behind me when things were rough and tough.

ACKNOWLEDGEMENTS

I thank God for health of body and mind and protecting my family during the period of this research work. Without this divine assistance, it would have been an impossible task to accomplish.

I remain absolutely grateful to my supervisor Professor Nomthandazo Ntlama for sharing her expertise and knowledge to ensure this work saw the light of day. Sincere thanks to my mother, Joan, and my wonderful siblings – Mary, Martin, Margaret, James, and Pius- for you were always there for me.

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DECLARATION

I, Dr. John Omo-Osagie Uhomoibhi, hereby declare that the work on which this dissertation is based is original (except where acknowledgment indicates otherwise) and that neither the whole work nor any part has been, or is being submitted for another degree at this or any other university.

Signed:

Date: 30th November 2017

ABSTRACT

Impaired medical practitioners constitute a huge public health burden and they impact negatively on patients' safety, security and overall medical care. Until recently, impairment in a doctor was addressed using disciplinary measures. However, while patients' security and safety remain paramount, the medical fraternity will achieve more by identifying and mitigating obstacles to the proper management and support to the impaired doctor.

This study is aimed at examining and analyzing the impact of the impaired medical practitioner in providing good quality care to patients. The objectives are to explore both the views and roles of physicians regarding the handling of impaired doctors and to offer suggestions on how to mitigate obstacles that negatively weigh on the provisioning of quality care to impaired practitioners.

This study is a descriptive qualitative study using the one-on-one interview technique. In-depth interviews were conducted using open-ended questions which enable the researcher to collect a broad range of responses.

Results from the study revealed the impaired medical practitioner to be a source of harm to himself and his family, the medical profession, the patients and the employing healthcare institution. Obstacles militating against adequate care to the impaired physician include lack of awareness and support for the impaired doctor, concerns regarding consequences following impairment report and impairment associated stigma. The legal duty to report may impede identification of impaired doctors and promote reluctance to appropriately refer the impaired doctor for professional help. Denial of impairment on the part of the impaired doctor, delayed identification resulting from subtle and paucity of signs of impairment and being in solo private practice are factors that weigh heavily against the adequate management of the impaired doctor.

Currently, the system for caring and assisting the impaired doctor is riddled with gaps and other impediments that negate his health and well being, ultimately stalling his recovery process. Protecting both patients' and impaired doctors' health is the ultimate goal and preferred solution. Education and support are key to achieving this.

ABBREVIATIONS AND ACRONYMS

AMA	American Medical Association
AIDS	Acquired Immuno Deficiency Syndrome
EAP	Employee Assistance Program
ECG	Electrocardiograph
HIV	Human immune virus
HPCSA	Health Profession Council of South Africa
ISMP	Institute for Safe Medication practice
JCAHO	Joint Commission on Accreditation of healthcare organization
MEDUNSA	Medical University of South Africa
UKZN	University of Kwazulu Natal
USA	United state of America

TABLE OF CONTENTS

DEDICATION	i
ACKNOWLEDGEMENTS	ii
DECLARATION	iii
ABSTRACT	iv
ABBREVIATIONS AND ACRONYMS	v
TABLE OF CONTENTS	vi
CHAPTER ONE	1
BACKGROUND	1
1.1 Introduction	1
1.2 Aims and objectives	3
1.3 Statement of the problem	4
1.4 Research methodology	5
1.5 Ethical consideration	6
1.6 Assumptions and limitations of study	7
1.7 Sequence of chapters	7
CHAPTER TWO	9
THE IMPAIRED MEDICAL PRACTITIONER: MEDICO-LEGAL ISSUES	9
2.1 Definition	9
2.2 Extent of the problem	10
2.3 Classification of impairments in doctors	12
2.3.1 <i>Impairment due to physical illness</i>	12
2.3.2 <i>Psychiatric impairments</i>	14
2.4 Identifying the impaired medical practitioner	15
2.5 Risk Factors Contributing to Doctors Becoming Impaired.	18
2.6 The HPCSA strategy for handling impaired physicians	19
2.7 Intervention	22
2.8 Conclusion	23
CHAPTER THREE	25
STUDY DESIGN, METHODS, AND POPULATION	25
3.1 Introduction	25
3.2 Study Design	25

3.3	Study population	26
3.3.1	<i>Inclusion criteria</i>	26
3.3.2	<i>Exclusion criteria</i>	26
3.4	Research sample, sampling, and size of sample	27
3.4.1	<i>Sample</i>	27
3.4.2	<i>The sampling process</i>	27
3.4.3	<i>Sample size</i>	27
3.5	Management of data	28
3.5.1	<i>Collection of data</i>	28
3.5.2	<i>Processing of data</i>	29
3.5.3	<i>Analysis of data</i>	29
3.6	Validity of the study	30
3.7	Reliability	31
3.8	Bias	32
3.8.1	<i>Researcher's role and influence on bias and measures to control it</i>	32
3.9	Ethical issues	33
3.9.1	<i>Permission</i>	34
3.9.2	<i>Confidentiality</i>	34
3.9.3	<i>Consent</i>	34
3.9.4	<i>Anonymity of Data</i>	34
3.9.5	<i>After-research relationship</i>	34
3.10	Conclusion	34
	CHAPTER FOUR	36
	RESULTS	36
4.1	Introduction	36
4.2	Sample Demographics	36
4.3	Theme 1: Implications of the Practising Impaired Doctor	37
4.3.1	<i>Harm to self and family</i>	37
4.3.2	<i>Harm to the medical profession</i>	38
4.3.3	<i>Harm to the employing healthcare Institution</i>	38
4.3.4	<i>Harm to patients</i>	39
4.4	Theme 2: Physician impairment: a major unaddressed issue	40
4.4.1	<i>Lack of Impairment awareness and support</i>	40

4.4.2	<i>Concerns Regarding Consequences Following Impairment Report to the HPCSA</i>	41
4.4.3	<i>Impairment Associated Stigma</i>	42
4.5	Theme 3: Consequences of the Legal Duty to Report	42
4.5.1	<i>Legal Duty to Report: An obstacle to identification</i>	42
4.5.2	<i>Reluctance to Refer: obstacle to seeking assistance</i>	43
4.6	Theme 4: Other Impediments Associated with uptake into the HPCSA Program for Handling Impaired Doctors	43
4.6.1	<i>Denial</i>	44
4.6.2	<i>Subtle and Paucity of Signs</i>	44
4.6.3	<i>Solo Private Practice</i>	45
4.7	Conclusion	45
	CHAPTER FIVE	47
	DISCUSSION, CONCLUSION, AND RECOMMENDATIONS	47
5.1	Introduction	47
5.2	Implications of Impairment in Doctors	47
5.2.1	<i>Harm to self and family</i>	47
5.2.2	<i>Harm to the healthcare facility</i>	48
5.2.3	<i>Harm to the medical profession</i>	49
5.2.4	<i>Harm to the patient</i>	50
5.3	Physician Impairment: A major unaddressed issue	51
5.3.1	<i>Lack of impairment awareness and support</i>	51
5.3.2	<i>Concerns regarding consequences following impairment report to HPSCA: Clarity needed</i>	51
5.3.3	<i>Impairment associated stigma</i>	52
5.4	Consequences of the Legal duty to Report	53
5.4.1	<i>The legal duty to Report: An obstacle to identification</i>	53
5.4.2	<i>Reluctance to refer: An obstacle to seeking professional help</i>	53
5.5	Obstacles to uptake into HPCSA intervention program	54
5.5.1	<i>Denial</i>	54
5.5.2	<i>Subtle and paucity of signs</i>	54
5.5.3	<i>Solo private practice</i>	55
5.6	Conclusion	55
5.7	Recommendations	56

Bibliography	57
Annexure 1	66
Annexure 2	67

CHAPTER ONE

BACKGROUND

1.1 Introduction

Since the inception of the new democratic South Africa, a lot has been done by the government to reverse the denial or violation of fundamental human rights which include, among other things, the right to health care service which used to be the order of the day many decades ago. The South African Constitution¹ is unambiguous in affirming that health care is a basic right. Notably, a Patient's Right Charter² was proclaimed by the Health Department as an instrument to attain these rights. Section 27 of the constitution of South Africa contains the following provision³

- Every individual has a right 'of access to healthcare service including reproductive health care'.
- No individual 'may be refused emergency treatment'.

The state is required to respect protect, promote and fulfil the rights in the bill of right. In the context of the healthcare service provision, the government must:

- Respect its citizen right of access to healthcare services by not unreasonably creating obstacle to people accessing healthcare services.
- Create and implement sound legal frame work to stop people who on purpose block the existing access of other citizens.
- Develop legal framework to enable its citizens to realise and enjoy their rights individually and collectively.
- Create an enabling environment for its citizens to access healthcare. This will involve the provision of the much needed healthcare services, social benefits and assistance.

¹ The Constitution of the Republic of South Africa 1996.

²Steyn HJ 'A strategy for primary health care – towards health for all' (1990) 1 (2) *Journal of Comprehensive Health* 130-132.

³ See supra note 1.

The right of access to healthcare has been addressed by our courts including the Constitutional court. The classic case of *Soobramoney*⁴ discussed section 27 of the 1996 Constitution. A distinction was drawn between emergency medical treatment and general medical treatment. The appellant was applying to have access to emergency treatment provided to him. The court deliberated on the importance of available resources which has an implication on the realization of the said right. His application failed on the grounds that his medical condition could not be regarded as one requiring emergency medical treatment therefore, the application was dismissed. The medical condition he suffered from which is called renal failure do require renal dialysis which may be needed urgently. However, renal dialysis is not considered an emergency treatment.

The courts have further addressed challenges regarding the right of access to healthcare. In the case of *TAC*⁵ the courts had to address the issue of mother to child transmissions of the HIV virus. Issues in dispute related to the roll out of this medicine (Nevirapine) that was proven to reduce the rate of Mother to child transmission of the HIV virus. The courts decided that the state had a positive duty to ensure that section 27 of 1996 constitution is realized. Furthermore, it was decided that the state had an obligation to adopt legislative means to ensure the implementation of the said right. The appellants succeeded in their claim. The jurisprudence from the courts highlights the many factors that impede on the realization of the right of access to healthcare.

It cannot be gainsaid that well-resourced hospitals and clinics are crucial in the provision of quality healthcare to the citizenry and in the fulfillment of the patient's right. However, medical care provision to hospitals and clinics users in the Durban area of KwaZulu Natal is viewed as being in disarray due to a variety of reasons. Shode⁶ contends that a significant contributor to the substandard state of health service delivery is the existence of 'impaired doctors' in the various health care facilities.

⁴ Soobramoney case found on <http://www.saflii.org/za/cases/ZACC/1997/17.html> accessed on 7th of August 2018.

⁵ The Treatment Action Campaign found on <http://www.saflii.org/za/cases/ZACC/2002/15.html> accessed on 7th of August 2018.

⁶Shode O Personal communications on Health Services Delivery and effects of Impaired Doctors 24 January 2014.

The situation facing medical practice is all the time confronted with ethical issues that require professional considerations to inform policy formulation and implementation. The Health Professions Council of South Africa (HPCSA)⁷ has developed and implemented a nonpunitive program to assist impaired doctors.⁸ The focus of this program is the care and rehabilitation of impaired doctors. However, referral to this system is less than optimal.⁹ A similar nonpunitive program for assisting impaired doctors is also in use in America.¹⁰ To date and in many countries, the medical profession is faced with ethical issues relating to how best to handle impaired doctors in practice.¹¹ Hence, a better understanding of the physicians' perceptions of impaired colleagues is required and cannot be over-emphasized.

1.2 Aims and objectives

This study is aimed at examining and analyzing the impact of impaired doctors in providing medical care to patients. The objectives are twofold: firstly, to explore both the views and role of physicians in the handling of impaired colleagues and secondly, to offer suggestions on how to mitigate obstacles that may negatively weigh on the provisioning of quality care to impaired doctors¹² in order to foster their overall care and management. This raises the following questions:

- (a) What constitute impairments in these doctors?
- (b) How are they perceived in the community of practice?

⁷Hereinafter referred to as 'HPCSA' established 1974.

⁸Benatar SR 'The impaired doctor' (1994) *South African Medical Journal* 651-652.

⁹Dhai A Szabi CP and McQuiod-Manson DJ 'The impaired practitioners-scope of the problem and ethical challenges' (2006) 96 *South African Medical Journal* 1069-72.

¹⁰Yancey JR Mckinnon H 'Reaching out to an impaired physician' (2010) 17 (1) *Family Practice Management* 27- 31.

¹¹Lindique BG 'Ethics opinion: The practitioner in need of care' (2012) *O AND G FORUM* 22-30.

¹²A doctor/medical practitioner/physicians all refers to a medical practitioner registered with the HPCSA.

- (c) To what degree does the environment influence ways of addressing the views and actions that are taken when handling impaired physicians?
- (d) What are the existing policies and strategies for handling these situations and what ways have been or could be devised for handling impaired doctors aimed at improving the care for them?

1.3 Statement of the problem

Impaired doctors do exist in some of our healthcare institutions in South Africa.¹³ Several factors contribute to making physicians become impaired. Physical illness, psychiatric disorders, substance, and alcohol abuse, and a combination of any of the above-stated conditions, can contribute to making a physician become impaired.

Doctors are much more vulnerable to opiate abuse because it is easily accessible to them. Apart from the substandard services provided by these doctors, the lives of the patients that they treat remain endangered. The medical profession may be viewed negatively and the career prospects of the doctors with impairment could be affected adversely as they are exposed to litigations resulting from medical negligence.^{14, 15} Recently a negligence damages claim of R19.2 million following the birth of a baby that developed cerebral palsy at birth due to brain injury was settled by the Gauteng department of health.¹⁶

The implications and negative impact of impaired doctors on our health care institutions are huge and far-reaching. The writing of faulty prescriptions and irrational ordering and wastage of expensive investigations coupled with poor patient compliance and a general dissatisfaction with the quality of care rendered are some of the consequences of the presence of an impaired doctor in the hospital. In April

¹³Dhai A. supra note 9.

¹⁴Botha E 'Medical malpractice claims have become a boom industry' *City press archive news 24 Online* 07 July 2012. Available at <http://city-press.news24.com/news/doctors-lose-patience-as-suits-spike-20120707> (Accessed 21 May 2014).

¹⁵*Truter v Deyssel* 2006 (4) SA 168 (SCA).

¹⁶Venter Z 'Medics' negligence leads to R19m payout for brain damaged girl' *Pretoria news Online* 13 March 2018. Available at <https://www.iol.co.za/news/south-africa/gauteng/medics-negligence-leads-to-r19m-payout-for-brain-damaged-girl-13752453> (Accessed 31 July 2018).

2012, the Gauteng health department was ordered by the High court to pay about R11 million as damages to a patient who was mismanaged in one of its' hospital.¹⁷

Many impaired physicians fail to use the rehabilitation program provided by the HPCSA because of the non-referral of suspected impaired doctors to the program by colleagues in the medical fraternity. This factor undermines the adoption of critical measures that are essential in dealing with the problem.

Why should this happen? Surely, the impaired physicians deserve no less than the same amount of compassionate care that non-physician patients receive when they are unwell. The non-existence of a culture (amongst doctors) that is committed to the well-being of impaired doctors in our hospitals and clinics constitute the 'crux' of the problem which is the focus of this study.

1.4 Research methodology

This was a descriptive qualitative study. The one-on-one interview technique was used for data collection. In-depth interviews were conducted utilizing open-ended questions. This research design was chosen because the information collected is not easily analyzable by using quantitative techniques.¹⁸ Using the qualitative research methods allows in-depth analysis of issues and problems. Notably, the use of this interview technique offers and allows the study respondents to express themselves without being detrimentally restrained in this regard.

The target population for this research study comprised of doctors who have been working in the Durban area health facilities for a period of 6 months or more. It was proposed to purposefully sample ten medical practitioners. This enabled the researcher to collect a broad range of responses to the many questions for which solutions were sought.

The primary data collection instrument is the researcher with qualitative research method training. The one-on-one interview technique was used. Five exploratory

¹⁷See Botha supra note 14.

¹⁸Cooper DR and Schindler PS *Business research methods* 10th ed (2008) 162.

open-ended questions contained in the interview schedule (Annexure 2) were posed to the participants by the researcher and their responses were recorded in a dual audio tape system.

Qualitative analysis techniques were utilized in the interpretation of the data collected. This involved the identification of themes contained in the study. As appropriate, an illustrative table are used. Critical description and data interpretation were undertaken for the diverse themes considered and investigated. Multiple coders were used during the analysis process to engender greater trustworthiness in coding data.

Furthermore, data quality, validity, and reliability were enhanced by submitting the collected data in the form of transcripts to the interviewees for review and correction of errors of facts. Finally, a process called 'member checking' was used to validate the study outcome. This process involves giving copies of the study draft report to the research participants and requesting for written comments on the findings of the report. As a measure of data quality, validity and reliability, there was peer debriefing where the researcher and those who were directly involved were subjected to responding to the same questions by an independent peer. This served to reduce bias of the interviewer/researcher towards the research topic. There was also the process of member checking whereby the interviewees would review, validate and verify the researcher's interpretation and conclusions so that facts are not misconstrued.

1.5 Ethical consideration

A written informed consent was requested and obtained from those who were interviewed for the study. Confidentiality was maintained during and after the study. Information for participation in the study was sent to the University of KwaZulu Natal ethical committee for approval.

1.6 Assumptions and limitations of study

It was assumed that every respondent in this study had sufficient knowledge and education to address the research questions and that they would freely give information in support of this research without restraints when answering questions.

Some of the limitations include the fact that the study findings cannot be generalized because of the small number of participants involved and the geography, that is, the size of the region used for the study implementation. The short time frame and the limited financial resources available for the study implementation actively limited the study. Finally, the researcher as a healthcare professional interviewing his colleagues in the same health district and on such a sensitive topic might have affected the study outcome by having unwittingly created some bias.

1.7 Sequence of chapters

In this study the following sequence of chapters was adhered to:

Chapter one presented a general overview of the study. Aspects discussed in this section include the research question, purpose, objectives as well as the reasons for the study.

Chapter two described the 'conceptual framework' for the research by providing a literature review with regards to information on the impaired physicians. This includes a discussion and analyses of various works and studies done in this field in the past.

Chapter three described the research process in detail. The research approach and techniques are fully discussed in this section

Chapter four addressed the presentation and analysis of the data collected. The results obtained during the course of the research were brought to the fore and outlined.

In chapter five, a summary of the research findings with a full discussion of these results is carried out. An informed conclusion about the study is drawn and recommendations for additional research are also offered.

CHAPTER TWO

THE IMPAIRED MEDICAL PRACTITIONER: MEDICO-LEGAL ISSUES

2.1 Definition

In the past, doctors who could not perform their duties as expected of them were simply referred to as impaired.¹ They were often ignored because they either did not have obvious clinical symptoms and signs or 'gross dereliction of duties' has not been associated with their work performance. However, the past few decades have witnessed a shift in the perception of what impairment means, as it was now considered to be a chronic illness which may be difficult to manage if not treated early.²

The American Medical Association (AMA), in 1973, defined an impaired physician as 'a doctor whose professional conduct is affected negatively due to mental or physical illness, alcoholism, or substance dependency, which results in the person being unable to conduct his work professionally'.³ In essence, any physician who is unable to discharge his/her⁴ duties at a level of competence that is at par with the accepted standard of practice for his/her discipline in medicine due to alcoholism, psychiatric illness or chemical dependency will be regarded as impaired.⁵

Functionally, the impaired doctor's capacity to provide good quality medical care to a patient is riddled with flaws due to substandard professional evaluation and judgment. Negative social issues such as conflict with the law, difficulties in family and professional/ work relationships are other adverse consequences the impaired doctor may manifest with.⁶ The impaired medical practitioner has no knowledge

¹Anonymous 'The Sick Physician. Impairment by Psychiatric Disorders including Alcoholism and Drug Dependence' (1973) 223 (6) *JAMA* 684-87.

²Breiner SJ 'The impaired physician' (1979) 54 (8) *J. Med Educ* 673.

³See supra note 1.

⁴ Hereinafter, He/She means male or female for purposes of this study.

⁵Lowinson JH *Lowinson and Ruiz's Substance Abuse: A Comprehensive Textbook* 5 ed (2011) 892 - 908.

⁶ Ibid.

regarding his impairment due to dysfunctional thinking and poor judgment.⁷ The application of reasonable skill to provide competent medical care by the physician is compromised.⁸ The reasonable skill or care of a doctor refers to the amount of caution and concern a prudent and rational medical doctor would apply in a similar situation. The reasonableness is the test used to determine negligence.

2.2 Extent of the problem

The number of impaired doctors in South Africa and the world over is unknown.⁹ However, it is believed that approximately '1 in 6' medical doctors are affected by an illness that can result in impairment.¹⁰ Psychiatric illnesses including depression and anxiety states are among the common health problems affecting doctors¹¹. Up to 20% of medical practitioners are affected by depression and approximately 21% of physicians who report work-associated stress also have suicidal ideation.¹² 'Complications from depression and substance abuse may lead to suicide'.¹³

'Suicide rate among physicians is estimated to be about 50% above that of the general population'.¹⁴ The misuse of alcohol, scheduled substances (any drug that has the potential to be abused) and other hard drugs contribute significantly to physicians' impairment.¹⁵ While the lifetime prevalence rate of alcohol misuse among physicians is approximately 14%, chemical substance use disorder approaches 6% to 8%¹⁶ and 'alcohol remains the most commonly abused substance'.¹⁷ This is

⁷Campbell S and Delva D 'Physician Do Not Heal Thyself. Survey of Personal Health Practices among Medical Residents' (2003) 49 (9) *Canadian family physician* 1121-27.

⁸ Ibid.

⁹Sekeyre E personal communications on Health Services Delivery in South Africa and the Impact of Impaired Doctors (2016).

¹⁰Roberts LW et al 'Medical Student Illness and Impairment: A Vignette-Based Survey Study Involving 955 Students at 9 Medical Schools' (2005) 46 (3) *Comprehensive psychiatry* 229-37.

¹¹Zabow T 'The Management of the Impaired Doctor and Student: The Health Committee (HPCSA) Experience' (2004) 48 (2) *Transactions* 40-42.

¹² Ibid.

¹³Farber NJ et al 'Physicians' Willingness to Report Impaired Colleagues' (2005) 61 (8) *Social Science & Medicine* 1772-75.

¹⁴Broquet KE and Rockey PH 'Teaching Residents and Program Directors About Physician Impairment' (2004) 28 (3) *Academic Psychiatry* 221-25.

¹⁵ Ibid

¹⁶Brewster JM 'Prevalence of Alcohol and Other Drug Problems among Physicians' (1986) 255 (14) *JAMA* 1913-20.

¹⁷Hughes PH et al 'Prevalence of Substance Use among US Physicians' (1992) 267 (17) 2333-2339.

closely followed by scheduled drugs such as opiates (a drug derived from opium) and cocaine.¹⁸ The rate of substance abuse is same for both health care professionals¹⁹ and in the general public.²⁰ Notably, the choice of the chemical substance or drug that is abused varies.²¹ It has been observed that a medical practitioner tends to abuse benzodiazepine (a form of organic compound that can be used as tranquilizer) and opiates at a higher rate than the general public because these drugs are easily available and accessible in the hospital setting.²² Self-prescribing of scheduled drugs by the affected doctors also contributes and facilitates the misuse of those scheduled medications.²³ It has been recognized over the years that doctors as a group differ from the general public in their help-seeking behavior when they become ill.²⁴ For example, when they become afflicted by mental illness they may fail to actively seek help for reasons ranging from:

- (a) 'Lack of insight into their psychiatric illness.
- (b) They may be in denial of the fact that they are actually being afflicted with such an illness.
- (c) They may hold on to the belief that they require no professional help even though they are ill.
- (d) They may fail to seek help even when it is obvious to them that they are sick and require appropriate medical care
- (e) The tendency for doctors to self-diagnose and treat themselves is well recognized. In this manner, they avoid the usual pathways and programs of the health services opting for advice from other colleagues'.²⁵

¹⁸Mansky PA 'Physician Health Programs and the Potentially Impaired Physician with a Substance Use Disorder' (1996) 47 (5) *Psychiatric services* 465-467.

¹⁹Gallegos KV et al 'Substance Abuse among Health Professionals' (1988) 37 (3) *Maryland medical journal (Baltimore Md. 1985)* 191.

²⁰Newbury-Birch D et al 'Drink and Drugs: From Medical Students to Doctors' (2001) 64 (3) *Drug and alcohol dependence* 265-70.

²¹See supranote 18.

²²Tyssen R et al 'Help-Seeking for Mental Health Problems among Young Physicians: Is It the Most Ill That Seeks Help?' (2004) 39 (12) *Social psychiatry and psychiatric epidemiology* 989-93.

²³Veldenz HC et al 'Impaired Residents: Identification and Intervention' (2003) 60 (2) *Current Surgery* 214-17.

²⁴Ibid.

²⁵Ibid.

2.3 Classification of impairments in doctors

Two types of impairment in doctors are recognised and these include:

- (a) Physical impairment.
- (b) Mental or psychiatric impairment.

Physical impairments are usually caused by medical illness such as HIV/AIDS (a spectrum of medical conditions caused by infection with human immunodeficiency virus), epilepsy, geriatric conditions and excessive or extreme tiredness. Psychological difficulties or conditions such as senile dementia, alcohol and substance abuse disorder, perverse sexual acts on patients may lead to mental impairment.

2.3.1 Impairment due to physical illness

Medical practitioners who are infected with highly virulent microorganisms such as Hepatitis B (infectious disease caused by hepatitis virus that affects the liver) and HIV/AIDS are expected to actively take measures to protect their clients from contracting such diseases during the process of caring for them.²⁶ Failure to carry out this duty as required will amount to the doctor's negligence.²⁷ It is noteworthy, that the negligence of a medical practitioner cannot be taken away by the fact that the said practitioner is impaired. Thus, the patient can subsequently institute an action against the doctor and claim for damages.²⁸ Any HIV positive medical practitioner who negligently infects his client is liable to that client for damages.²⁹ The demise of such a client may lead to the doctor being charged for culpable homicide³⁰ in criminal law.³¹ The deceased client's family may also claim for 'loss of support' (civil claim)³² from the doctor. A medical practitioner who is aware that he/she has a dangerous notifiable infectious disease such as HIV and Hepatitis B and fails to

²⁶Mitchell v Dickson 1914 AD 519. Medical negligence refers to a situation in which a healthcare professional acts in a manner that fails to conform to the accepted standard of care as required by the profession which may be in the form of an act or an omission.

²⁷Strauss SA *Doctor patient and the Law* (1991) 252.

²⁸Ibid.

²⁹HPCSA *Management of Patients with HIV* July 2001: para 11.3.

³⁰Unlawful taking of a life of another through negligence, this offence occurs without the element of intention.

³¹McQuoid-Mason DJ 'The impaired doctor: Legal Aspects' (2004) 48 (2) *Transactions* 37- 39.

³²A civil claim, is any claim made against a party who suffers harm at the hands of another. A civil claim if successful will be awarded in damages. This type of claim is regulated by the law of obligations under private law.

protect his client by taking precautions shall be deemed to have the 'intention to deliberately infect others'.³³ This shall result in the physician having to face not only a criminal action for assault but also a civil action for damages and for murder³⁴ should the patient die. Civil action can also be instituted against such a medical practitioner'.³⁵ An important question that must be answered at this juncture is whether the doctor is legally obliged to disclose his HIV status to his or her client about the fact that is HIV positive. According to the HPCSA guidelines regarding doctors who are HIV infected it is provided that:

'An infected doctor may continue to practice. They must, however, seek and implement the counselor's advice on how to adjust their professional practice in order to protect their patients'.³⁶

Doctors who are physically impaired and are unable to competently carry out some medical procedure are best advised to avoid engaging in such procedures. Therefore, an elderly doctor may not carry out procedures that he is no longer competent to engage in. Similarly, a medical practitioner that is exhausted may not assist clients unless in 'an emergency'. Obtaining an informed consent from the patient prior to attending him becomes not only essential but also obligatory.

The right to privacy is one that encapsulates important aspects of healthcare including but not limited to confidentiality. The right to privacy is contained in the 1996 constitution under section 14. As a general rule a party including a healthcare professional has no obligation to disclose his impairment. However, if the impairment is such that it poses a material threat to the public he is placed under an obligation to disclose. The Promotion for the Protection of Personal information Act³⁷, defines personal information as information about an identifiable individual.³⁸ It can be deduced that when this act is applied in context with regards to section 14 of the constitution it can be construed to mean the right to privacy remains protected, save

³³ Annas GJ et al *'Rights of Doctors, Nurses and Allied Health Professionals: A Health Law Primer (1981) 382.*

³⁴ Murder is the unlawful, intentional causing of death of another.

³⁵ McQuoid-Mason D and Dada M *Introduction to Medico-Legal Practice: Legal Aspects of Medical Practice (2001) 13-23.*

³⁶ *ibid.*

³⁷ The Promotion of the Protection of Personal Information Act 2 of 2000.

³⁸ The promotion for the protection of personal information act, definitions, found on <http://www.justice.gov.za/legislation/acts/2000-002.pdf> accessed on 01/08/2018.

for evidence of reasonable grounds that would compel disclosure. The attending physician must give full disclosure of his impairment to the client³⁹. Informed consent is described as a process by which a client learns about and understands the purpose, benefits and potential risk of a medical or surgical intervention, and then agrees to undergo the treatment. 'Informed consent' means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed.⁴⁰ The crucial elements of informed consent are; the capacity to understand and make a decision, voluntariness in decision making, disclosure of full information, recommendation of a plan, understanding of the information provided and a clear decision on a plan and authorization of such plan. McQuoid Mason⁴¹ holds the view that 'a patient gives consent, if the patient knows that a doctor is impaired and still agrees to receive treatment from the said doctor and the patient is able to understand the implications thereof. This consent could be regarded as a ground for defence against any action that the doctor may face subsequently'.⁴²

2.3.2 *Psychiatric impairments*

Any physician that engages in perverse sexual acts with children or any of his patients will expose himself to criminal action for 'indecent assault' or '*crimen injuria*'⁴³ which is a wilful injury to someone's dignity caused by the use of obscene or racially offensive language or gestures. Instituting a civil action against a doctor for invading the personality right of his clients may occur.⁴⁴

Any medical practitioner whose mental capacity becomes impaired by an illness such as dementia and substance abuse risks providing substandard care to his/her patient. Should this happen, the conduct of the affected doctor will be measured against that of the reasonably competent physician in the medical discipline to which the impaired doctor belongs.⁴⁵ Legal action against the doctor for medical malpractice and professional negligence may be instituted and the courts may award

³⁹ Ibid.

⁴⁰ S 7(3) of The National Health Act 61 of 2003.

⁴¹ See McQuoid Mason Supra note 31 at 37-39.

⁴² *Buls v Tsatsarolakis* 1976 (2) SA 891(T).

⁴³ *S v Mkwetshana* 1965 (2) SA 493 (D) at 497.

⁴⁴ Ibid.

⁴⁵ See *supra* note 42.

claims for damages suffered by the patient.⁴⁶ Medical malpractice refers to a breach of the duty to care by a doctor or health facility while medical negligence describes a situation where a medical doctor makes a mistake in treating a client and that mistake results in harm to the client. The family and dependents of the patient may also sue the physician for loss of support should the patient die.

2.4 Identifying the impaired medical practitioner

Medical practitioners hardly acknowledge the potential magnitude of and the resultant negative effects and dangers posed by a large number of unrecognized impaired doctors who are still in active clinical practice.⁴⁷ This is further complicated by the tendency of doctors to deny the existence of problems in themselves and their colleagues.⁴⁸ Whereas an impaired medical practitioner will resist being identified due to the inherent stigma associated with such labeling, other medical colleagues may be unwilling to report impairment in a colleague due to unpleasant implications of being tagged 'impaired'.⁴⁹

A medical practitioner that is impaired can easily be identified if his impairment results in his falling foul of the laws of the land and his subsequent interactions with the law enforcement agencies.⁵⁰ The ramifications and consequences of impairment are not limited to the impaired doctor's professional life⁵¹. For example, any medical doctor who is caught in drunken driving act may be arrested, tried and convicted. However, his problems may not yet be over as the report concerning such conviction will still have to be sent to the (HPCSA) as would happen in all criminal proceedings that involve a medical practitioner.⁵² The HPCSA⁵³ as the professional regulatory body may also find him guilty of 'unprofessional conduct' and apply commensurate

⁴⁶ See supra note 43.

⁴⁷ Preamble to the Constitution of the World Health Organization (1948).

⁴⁸ Taylor FK *The Concepts of Illness, Disease, and Morbus* Cambridge University Press (1979) 32.

⁴⁹ Hall PB 'Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence' (2009) 105 (5) *West Virginia Medical Journal* 36-37.

⁵⁰ Edwards G 'The Alcoholic Doctor. A Case of Neglect' (1975) 2 (7948) *Lancet* 1297-98.

⁵¹ Feinberg RS 'Impaired Physician: Medical Legal, and Ethical Analysis with a Policy Recommendation' (2009) 34 *Nova Law Review* 595.

⁵² Taitz 1988 *Acta Juridica* 40.

⁵³ The role of the HPCSA is to protect the public and guide the profession. It also has its own role to play and a code of conduct that compels its members to subscribe to. It is therefore authorized to sanction its members independently from the courts. This is also applicable to other regulatory bodies such as the law society and the members registered with it.

sanctions to the offending physician.⁵⁴ In an American study, it was demonstrated that law enforcement agencies are very strict in identifying impaired doctors in contrast to what obtains in the medical profession.⁵⁵ In situations involving impaired medical students, the supervising consultant or specialist may only come to recognize their incompetence or lack of skills to perform adequately through the poor quality of work done.⁵⁶ Usually, the family and close associates are the first to recognize signs of impairment in a medical practitioner.⁵⁷

A lot of medical doctors are reluctant to make a move and identify a medical colleague as impaired.⁵⁸ ⁵⁹ Some doctors have doubts in themselves as to whether they are correctly evaluating the impaired doctor's status. In addition, none of the impaired doctors' colleague wants to be labeled a 'whistle-blower'.⁶⁰ Most doctors often fail to identify impaired colleagues because they can easily put themselves in their colleague's shoes apart from identifying with him or her. The attitude of the medical profession towards addiction is partly responsible for the reluctance of the medical practitioner failing to identify impaired colleagues.⁶¹ ⁶² The medical practitioner's impairment usually starts in medical school.⁶³ It is at this point in time that the medical student may experiment and use most of the chemical substances and drugs. This usually indicates or foreshadows future abuse. Medical training facilities or institutions as training grounds often fail or neglect to deal with substance abuse.⁶⁴

It is generally believed that early identification and timely intervention are critical in the handling of issues of this nature. However the medical schools lack well-outlined

⁵⁴Carstens PA and Pearmain D *Foundational Principles of South African Medical Law* (2007) 263-264.

⁵⁵Bissell L and Jones R 'The Alcoholic Physician: A Survey' (1976) 133 (10) *The American journal of psychiatry* 1142-46.

⁵⁶McNamara RM and Margulies JL 'Chemical Dependency in Emergency Medicine Residency Programs: Perspective of the Program Directors' (1994) 23 (5) *Annals of emergency medicine* 1072-76.

⁵⁷ Ibid.

⁵⁸See Feinberg supra note 51 at 595.

⁵⁹See Edwards G supra note 50 at 1297-98.

⁶⁰ Ibid.

⁶¹See Feinberg supra note 51 at 595-628.

⁶²Lloyd G 'I Am an Alcoholic' (1982) 285 (6344) *British medical journal (Clinical research ed)* 785.

⁶³Nelson HD *et al* 'Substance-Impaired Physicians Probationary and Voluntary Treatment Programs Compared' (1996) 165 (1-2) *Western Journal of Medicine* 31.

⁶⁴Blondell RD 'Impaired Physician in 20 Primary Care, Clinics in Office Practice' (1993) *Substance abuse* 209- 210.

approach geared towards handling impairment in their school curriculum.⁶⁵ It is often recommended that an objective standard⁶⁶ tool should be adopted and utilized for the identifying impaired doctor.⁶⁷ For example, the most commonly used instrument to detect alcohol abuse in an individual is the 'CAGE questionnaire'.⁶⁸ The Cage questionnaire is a medical screening tool used for detecting excessive drinking and alcoholism. This assessment tool critically looks at questions concerning the person's need to reduce drinking, the person's attitude toward being criticised for drinking, the associated guilt feelings and how they addressed hangover issues.⁶⁹

Any person answering yes to two or more of the questions in the questionnaire is more likely to have a serious problem of alcohol consumption. The occurrence of multiple symptoms and clinical signs in the impaired physician can act as identifiers of such impairment. Some of these clinical features include:

- (a) 'Absence from work which may take the form of extended weekends (inclusive of Mondays).
- (b) Conduct that is bizarre and volatile including irritability.
- (c) Conducting ward rounds in hospitals at awkward hours.
- (d) Delays or outright failure to attend the sick when required to do so.
- (e) Falling off to sleep during the consultation process, surgical procedure or office visits.
- (f) The frequent occurrence of missed diagnoses especially in situations or tasks that require a lot of attention and concentration. These situations may include the interpretation of radiographic images and electrocardiographic tracings (ECG).
- (g) The existence of alcohol breaths when reporting for duty'.⁷⁰

⁶⁵ Ibid.

⁶⁶ Mc Namara supra note 56 at 1074.

⁶⁷ Impaired doctor refers to medical students and qualified doctors.

⁶⁸ Ewing JA 'Detecting Alcoholism: The Cage Questionnaire' (1984) 252 (14) *Jama* 1905-07.

⁶⁹ Ibid.

⁷⁰ Clark DC et al 'Alcohol-Use Patterns through Medical School: A Longitudinal Study of One Class' (1987) 257 (21) *Jama* 2921-26.

Furthermore, an American Body called 'the Committee for Physician Health of the Medical Society of the State of New York' outlined the following clinical features for the identification of an impaired physician:

- (a) 'Unkempt or disheveled appearance including neglect of personal hygiene.
- (b) Bloodshot eyes.
- (c) Depressed mood or irritability.
- (d) Irresponsible conduct and impaired memory reflecting poor concentration.
- (e) Alcohol intoxication at social events.
- (f) Financial difficulties and legal problems.
- (g) Prescribing of scheduled substances excessively.
- (h) Making dangerous orders and prescribing inappropriate medical treatment for patients.
- (i) Uttering of slurred speech and tremors.
- (j) Excessive and unusual complaints from the staff and patients.
- (k) Incidents of deliberate self-harm and unexplained accidents.
- (l) Failure to take phone calls and returning calls.
- (m) Traffic law violation including driving under the influence of alcohol.
- (n) Negligence of duties towards the patients and failure to carry out other staff obligations as required by law'.⁷¹

Notably, addict will spare no efforts in trying to convince others that they do not have any problem.⁷²

2.5 Risk Factors Contributing to Doctors Becoming Impaired.

Prolonged work hours and a huge amount of stress are crucial factors the medical doctors are exposed to on a daily basis in their professional life.^{73 74} Consequently,

⁷¹Avery DW and McCormick M 'The Impaired Physician' (2000) 7 (4) *Primary care update for Ob/Gyns* 154 -160.

⁷²Ibid.

⁷³Yancey JR and McKinnon H. 'Reaching out to an Impaired Physician' (2010) 17 (1) *Family Practice Management*: 27.

they become vulnerable to addiction with alcohol, tobacco and scheduled substances as they resort to drinking alcohol and using narcotic agents (chemical substances that induce stupor, coma or insensitivity to pain) to deal with stress and anxiety problems.⁷⁵ The expectations from the society are huge and room for mistakes in their work is almost non-existent. Long stressful hours of work also impact negatively on the physician's family and personal life. A breakdown in personal relationships is inevitable as the physician becomes entangled in a web of conflicts in which various forces of equal importance ranging from a commitment to the patient, the family, and other responsibilities take its toll. The easy access and availability of narcotics and scheduled drugs in the hospital environment are thought to be the reasons for the increased risk of susceptible physicians becoming impaired through drug addiction. Therefore, 'the increased incidence of impairment seen in doctors as a group is attributable to both the high and intense stress associated with the practice of medicine and easy access and availability of the scheduled drug in most medical facilities'.⁷⁶

Generally, physicians are subjected to a prolonged training schedule and in medical practice, a lot of emphasis is placed on 'self-reliance and competence'. As a result of the experiences gained from training and practice, the doctor finds it difficult to realize or accept his or her impairment. The stigma attached to physician impairment negates help-seeking tendencies. Self-denial coupled with sophisticated resistance and concealment play a huge role in limiting early identification and rendering of care to impaired doctors.⁷⁷ 'Doctor colleagues and close family relatives may find it hard to detect obvious signs of impairment, especially in doctors that are drug addicts, due to the very trusting relationships that exist between them'.⁷⁸

2.6 The HPCSA strategy for handling impaired physicians

The HPCSA established by the Health Professions Act is a statutory body that regulates the medical profession in South Africa. The main role of this statutory Body

⁷⁴Karp D 'Dealing with an Impaired Colleague' (2007) 84 (8) *Medical economics* 30.

⁷⁵Ibid.

⁷⁶Ibid.

⁷⁷Veldenz et al 'Impaired Residents: Identification and Intervention' (2003) 60 (2) *Current surgery* 214-217.

⁷⁸Kushner TK and Thomasma DC *Ward Ethics: Dilemmas for Medical Students and Doctors in Training* (2001) 79-84.

and the twelve boards that operate under its umbrella are to promote and enhance the health of all South Africans, set standards of professional education and training as well as maintain adequate standards for professional practice. Therefore the HPCSA has a huge role to play in the regulation of the medical profession in South Africa especially in the context of professional misconduct and in the way the professional boards exercise their disciplinary powers.

Impaired medical practitioners' presence in any given society is a genuine cause for concern because of the substandard level of care that will be available to the healthcare users.⁷⁹ Reports of unethical behavior, incompetence and medical negligence on the part of doctors, are bound to occur.⁸⁰ Failure to promptly handle cases of doctors' impairment can lead to huge financial losses, poor quality of life coupled with some tragic outcome (for example, major depression and suicide).⁸¹ When doctors become 'sick' and impaired they deserve high-quality care just as any other healthcare user. The provision of prompt professional care that reflects empathy and compassion, both from the profession and the society in general, is desirable.⁸²

Substance abuse and alcohol dependence by doctors is a huge threat to the patients. The associated scandals and other damaging fallout negatively impact on the way the public view the profession.⁸³ In South Africa, the statutory body responsible for assuring the physicians' competence and thus protecting the public and caring for 'sick' doctors is the HPCSA.⁸⁴ The HPCSA has established a health committee charged with the responsibilities of looking after the interest of medical practitioners registered with the council.⁸⁵ The health committee places a lot of emphasis on preventative and supportive functions while excluding disciplinary role.

⁷⁹Boisaubin EV and Levine RE 'Identifying and Assisting the Impaired Physician' (2001) 322 (1) *The American journal of the medical sciences* 31-36.

⁸⁰Peterman J and Desbiens N 'Should Physicians Be Allowed to Use Alcohol While on Call?' (2005) 31 (1) *Journal of medical ethics* 21-26.

⁸¹Ibid.

⁸²Gastfriend DR 'Physician Substance Abuse and Recovery: What Does It Mean for Physicians—and Everyone Else?' (2005) 293 (12)*JAMA* 1513-15.

⁸³Brewster JM 'Prevalence of Alcohol and Other Drug Problems among Physicians' (1986) 255 (14) *Jama* 1913-20.

⁸⁴See McQuoid-Mason *supra* note 35 at 29-30.

⁸⁵Ibid.

All reports to the HPCSA concerning alleged impairment in doctors registered with the council are assessed and investigated by the health committee. The role and objectives of the health committee as stated by Zabow include formulating, establishing and implementing policies and procedure regarding early identification of impairment and ways to handle situations that may arise thereof. The committee may also undertake formal and informal evaluation of alleged impaired doctors. They also monitor and supervise the management of such a doctor.⁸⁶

In 1998, 'two new ethical rules' were formulated and added to the ethical rules that were already in existence by the HPSCA. Hence, the following 'acts or omissions' may lead the HPCSA to take disciplinary measures against any individual registered in terms of the Act:

'If the practitioner do not;-

- (a) Report impairment in another student or practitioner to the council if he/she were convinced that such other student or practitioner was impaired as defined in the Act;
- (b) Self-report his or her impairment or alleged impairment to the Council if he/ she was aware of his/her impairment or has been publicly informed of being impaired or has been seriously been advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment'.⁸⁷

Through these rules, a positive duty has been placed in all individuals registered with the HPCSA to actively provide information on impaired colleagues. All registered students and practitioners are also required to self-report their own impairment.⁸⁸ In 2002, there were about thirty impaired doctors who got reported to the HPCSA.⁸⁹ In 2003, the number of reported cases of impaired doctors increased to thirty-three with over fifty percent of the cases resulting from substance abuse.⁹⁰ Since 2004, the HPCSA has adopted an approach of management for these doctors which entails

⁸⁶ See Zabow supra note 11 at 40-42.

⁸⁷ Ibid.

⁸⁸ Health Profession Council of South Africa Ethical Rules 2001.

⁸⁹ Dhai A *et al* 'The Impaired Practitioner-Scope of the Problem and Ethical Challenges' (2006) 96 (10) *South African Medical Journal* 1069-72.

⁹⁰ Ibid.

the provision of assistance and rehabilitation rather than employing disciplinary measures. In this manner, the impaired practitioner is afforded the opportunity to regain his or her capacity to function optimally while protecting the patient from harm.

2.7 Intervention

A lot of concerns may be raised by various stakeholders whenever an impaired doctor is positively identified in a given hospital or clinic.⁹¹ These concerns should be addressed and discussed with the relevant supervisor utilizing by-laws, established institutional policies, and procedures. Realizing that a 'random drug screening policy' may not identify some impaired doctors, a stringent evaluation process using 'unbiased and uninvolved' medical personnel such as psychiatrists, occupational health physicians, and other experts can be of great help or assistance.⁹²

Drug screen positive individuals should be precluded from every form of clinical work or duties.⁹³ This will obviously guard against future harm to the client utilizing his/her practice. As a form of professional courtesy, other colleagues can assume or take over the care of the 'sick' doctor's patients until adequate arrangements for coverage are made. At all times, confidentiality must be maintained by the attending physician regarding the medical information about the 'sick' doctor.⁹⁴ This is best served by making others aware that the doctor had a problem that required him being away.⁹⁵

Intervention as a concept was first developed and used by Vernon Johnson in the 1970s.⁹⁶ He recognized that one or more crisis can assist an alcoholic to identify alcohol as a root cause of their predicaments. This led Vernon Johnson to start using 'the crisis' as a means of motivating and facilitating the rehabilitation of people with addiction problems. According to Benzor and Winslow, there are different types of

⁹¹Centrella M 'Physicians and Other Health Professionals'(1994) *Principles of addiction medicine. Chevy Chase: American Society of Addiction Medicine* 1-7.

⁹²See Lowinson Supra note 4 at 892 -908.

⁹³Talbott et al 'The Medical Association of Georgia's Impaired Physicians Program: Review of the First 1000 Physicians: Analysis of Specialty' (1987) 257 (21) *Jama* 2927-30.

⁹⁴ *ibid*

⁹⁵ Avery DM 'The impaired physician: treatment programs' *Medico-legal* 03/GVN Newsletter 1997 October 1-10.

⁹⁶O'Connor PG and Spickard A 'Physician Impairment by Substance Abuse' (1997) 81(4) *Medical Clinics of North America* 1037-52.

intervention.⁹⁷ These interventions could be described as physician intervention, family intervention, collegial intervention, employer intervention and formal intervention.⁹⁸

It has been noted that 'collegial interventions do have preferred impact on addicted doctors and benevolent coercion can be utilized by fellow physicians to get an addicted colleague into treatment'.⁹⁹ In this regard, the fear of losing his/her practicing license and employment can assist in speeding up the uptake of evaluation and treatment.

Team selection is very important because a team that cares and shows compassion is preferred. Any form of degrading or hostile attitudes directed from team members towards the impaired physician should be promptly identified and addressed as the intervention process can be thwarted by those negative attitudes.¹⁰⁰

A formal evaluation remains the main objective of any interventions concerning the impaired physician.¹⁰¹ Before any intervention, specific and detailed plans and treatment must be outlined. At the start of the intervention process, the impaired doctor cannot continue with his/her medical practice. This must be made explicit from the very beginning of the evaluation process. The intervention process must be taken seriously as it offers hope for recovery with better career prospects and brighter future.¹⁰²

2.8 Conclusion

The impairment of a medical practitioner constitutes a major source of worry for the public and the medical profession because of the potential adverse consequences associated with impairment. Duty demands that all doctors protect and prevent their clients from harm and maintain a high reputation for the profession and themselves.

⁹⁷ Benzor DG Winslow K F 'Formal intervention' (1994) *Principles of addiction medicine Chevy Chase, MD: American Society of Addiction medicine* 1-4.

⁹⁸ See Avery Supra note 87 at 1-9.

⁹⁹ Fletcher CE 'Michigan's Unique Approach to Treating Impaired Health Care Professionals' (2001) 20 (4) *Journal of addictive diseases* 101-16.

¹⁰⁰ Skipper GE 'Treating the Chemically Dependent Health Professional'(1997)16 (3) *Journal of Addictive Diseases* 67-73.

¹⁰¹ Ibid.

¹⁰² Avery DM and McCormick M 'The Impaired Physician' (2000) 7 (4) *Primary care update for Ob/Gyn* 154.

The public also expects high-quality medical care from competent members of the medical profession. There is an ethical obligation on the part of professional colleagues, friends, and family to actively assist in identifying the impaired practitioner. This should be followed by offering appropriate assistance and treatment intervention that will help restore him to his pre-morbid state and functional capacity. Early identification and the institution of appropriate interventions remain crucial in this regard as this offers a window opportunity for the successful healing and restoration of personal lives and career of the impaired medical practitioners.

CHAPTER THREE

STUDY DESIGN, METHODS, AND POPULATION

3.1 Introduction

This section of the study is focussed on describing all the different approaches and techniques used to process, analyze and interpret the results emanating from the study. In this regard, issues relating to the study design, the study population, the study sample and the sampling process and procedures are clearly defined.

An outline of the approach used for the information collection and data analysis activities is provided. Issues pertaining to bias, reliability, validity, and ethical consideration are also addressed.

3.2 Study Design

The term 'study design' in any project represents the 'blue print' for conducting the research. Outlining and utilizing such a blueprint provides the necessary impetus to the researcher to gain maximal control over elements that could jeopardize the validity of the research findings as the researcher is now able to effectively plan and implement the research plan in a manner that increases the likelihood of obtaining the intended results.¹

Critical factors to consider when deciding which research blueprint to adopt in conducting a specific study are the following:

- '(a) The research orientation.
- (b) The respondent.
- (c) The time frame for the research'.²

¹Burns N and Grove SK *Understanding Nursing Research-Ebook: Building an Evidence-Based Practice* Elsevier Health Sciences (2010) 34.

²ibid.

The qualitative approach was adjudged appropriate and was thus utilized in the conduction of this study. The raw information gathered and used focussed on the respondents' subjective experiences and the meaning they ascribed to them. Furthermore, the qualitative method of information gathering is most suited for exploring and exposing unexpected information.³

3.3 Study population

In definitional terms, a study population can be equated to the sum total of all respondents that meet the requirements as set out in the study.⁴ Therefore, the 'study population' in this research refers to medical practitioners of all ages, sex, racial groupings and socioeconomic status who practice medicine in Durban.

3.3.1 Inclusion criteria

Medical practitioners who have the following characteristics were deemed eligible for inclusion in the study:

- (a) Be currently registered with the HPCSA.
- (b) Be gainfully employed and be a practising doctor for more than six months.
- (c) Be willing to take part in the study.

3.3.2 Exclusion criteria

- (a) All medical doctors with less than six months work experience in the Durban area.
- (b) Medical doctors who declined to participate in the research.

³Creswell JW *Qualitative Enquiry and Research Design: Choosing among Five Approaches* (2007) 20.

⁴Polit DF *et al Nursing Research Principles and Methods* (1999) 37.

3.4 Research sample, sampling, and size of sample

3.4.1 Sample

A sample is regarded as that part of the population that is selected to participate and act as respondents in the study.⁵ In this research, a subset of ten medical practitioners was selected from the entire doctor population working in the Durban area.

3.4.2 The sampling process

The nonprobability sampling approach was utilized in the selection of participants. The major drawback of this approach includes the production of less accurate and less representative samples since not every medical practitioner in the health district had the opportunity of being selected. The utilization of this approach also limited the generalization of the research findings.⁶

3.4.3 Sample size

A general rule often utilized in research is 'to always use the largest sample size possible'.⁷ The bigger the sample sizes the more representative of the population being studied while the converse is true for smaller samples.

In this study, a convenient study sample of ten doctors was decided upon. It made more economic sense to select this sample size instead of engaging in a tedious and cumbersome work involved in studying all the practitioners in the entire area.

In addition, it was unnecessary to obtain data from every doctor in the Durban area as the data provided by the sample selected was enough to illuminate and provide the required information needed in the study.

⁵Brink H *et al* *Fundamentals of Research Methodology for Health Care Professionals* (2006) 123 - 126.

⁶ Ibid.

⁷ Ibid.

3.5 Management of data

3.5.1 Collection of data

Collection of information through in-depth interviews was done by the researcher. He was trained on how to conduct qualitative research at the Medical University of South Africa (MEDUNSA), South Africa. All the respondents were interviewed by the same researcher and this helped in limiting inconsistencies between interviews. Each interview lasted for an average period of about 25 minutes.

Prior to any interview taking place, an informed consent was accordingly obtained from the participants and the protocol approved by the UKZN Research Ethics Committee (reference number: HSS/0833/014M) was strictly adhered to. The 'free-attitude-interview' technique which involves utilizing the face-to-face method of obtaining information from a respondent without the interviewer directing the response was utilized. The interview comprised of an introduction to the study, the researcher and the conditions under which the respondents may participate in the study. Every participant fully grasped and acknowledged comprehension of the information provided concerning the study and their respective role in the study.

Confidentiality issues regarding the participants' identity were assured. All the respondents in the study were informed of their right to withdraw from the study at any given point in time should they no longer be interested to participate further in the study. No adverse consequences would ensue against any respondent that withdraws from the study.

The data collection process was facilitated by the researcher using reflective summaries, appropriate silences, and clarifications. By adopting a supportive and non-judgemental approach, the data collection process was further enhanced. All the interviews were captured in audiotapes utilizing the dual taping system to ensure that no audiotape failure occurred. In addition, the micro cassette recorders were subjected to several tests runs to ensure their adequacy for use during the data capturing process.

3.5.2 Processing of data

The researcher did verbatim transcription of all the interviews from the tape recordings. The raw data obtained was subsequently qualitatively analyzed. Although the transcription process was a difficult and time-consuming process, it afforded the researcher the opportunity to get familiarized with the very important contents intrinsic in the interview.

3.5.3 Analysis of data

In qualitative research, the recording of observation and transcription of the interviews usually result in the generation of a vast amount of textual data. Such raw data cannot be utilized or put into a report directly. On the contrary, it must be processed and put into a form that promotes further processing and analysis.⁸

It is against this backdrop, therefore, that the process of data analysis was made to involve the following key stages:

- (a) Organizing and reducing the generated raw data to a manageable size.
- (b) Generating categories and identifying important themes and patterns.
- (c) Evaluating emergent hypothesis by assessing the data for their credibility, usefulness, and informational adequacy.
- (d) Mounting further challenges to the emergent hypothesis by finding alternative explanations until a most reasonable one was arrived at.
- (e) Reporting.

The raw data was analyzed by the researcher under the guidance of Ms. Nomsa Malete who is a colleague and has vast knowledge and experience in qualitative research. The first three interviews were analyzed by both the researcher and Ms. N. Malete and the remaining interviews were done by the researcher. This was done with the aim of transferring the much-needed requisite analytic skills from Ms. Malete to the researcher.

⁸Pope C et al *Synthesising Qualitative and Quantitative Health Evidence: A Guide to Methods* (2007) 72.

The inductive approach⁹- a form of reasoning that entails the generation of new theory from the data was used to analyze the information obtained during the interviews. Notably, this process involves a systematic examination of textual data and field notes leading to the generation of categories, themes, and patterns. The researcher identified and developed the most significant recurring ideas, themes, and patterns throughout the data analysis process. Such sequential analysis did assist the researcher in developing and refining of the hypotheses.

The themes generated arose from the data and not vice versa.¹⁰ Categorization of the themes with their illustrative excerpts was organized using NVIVO- a qualitative data analysis computer software package (version 8 2008). Finally, a three-level process gradually led to the generation of themes in this study and this process involved the following:

- (a) Familiarization with the data.
- (b) Establishing a logical link with the interview questions.
- (c) Reflecting on the lessons learned from the literature review.

As the themes progressed from a low to a higher level of abstraction, major results and themes emerge.

3.6 Validity of the study

The validity of a research is focussed on the truthfulness or accuracy of the research findings.¹¹ It describes how accurately a given research reflects the reality it portends to represent.¹² A valid research study is one that is capable of demonstrating what actually exists. There are four measures against which validity must be evaluated and they include:

- (a) Inter-rater validity.
- (b) Content validity.
- (c) Correctional validity.

⁹Strauss A et al *J Basics of Qualitative Research: Procedures and Techniques for Developing Grounded Theory* (1998) 57.

¹⁰Patton MQ *Qualitative Research & Evaluation Methods* (2002) 62.

¹¹Bush T 'Authenticity in Research: Reliability, Validity, and Triangulation' (2012) *Research Methods in Educational Leadership and Management* 75-89.

¹²See Brink supra note 5 at 123 -126.

(d) Sematic validity.¹³

In this study, Ms. Malate of MEDUNSA provided assistance during the data analysis process and this greatly enhanced the inter-rater validity. A comparison was also made between the findings from the literature review and the in-depth interviews obtained from the respondents to enhance content validity. Furthermore, it was adjudged by the researcher and Ms. N. Maletle that the categories identified were all mutually exclusive and exhaustive and this assured and enhanced sematic validity.

Other steps adopted to enhance validity were;

- (a) A detailed and in-depth review of the literature to illuminate and identify variables that must be outlined.
- (b) The questions contained in the questionnaires were kept simple and well aligned with the 'conceptual framework' of the research study.

Member checking was carried out by the researcher. This mainly involved discussing the research findings with the respondents and getting feedback. Emphasis was placed on validating the major and minor themes as it affects the respondents.

3.7 Reliability

Reliability has been described as 'freedom from random or non-systematic errors'.¹⁴

¹⁵ Aply put, reliability equates to the virtual repeatability of results on retesting. It entails a researcher being able to reproduce the same result as those of a previous study under same conditions while using the same research techniques.¹⁶

Several factors have been suggested as major contributors to the difficulty in achieving reliability in qualitative research. These include:

- '(a) The subjectivity of the observer or researcher.

¹³Torn A and McNichol E 'A Qualitative Study Utilizing a Focus Group to Explore the Role and Concept of the Nurse Practitioner' (1998) 27 (6) *Journal of Advanced Nursing* 1202-11.

¹⁴Smaling A 'Inductive, Analogical, and Communicative Generalization' (2003) 2 (1) *International Journal of Qualitative Methods* 52-67.

¹⁵Cooper DR and Schindler PS *Business research methods* 10th ed (2008) 292.

¹⁶ibid

- (b) Presenting ambiguous and confusing questions to the research participants.
- (c) Failure to appropriately interpret information obtained from the research respondents'.¹⁷

To enhance reliability, the researcher adopted the following steps:

- (a) A concise description of the researcher role, characteristics of the study population, the research setting and the methodology used were clearly provided.
- (b) Audiotapes recording in combination with questionnaires were used. In this manner, the data collected would be preserved and its' veracity can be checked at a future date by other interested and authorized party.
- (c) The researcher's competence was assured because he subjected himself to further training in qualitative research methods in order to achieve competence in conducting in-depth interviews.

3.8 Bias

Bias is described as 'a systematic distortion that can influence the research process and results'.¹⁸ The researcher as well as the research participants can produce bias in a study.

3.8.1 Researcher's role and influence on bias and measures to control it

It is noteworthy that the researcher and respondents work in the same health district. Being colleagues and working in the same environment can create some degree of familiarity and sensitivity which may influence the responses from the study participants. This may manifest in the form of withholding of information the respondents may consider sensitive.

¹⁷Babbie E and Mouton J *The Practice of Social Research* 10th ed (2010) 67.

¹⁸ Cooper DR and Schindler PS *Business research methods* 10th ed (2008) 216.

In addition, the researcher has his own views concerning how impaired doctors are handled in Durban based on his experience. This can introduce some systematic distortion and influence the study.

The researcher took the following steps to curtail bias;

- (a) By subjecting himself to peer - debriefing.
- (b) Conducting all interviews in a no-judgemental manner and,
- (c) By doing participant member-check.

3.9 Ethical issues

Medical practitioners face multiple ethical issues in their day-to-day work as do some researchers who carry out investigations or research that involve human beings or respondents. The application of ethical considerations when carrying out research that involves human respondents is an area that cannot be ignored. The rights of the research participants must be protected actively.¹⁹ It is the responsibility of researchers to create and put forward projects that have study designs in which ethical principles such as autonomy, human dignity and justice are projected and promoted.

Informed consent is established when the following conditions are fulfilled:

- ‘(a) Research respondents must have the capacity or be of the right age and understand the choices that they make. In the case of children, parents or guardians must be available to assist.
- (b) Full disclosure of research purpose.
- (c) Full disclosure of all risks to research participants.
- (d) A clause that allows respondents to withdraw from participating in the research’.²⁰

Considering the ethical issues stated above, the following steps were adopted in this research.

¹⁹Cohen L *et al* *Research Methods in Education* 6 ed (2007) 71.

²⁰*ibid.*

3.9.1 Permission

Permission to conduct this research in Prince Mshiyeni Memorial hospital was requested from and authorized by the medical manager of the institution. The aim and objectives of the study was fully explained to the respondents prior to their participating in the research.

3.9.2 Confidentiality

Assurance on all issues pertaining to confidentiality was guaranteed and provided to all the research participants in writing. The participants were made aware about their freedom to pull out from the study at any time. Furthermore, the respondents were assured of the confidentiality as well as the anonymity of all information that they were going to provide in response to the research questions asked.

3.9.3 Consent

Voluntarily and under no duress or coercion, informed consent (in writing) was taken from each participant. A full explanation regarding the purpose, objectives, methods and the duration of the research was provided to the participants.

3.9.4 Anonymity of Data

All the participants in this study were assured that all information provided by them will be treated as confidential. The raw information generated had no name except the unique number. After the research is completed and a final written report compiled, all information produced during the research will be destroyed.

3.9.5 After-research relationship

The study report will be presented to the library at our various local hospitals in Durban and the University of KwaZulu-Zulu Natal where the participants could access it. Efforts will be made to have it published in one of our local medical or law journals.

3.10 Conclusion

The qualitative research approach was adopted in carrying out this study. This chapter addressed issues dealing with the qualitative research 'blue print' and

research techniques used in addressing the research topic. An in-depth review of all the information gathering techniques was done.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter is focused on presenting the results of the interviews obtained from the medical practitioners that took part in the study. Doctors were specifically selected for interview because they have a significant role to play in the identification, management and appropriate referral of suspected impaired colleagues. Standard demographic data of the participants are provided and interview reports in the form of themes generated from the analysis of the responses in the interviews are presented. The results are derived directly from the interview *transcripts*. *Quotes* from the participants are used whenever indicated.

4.2 Sample Demographics

Of the 10 respondents that participated in the study, a majority were over 40 years old. Both male and female genders were equally represented and all respondents are currently registered with the HPCSA as medical practitioners.

RESPONDENTS	AGE	SEX	MARITAL STATUS
K.J	35 years	Male	Married
P.M	40 years	Female	Single
R.D	52 years	Male	Married
D.M	62 years	Female	Married
T.P	49 years	Male	Married
S.K	30 years	Female	Single
A.B	47 years	Male	Married
C.D	44 years	Male	Married
H.P	39 years	Female	Single
D.M	28 years	Female	Single

Table 1: Standard Demographic Data of the Respondents

4.3 Theme 1: Implications of the Practising Impaired Doctor

The presence of an impaired physician in a health care setting is perceived as a huge challenge with adverse implications. The impaired doctor, the institution he works for, his profession, his clients and the society in general are impacted. The ramifications of this challenge as identified by the participants include financial, social, clinical and medico-legal consequences.

4.3.1 Harm to self and family

Many respondents noted the potential harm that can befall a practicing impaired physician and his family. Prominent among these were medical negligence and malpractice, as well as job loss and associated financial consequences. Disciplinary issues, harm to the family and reputational damage to self are other problems the impaired doctor has to contend with.

'We are also in a risky profession because there is litigation for medical negligence and malpractice. It destroys you as a person...you blame yourself for the rest of your life...for being negligent or killing someone...it can negatively impact your career...it will involve disciplinary action by HPCSA. It might have implications for your family, because if you lose your job and you happen to be the breadwinner or even if you are not the breadwinner...I mean having an income to sustain you and your family is quite important. So if you lose that the future of your family and your reputation is at stake'. (Interview 5)

'They get a lawyer; they file a suit against the hospital. It tarnishes the doctor's image and the worst thing it goes on the internet...all cases that have been charged. There is a legal record of it. If you Google the doctor's name it comes up as 'he was accused of whatever' on the internet. It is terrible'. (Interview 8)

'If we are impaired one way or another, our capacity to make accurate and conscious decisions become jeopardized, for instance, tasks like the taking of blood for investigation will require the doctor to apply the universal precaution rules. However, an impaired physician is at an increased risk of injury or contracting an infectious disease during such procedure because needle-stuck injury can easily occur since

such an impairment may make him to be unable to take adequate precaution to stay safe.....'. (Interview 10)

4.3.2 Harm to the medical profession

Three participants noted the significant social harm that may accrue to the medical profession because of the activities of an impaired doctor. The occurrence of few medical mishaps unfortunately get publicised in the media resulting in a huge reputational damage to the medical profession.

'The actions of an individual may well hamper the perception of the profession as a whole. If an impaired doctor engages in and jeopardizes the safety of his patient resulting in the loss of life, these things often reach the media and the medical practitioners in the same area will be surrounded by the negative impact of that activity because it is often publicised'. (Interview 10)

'I know recently there were lots of incidents where doctors were physically and sexually abusing patients...we read about it in the media.....they gave the profession a bad name'. (Interview 7)

'Everybody noticed...even the patients now started talking that...that person is not Ok. They were even calling to say they think the doctor is not fine. One morning he came very late to work, very drunk, he couldn't even stand... very disgraceful!!' (Interview 6)

4.3.3 Harm to the employing healthcare Institution

Many respondents noted an association between having a working impaired doctor in the workplace and the occurrence of certain unpleasant consequences. The notable problems the healthcare facility must face up to include litigation and financial losses, reputational damage, safety and security concerns. In addition, the institution must contend with problems such as service disruptions resulting from interpersonal problems and conflicts that breed anger and frustration in work colleagues, clinical governance issues, and reduced work output.

'They come late to work, they abuse sick leave and call in sick a lot of times making the whole place dysfunctional and difficult to manage'. (Interview 2)

'You get a doctor who is abusing substance, a doctor who is not seeing adequate number of patients or not assessing his patients according to policies and guidelines.....not assessing patients properly or fully,might have negative incidents and might have medico- legal consequences for the institution. This doctor may also have frequent absences from work. Frequently absent himself from work point, may appear intoxicated or under the influence of drugs at work. These doctors have squabbles and discord with colleagues and even patients. Patients and workers feel unsafe and insecure; this way the department is not able to achieve its goal'. (Interview 3)

'suddenly we see this change and they come in late, they are not dressing appropriately.... they are not speaking to people appropriately or they come to work intoxicated, they refuse to see patients, they get into arguments unnecessarily with patients, nurses and colleagues'. (Interview 4)

'He comes in late all the time, he is not able to function well and just sitting down.....he is supposed to be seeing patients and he's not doing that... We had someone that was always drinking... comes to work drunk to the extent that the patient now like...call somebody and say..... is the doctor alright? Because the doctor is sleeping and he's got the smell of alcohol, he is not steady, he is obviously drunk. The doctor shouts at the patients and everybody around, even the patient is afraid to go into the consulting room. People like him can pose a danger to patients'. (Interview 6)

4.3.4 Harm to patients

Four participants expressed a lot of negativity with regards to having an impaired doctor in the workplace. They were of the view that patients using such healthcare facility will be exposed to various forms of dangers and difficulties. Prominent among these are medical errors, delayed access to care and treatment. Emotional and physical abuse of patients during interaction leading to the generation of anger and frustration can also occur.

'They talk to patients inappropriately, rudely, brazenly...and not respecting them as fellow human beings'. (Interview 9)

'Some impaired doctors may be aggressive towards others... they shout at patients, they would not manage patient properly, and they forget to prescribe treatment'. (Interview 8)

'they get forgetful...commit medical errors...maybe make an improper diagnosis, write an improper prescription, mistakes can be grave and very costly resulting in the loss of life...sometimes they are irritable and they don't handle patients well. Patients get angry and are frustrated'. (Interview 2)

'This kind of doctor might have frequent sick leave...he may be slow in attending to the patients and he may be seeing an inadequate number of patients resulting in the delayed rendering of care to the patients'. (Interview 3)

4.4 Theme 2: Physician impairment: a major unaddressed issue

All participants recognized physician impairment as a major public health issue that is yet to receive the attention it deserves. Some of the factors identified as major contributors include: lack of awareness and support programs for impaired physicians, concerns regarding consequences following impairment report to HPCSA, as well as the stigma that is associated with such impairment. Some of the suggestions to address the above issues include the establishment of a dedicated support program for impaired doctors. Further education for all doctors on issues associated with physician impairment was also advised. This will help limit stigmatization and enhance the early identification and reporting of impaired medical practitioners for professional assistance.

4.4.1 Lack of Impairment awareness and support

Some respondents opined that more work and effort was required now to effectively address impairment issues in doctors. They bemoaned the lack of vibrant institutional support structures and programs for impaired doctors. They believed that educational programs that are geared towards educating doctors about impairment can help create the necessary awareness and understanding that is required in helping the impaired doctor. The HPCSA was viewed as not doing enough to assist the impaired medical practitioner. These negative perceptions must be addressed through education.

'From what I know you only hear about the HPCSA when they require your annual fees or they discipline the doctor and strike him off the roll. I don't think we hear of them making any headway in terms of assisting practitioners with this level of difficulty.....that is left to the individual doctor and the health department to sort out'. (Interview 10)

'Well in our setting I don't see any support system for these individual as such...maybe at the HPCSA level, they do. I think these individuals need a support system, support structures and we don't have these in our hospital'. (Interview 9)

'Well...I am not sure, to be honest with you...because sometimes I feel as much as the Health Professions Council is there to protect the public...they should be protecting us as doctors as well...and in most cases that I have come across, I think the public is more protected than us'. (Interview 5)

4.4.2 Concerns Regarding Consequences Following Impairment Report to the HPCSA

Some respondents were worried about the consequences that may follow after an impaired doctor is reported to the authorities and the HPCSA. Uncertainty and lack of clarity associated with the post reporting process can be unnerving for the impaired doctor and the colleagues. These worries can only be allayed through the provision of an unambiguous description of what the impaired physician can expect, especially in situations where the role of the HPCSA in the handling of doctors is negatively perceived.

'Well...the HPCSA, it needs to take care of us. I mean we pay it, the exorbitant amount each year...Ok. This is on record, but usually, all we hear about HPCSA is prosecuting the doctor instead of protecting them...so I really would not expect much from the HPCSA in terms of the doctors' welfare. All they are interested in is the doctor's malpractice. They just think.... ok, malpractice, negligence, this doctor needs to be sanctioned, we are tearing off your certificate, and we are suspending him'. (Interview 2)

'I suppose we are afraid that once the HPCSA gets involved, this doctor will not be able to practice and there will be a loss of income and other consequences. The HPCSA needs to do more in terms of transparency and communication with the doctors. More road shows are needed. The doctors need to know more about what will happen after self-reporting. That way people will be willing to seek help and fear will be a thing of the past'. (Interview 3)

4.4.3 Impairment Associated Stigma

Stigmatization is one of the important social consequences that is associated with impairment in doctors. Some respondents opined that issues concerning the handling of impairment in doctors must be addressed sensitively and in strict confidence. A respondent explained that being described as an impaired doctor is quite terrible and shameful.

'Somehow we hold back and not report to the authorities, because we are afraid of the doctor being labeled as impaired...then it has consequences, financial consequences...but the labeling and stigmatization of an impaired doctor are both terrible and shameful'. (Interview 3)

'There is a need to have at every institution an employee assistance program [EAP], occupational health clinic and access to counseling services. These services must be rendered in strict confidence because it is a sensitive thing... it comes with a stigma'. (Interview 2)

4.5 Theme 3: Consequences of the Legal Duty to Report

All participants were aware of their legal duty to report an impaired colleague to the HPCSA. However, some of them perceive this 'duty to report', as an impediment to making such a report. Non-compliance with the law and reluctance to get involved and refer impaired colleagues for professional help was noted.

4.5.1 Legal Duty to Report: An obstacle to identification

Some respondents viewed the 'legal duty to report' impairment in colleagues as an obstacle to reporting. Impaired medical practitioners may restrain themselves from

accessing support or professional help because of the notion that medical colleagues are under the obligation to report them to HPCSA. In other instances, shame and embarrassment that is associated with impairment may impede the reporting process.

'The legal duty to report is very concerning...the duty to report impaired colleagues to HPCSA can have negative consequences on those seeking help including embarrassment, shame, and stigma. People don't want to get involved'. (Interview 1)

'Somehow we hold back and not report to the authorities because we are afraid of the doctor being labeled and stigmatized'. (Interview 3)

4.5.2 Reluctance to Refer: obstacle to seeking assistance

A participant identified reluctance to refer as an important obstacle to seeking professional help for the impaired doctor. Lack of awareness or ignorance regarding impairment management and the wish to protect a 'colleague or brother' from losing income and other consequence associated with impairment are the drivers for this attitude.

'There is always this conspiracy of silence about impaired medical practitioner...you know, from their colleagues. I suppose doctors are afraid to refer and report impaired colleagues to appropriate authorities because of the uncertainties in the post-reporting period and the need to protect one of their own. As a result, they may just choose to ignore the presence of an impaired colleague in their midst'. (Interview 3)

4.6 Theme 4: Other Impediments Associated with uptake into the HPCSA Program for Handling Impaired Doctors

The participants recognized the existence of some subtle but crucial factors that contribute significantly to limiting uptake into the HPCSA program for handling impaired doctors. It emerged that delayed identification of the impaired physician could result from factors such as:

- Denial of the existence of impairment, on the part of the 'sick' physician due to lack of insight into his clinical condition
- Delayed identification of impairment in the sick doctor. This can result from the failure of colleagues and co-workers in recognizing such subtle signs of early impairment.
- Being in solo practice may lead to a long delay in the identification and subsequent referral of the impaired doctor.

4.6.1 Denial

Every suspected case of impairment deserve some sort of intervention, However, some respondents hold the view that some impaired doctors may not agree to participate in such intervention process because of lack of insight.

'A lot of practitioners don't admit to themselves that they are dysfunctional or impaired'. (Interview 10)

'Very challenging...I mean I am in a supervisory position. It's not really nice to do. You often have impaired doctors who refuse...despite counseling from a colleague or from their supervisor or EAP to acknowledge that they have a problem...and that they should try to find help'. (Interview 3)

'The reason we end up not being protected is that...somewhere, somehow someone didn't acknowledge existence of a problem and that they require help'. (Interview 5)

'I have never mentioned this to them, but what I think they should do is that they should approach the individual because maybe this person is not even aware, he is in denial...he has no clue as to what is happening ...that he has a condition or impairment'. (Interview 9)

4.6.2 Subtle and Paucity of Signs

In the early stages of impairment in some instances, it may be difficult to identify subtle signs. Early identification and prompt referral for professional help are delayed because of the failure of colleagues and co-workers to recognize the subtle signs of impairment.

'I am talking from experience with of a previous colleague. She had this problem slamming the door...and it was going on for years. Unfortunately, it was taken for granted that this was her 'normal' behavior'. (Interview 7)

'I used to be in anesthesia, some colleagues were abusing opioids. The nurses count their things, something may be missing or initially you don't know...you think he is giving it to the patient but gradually it begins to show that the person is actually taking or using this substance'. (Interview 6)

'Somewhere somehow something has been missed and someone didn't pick up the signs and gets to a point whereby there is a negative incident and unfortunately the negative incident is irreversible'. (Interview 5)

4.6.3 Solo Private Practice

Being in solo private practice was viewed by the participants as a huge challenge to identifying and getting professional help for the impaired medical practitioners. This is in contrast to what obtains in public health sector where teamwork is the norm and programs such as EAP are available and accessible.

'I suppose in the public sector it's a little bit easier because we have EAP programs...we work closely with colleagues...but if you are in a specialist private practice, that is more difficult...the anaesthetist... often when they are in private practice, they get reported much later, when the situation is much worse'. (Interview 3)

'Isolation in private practice is real, unlike what obtains in the state service. If you look at private practice, the high addiction rate amongst doctors especially those who are anesthetic doctor is worrying. They have access to all those drugs and get addicted and become impaired but no one to intervene'. (Interview 7)

4.7 Conclusion

Four major themes were noted after the analysis of the raw information gathered from the interviews. These were: the impact of the practising impaired doctor, the implications of the compulsory duty to report impairment, impediment remaining

largely unaddressed and the non- HPCSA associated barriers to reporting of impairment.

CHAPTER FIVE

DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

5.1 Introduction

This chapter is devoted to the discussion of the study results. References are made to America and Australia because the healthcare profession is one that is uniform in terms of the ethical code of conduct of its members and standards of practice. Thus, the medical practice in South Africa stands to gain a lot from such international jurisprudence. Conclusions are drawn and recommendations made.

5.2 Implications of Impairment in Doctors

A number of adverse effects associated with having a practising impaired doctor in the workplace were reported by the participants. These consequences are a cause for alarm as they have direct implications for the workplace and work performance at all levels. This finding is similar to what was reported in the literature by Merlo and Gold who concluded that 'physician impairment is a significant issue with important public health implications'.¹ In order to have a full grasp of the consequences for the impaired physician himself, his profession, his workplace and his clients, a brief look at these ramifications is essential.

5.2.1 *Harm to self and family*

When doctors are impaired, their conduct becomes problematic and they often exhibit disruptive unprofessional behavior inside and outside their workplaces. Unattended, these irrational actions and behavior can progress and easily become complicated by disciplinary issues and job loss with the attendant negative financial consequences both for the 'impaired doctor' and his family. Reputational damage

¹Merlo LJ and Gold M 'Prescription opioid abuse and dependence among physicians: hypotheses and treatment' (2008) 16 (3) *Harvard Review of Psychiatry* 181-194.

and threats of lawsuits arising from medical negligence and malpractice are real. Criminal charges and the loss of doctor license to practice are other complications the impaired physician might have to face up to.

From the above, it is obvious that the impaired doctor is under a tremendous amount of stress that can result in him developing a major depressive illness, drug addiction problems with associated suicidal tendencies. His professional problems and personal difficulties may worsen as a significant number of colleagues are reluctant to document and refer him for appropriate professional help.²

5.2.2 Harm to the healthcare facility

The participants identified the negative consequences of having a practicing impaired doctor in a healthcare facility. These include adverse effects on the workforce, direct negative impact on patient's security and safety, litigations, financial loses, reputational damage, service disruptions, and reduced work output.

An important adverse effect of an impaired doctor conduct is the increased turnover rate of co-workers. Manifestation such as fear, feelings of low self-esteem, anxiety, and worthlessness are common among verbally abused healthcare professionals.³ Healthcare workers perceived the disruptive behavior of some impaired colleagues as contributing to lack of job satisfaction and dwindling moral in the workplace.

A report on a study by Cox on verbal abuse in nursing revealed an 18% turnover rate in nursing staff that is directly linked to verbal assault.⁴ The replacement cost of such staff members constitutes a huge financial burden for the healthcare facility. Disruptive conducts in the impaired physician do negatively impact patients' security and safety in the hospitals and clinics. The 2003 Institute for Safe Medication Practices (ISMP) survey report that looked into Intimidation that indicated disrespectful behaviours in the healthcare workplace, revealed that some 49% of doctors felt coerced to administer a medication even amidst unresolved serious

²Mustard LW 'The culture of silence: disruptive and impaired physicians' (2009) 25 (3) *The Journal of medical practice management: MPM* 153-155.

³ Ibid.

⁴Cox HC 'Verbal Abuse in Nursing: Report of a Study: Research explores whether or not-and to what extent-verbal abuse affects nursing practice and turnover rates' (1987) 18 (11) *Nursing management* 45 -50.

safety concerns, while another 40% remained quiet and did not oppose any intimidator.⁵ Several studies revealed that those individuals that suffered abuse in the past adopted and utilized avoidance behavior towards the intimidator in order to cope with their circumstances, notwithstanding their best intentions to improve services and care.⁶ Unprofessional acts in the impaired doctor have some hidden costs. Chronic absenteeism, work disruptions, late coming to work and sick leave abuse tend to result in low morale in the workforce. This tends to create an administrative nightmare leading to reduced productivity. Wastage of material resources and a rise in the occurrence of medical errors with the associated medico-legal consequences and litigations do contribute to the financial consequences and reputational damage the healthcare facility may suffer. Indeed, the 'Joint Commission on Accreditation of Healthcare Organization (JCAHO)' viewed and linked these unprofessional actions and behavior to patients dissatisfaction with the care received, medical mistakes, negative outcomes and escalated costs resulting from wastages and staff turnover.⁷

5.2.3 Harm to the medical profession

Every medical doctor registered with the HPCSA is expected to uphold the goals of professionalism. This include amongst others, a dedication to provide high-quality medical care and maintenance of a high standard of professionalism.⁸ Impairment in these doctors negate their capacity to maintain professionalism and offer competent care to their clients. The participants noted that impaired physician's actions and conduct do lead to 'dishonourable conduct'.⁹

Unprofessional conduct that includes taking advantage of patients or their relatives, indulging in a sexual relationship with patients or breaching patient confidentiality as

⁵ Institute for Safe Medication Practices (2003) survey on workplace intimidation Available at, <https://www.ismp.org/Survey/surveyresults/Survey0311.asp> (Accessed: 15 Sep 2017).

⁶Rosenstein AH and Michelle O'Daniel 'Disruptive Behavior and Clinical Outcomes' (2005) 36 (1) *Nursing Management* 18 -28.

⁷Ibid.

⁸National Health Act 61 of 2003.

⁹ibid

in *De Beer v HPCSA* 2005 (1) SA 332(T)¹⁰, may lead to the doctor being disciplined by the HPCSA for bringing the medical profession to disrepute.

5.2.4 Harm to the patient

Participants positively identified the existence of the potential for harm to the patient during an impaired doctor-patient interactions or consultation process. Unprofessional behavior and conduct by the impaired doctor do generate a sense of insecurity and fear in the patients of the impaired doctor. The patient's right to security and safety as guaranteed by the Constitution¹¹ is undermined and their trust in the health establishment and the multidisciplinary healthcare team is guaranteed to plummet. Outright physical and emotional abuse of patient leading to anger, frustration and general dissatisfaction with medical care can occur. Patients experience delayed access to care arising from the impaired physician's absenteeism, late coming to work, inappropriate and unproductive arguments with colleagues, nursing staff, and the patients.

The medical profession has an ethical obligation to inflict no harm on anyone.¹² This is completely encapsulated in 'the *maxim, primum non nocere*, first does no harm'.¹³ When a doctor becomes impaired, the main issue that arises in terms of nonmaleficence is the protection of the clients from the impaired medical practitioner. This is because impaired doctors can cause harm to their clients. Therefore, all policies dealing with impairment in doctors should incorporate aspect that deals with prevention of impaired doctor induced injury to his/her clients.

¹⁰In the *De Beer* case. The appellant was a Medical Practitioner registered with the HPCSA. He appealed in the Pretoria High court against the removal of his name from the register of doctors. This comes after a series of allegations of professional misconduct one of which was sexual in nature. The appeal was subsequently dismissed.

¹¹Constitution of South Africa s24a.

¹²Beauchamp TL and Childress JF *Principles of Biomedical Ethics* Oxford University Press USA (2001) 114-119.

¹³Ibid.

5.3 Physician Impairment: A major unaddressed issue

5.3.1 *Lack of impairment awareness and support*

The HPCSA in 1996 produced a report detailing how doctors with impairment should be handled in the country.¹⁴ The report represented a policy shift from the largely disciplinary system which was in place in the 1996 era, to a more humane non-punitive system of care that represents a 'win-win situation' for both the impaired doctor and his patients.

The study participants noted the absence of clear policies and guidelines outlining how impaired physician ought to be handled or managed in the workplace. The participants viewed the HPCSA as being unhelpful towards the impaired doctor. In addition lack of adequate institutional support structure and support system were also highlighted by the respondents.

5.3.2 *Concerns regarding consequences following impairment report to HPSCA: Clarity needed*

There was a unanimous call for improved transparency when handling impairment issues by the HPCSA. The fear and unhappiness that exist in the medical profession regarding the 'post reporting process' were given a full expression as the negative perceptions associated with the process became manifest. Providing a full description of what the impaired doctor can expect following a report to the HPCSA may go a long way in helping to mitigate the fear and unhappiness that is associated with reporting an impaired practitioner. A detailed list of clinical features that are associated with impairment and when it must be reported will assist in the early identification process of impaired individuals. Therefore improved clarity will aid the prompt detection and education process.¹⁵

This idea was well received by the Pharmacy Board in the USA.¹⁶ Indeed, this led to the adoption of a policy of transparency in all issues concerning impairment in this group of healthcare professionals internationally. In America, the Pharmacy Board in Alabama stated online its policy of transparency regarding how it handles impaired

¹⁴HPCSA report 1996.

¹⁵Coombs RH 'Drug Abuse Prevention for Trainees in the Health Professions' (1998) 3 (1) *Journal of Substance Misuse* 42- 49.

¹⁶ Ibid.

pharmacists. This policy provides further impetus to the mission and vision of the program which entails the prompt 'identification, intervention, rehabilitation, monitoring of recovering pharmacists'.¹⁷ Furthermore, clarity is provided on what the post-reporting process entails utilizing case studies of pharmacists who self-reported themselves to the board.¹⁸ A transparency policy of this nature may contribute positively to improving reporting in South Africa.

5.3.3 *Impairment associated stigma*

The study participants perceived and called for the individualization of education as an important tool for righting the stigma that obstruct the identification and reporting process of impaired doctors. In an Australian study¹⁹ conducted in 2011, stigma was identified as a major obstacle to reporting impaired healthcare professionals. Some respondents in the study were reluctant to reporting impaired colleagues to authorities for reasons ranging from threats to job security and its associated financial implications as well as fear of punitive actions that can result from such reports. Ignorance and complete lack of knowledge concerning impairment in doctors as a disease process may contribute to the stigmatization process.

Impairment associated stigma is a recognized impediment to reporting impairment in Australian medical practitioners.²⁰ It has been suggested that inaccurate documentation and reporting of the prevalence of impaired doctors usually result from colleagues ignoring or offering protection to the impaired doctor through avoiding 'labelling' the impaired doctor with a potentially harmful diagnosis.²¹

To fully address 'stigma' as an obstacle to reporting, it is crucial to raise the level of awareness of impairment by unambiguously defining it as a disease. A 1989 American study of 86 pharmacists in a rehabilitation programme and recovering from substance abuse revealed that most of them do not have the capacity to adequately identify or handle the early clinical feature indicating addiction. Intensive education

¹⁷ Ibid.

¹⁸ Alabama Board of Pharmacy. The Board of Pharmacy wellness Program (2011) Available from <http://www.albop.com/> (Accessed 21 Sept 2017).

¹⁹ Mohammad A et al 'Fitness to Practise in Pharmacy: A Study of Impairment in Professional Practice' (2012) 34 (2) *Int J Clin Pharm*.

²⁰ Cadman M and Bell J 'Doctors Detected Self-Administering Opioids in New South Wales 1985-1994: Characteristics and Outcomes' (1985) 169 (8) *The Medical Journal of Australia* 419 - 421.

²¹ Ibid.

on 'impairment' issues at undergraduate university level will be of great benefit.²² This will indeed promote research activities on all issues concerning the impaired doctor.²³

5.4 Consequences of the Legal duty to Report

5.4.1 *The legal duty to Report: An obstacle to identification*

The legal obligation to report impaired colleagues has created fear and uncertainty in the medical profession. Doctors are not willing to identify and report impaired colleagues because of shame, stigma, and embarrassment that such reporting process might bring to the impaired colleague.

5.4.2 *Reluctance to refer: An obstacle to seeking professional help*

A key result in this research was reluctance by colleagues to refer impaired doctors to other healthcare professionals for treatment. The main drivers of this attitude among the doctors were the need to protect 'one of our own' and the uncertainties that may accompany the post-reporting period in terms of adequacy of management. An American Medical Association (AMA) report that deals with the reporting of doctors that are incompetent or display unethical behaviour affirms that 'all physicians are obliged to note and report doctors with impairment'.²⁴ The mandatory reporting of impaired doctors that may endanger the lives of their clients is recognised in law and the ethical standards of the medical profession. It is intended that this rule will help protect patients and ensure that impaired doctors receive appropriate management so that they are able to regain their health and return to practice medicine safely and ethically. This ethical duty notwithstanding, many doctors are reluctant to report an impaired colleague due to a general feeling amongst doctors that the counseling program on offer is substandard. In addition, doctors are concerned about liability for slander.

²²Kenna G and Lewis D 'Risk Factors for Alcohol and Other Drug Use by Healthcare Professionals' (2008) 3 (1) *Substance Abuse Treatment Prevention and Policy* 3.

²³Ibid.

²⁴Hall BP 'Impairment by Psychiatric Disorders Including Alcoholism and Drug Dependence' (2009) 105 (5) *West Virginia Medical Journal* 36 – 37.

5.5 Obstacles to uptake into HPCSA intervention program

5.5.1 Denial

The participants noted denial in the 'afflicted doctor' as an important obstacle that is closely associated with the limited uptake into the HPCSA program for handling impaired doctors.

It is common knowledge that impairment in doctors constitutes a huge risk to the clients. Consequently, is not compatible with good medical practice.²⁵ The incompatibility produced form the crux of further concealment of impairment as the doctor continues to practices while being impaired.²⁶

The medical profession by nature places a lot of emphasizes on competence and self-reliance.²⁷ This has greatly influenced doctors to such a level that they find it difficult to identify and accept their impairment.²⁸ Impairment do negatively impact the 'afflicted doctor's' insight. In addition, impaired doctors often engage in elaborate plans to hide impairment because of the associated stigma which often limits their help-seeking behavior.²⁹ Potential disciplinary actions may also play a role in promoting concealment.³⁰

5.5.2 Subtle and paucity of signs

It is easy to identify, document and refer an impaired physician with overt signs for appropriate intervention. However, the participants identified a group of impaired doctors who present with subtle clinical signs. This group of doctors is usually in the early stages of impairment and it may be very difficult to recognize them and institute any form of intervention process that will assist and prevent them from harm. The impairment may progress and become complicated resulting in grave harm to the doctors and his patients. Therefore, measures to promote early identification and

²⁵Edwards G 'The Alcoholic Doctor. A Case of Neglect' (1975) 2 (7948) *Lancet (London, England)* 1297 -1298.

²⁶Brooke D 'The Addicted Doctor. Caring Professionals?' (1995) 166 (2) *The British Journal of Psychiatry* 149 150.

²⁷Gossop M et al 'Health Care Professionals Referred for Treatment of Alcohol and Drug Problems' (2001) 36 (2) *Alcohol and Alcoholism* 160 -161.

²⁸ See Brooke, supra note 26.

²⁹See Gossop et al supra note 27.

³⁰ ibid

prompt referral for professional help are crucial and must be developed and adopted to overcome this impediment.

The duty of professional colleagues in providing care to impaired doctors has been outlined by the HPSCA.³¹ However, prompt identification and offering of help are delayed because some doctors have no clue as to what clinical features may indicate impairment. This situation is compounded at the early stages of impairment when the presenting signs are subtle. Providing appropriate education on how to recognize early signs of impairment will greatly help in this regard.

5.5.3 Solo private practice

Being in solo private practice was identified by the participants as an impediment to gaining early entrance into the HPCSA program for handling impaired doctors. Typically, impairment in doctors is associated with failure to fully appreciate the presences of such impairment or its significance. Consequently, the intervention process is delayed or stalled due to non availability of concerned colleagues to help facilitate the 'confrontation and coercion' process that is needed to aid uptake into the HPSCA intervention program for handling impaired doctors.

Failure of the 'afflicted doctor' to self-report or engage in the intervention process that will benefit him, constitute a huge problem. The availability of trained colleagues who are proficient in carrying out "empathic confrontation" is urgently needed but this may remain a rarity in the solo practice scenario for a long time to come.

5.6 Conclusion

This study has helped to shed light on the implications of having a practicing impaired medical practitioner. The implications and adverse consequences for the practitioner and his family, his workplace, the medical profession and the patients are dire and cannot be ignored.

Currently, the efforts in place to assist the impaired doctor is riddled with gaps and other impediments that negate his health and well being, ultimately stalling his recovery process. Protecting both patients' and impaired doctors' health is the

³¹HPSCA Ethical Rules 2001.

ultimate goal and preferred solution. This calls for a deliberate initiative that will address substantive issues pertaining to the recognition, documentation, referral, monitoring, and treatment of the impaired doctor.

Policies addressing stigma, the responsibility of co-workers, confidentiality and informed consent in all matters concerning the impaired practitioner must be developed. In all of these, the importance of education cannot be over-emphasized.

5.7 Recommendations

These recommendations are made concerning this study:

- Educational initiatives and programs aimed at early identification, documentation and appropriate referral of the impaired doctor should be established and promoted in all healthcare facilities.
- Structures and health programs that provide the necessary impetus to supporting countrywide physician's health and wellness should be established.
- Adequate support should be provided to recovered practitioners as they resume that practice.
- The identification process of impaired practitioners by colleagues and co-workers should be adequately supported.
- More education and training on how to address the impaired doctors' ethical and medico-legal issues should be provided to all doctors.
- All health facilities should have in place clearly defined and detailed policies and procedures for handling impaired practitioners.
- The HPCSA should do more road shows aimed at increasing impairment awareness amongst doctors. Such road shows should be utilized in clarifying the HPCSA's role in the care of the impaired doctors and to solicit assistance in mitigating the scourge.
- Further research should be done to help the medical profession develop new tools and excellent health programs that will better assist in the care of the impaired doctors and medical students.

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Annexure 1**CONSENT FORM**

Dear Participant,

My name is Uhomoibhi John Omo-Osagie, a Master of Law (LLM) student at the School of Law, Howard College Campus attached to the College of Law and Management Studies, University of Kwazulu Natal. I am currently doing a research on the perceptions of Durban physicians in the handling of impaired doctors.

The purpose of this study is to examine and analyze the impact of impairment / impaired doctors/physicians in the provision of quality health care in South Africa with specific reference to Durban physicians. Please be advised that your response will be kept confidential during and after this study. Participants are not obliged to identify themselves by names. Please feel free to be as objective as possible. Participation in this study is voluntary.

Kind regards

Uhomoibhi J O

E mail: osagie@mweb.co.za

I have read the information above and understand that participation in the study is voluntary.

Name/ Signature of participant _____

Date _____

Place _____

Witness _____

Annexure 2

RESEARCH QUESTIONNAIRE

Dear Participant,

My name is Uhomoibhi John Omo-Osagie, a Master of Law (LLM) student at the Howard College Campus attached to the College of Law and Management Studies at, University of KwaZulu Natal. I am currently doing a research on the perception of Durban physicians in the handling of impaired doctors.

The purpose of this study is to examine and analyse the impact of impairment / impaired doctors/physicians in the provision of quality health care in South Africa with specific reference to Durban physicians. Please be advised that your response will be kept confidential during and after this study. Participants are not obliged to identify themselves by names. Please feel free to be as objective as possible. Participation in this study is voluntary.

Kind regards

Uhomoibhi J. O.

E mail: osagie@mweb.co.za

QUESTIONNAIRE**PART A****Demographics**

1.1 Gender

male		female	
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1.2 Race

African		Coloured		Indian		White	
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1.3 Age

20 - 30yrs	31-40 yrs	41-50 yrs	> 50yrs
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PART B**Question 1**

What is your understanding of the term 'impaired doctor'.

Question 2

What are the signs you may find in such doctors?

Question 3

What obligations do physicians have to act when a colleague becomes dysfunctional in the workplace?

Question 4

What are the reasons for you taking such action(s)?

Question 5

How can the current system of care and handling of impaired doctors in South Africa be fostered?

Thank you very much for your participation in the study



09 October 2014

Dr John Omo-Osagie Uhomoibhi (213573969)
School of Law
Howard College Campus

Protocol reference number: HSS/0833/014M
Project title: The perception of Durban physicians in the handling of impaired doctors

Dear Mr Uhomoibhi,

Full Approval – Expedited Application

In response to your application received on 16 July 2014, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Professor N Ntlama
Cc Academic Leader Research: Dr Shannon Bosch
Cc School Administrator: Mr Pradeep Ramsewak

Humanities & Social Sciences Research Ethics Committee

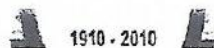
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