HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

GUIDELINES FOR GOOD PRACTICE IN THE HEALTH PROFESSIONS

ETHICAL GUIDELINES OF GOOD PRACTICE FOR THE MANAGEMENT OF CHRONIC DISEASES

BOOKLET 6

PRETORIA
JUNE 2024

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THE SPIRIT OF PROFESSIONAL GUIDELINES

High quality health outcomes are only achieved if patients and healthcare professionals trust each other explicitly. Practice in the health profession is therefore a moral enterprise and demands that health practitioners have a life-long commitment to sound, ethical professional practice and an unstinting dedication to the interests and wellbeing of society and their fellow human beings.

It is in this spirit, that the HPCSA formulates these ethical guidelines, to guide and direct the practice of health practitioners. They apply to all persons registered with the HPCSA and are the standard against which professional conduct is evaluated.

[In these guidelines, health practitioner and health professional refer specifically to persons registered with the HPCSA]

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1. INTRODUCTION

1.1 The World Health Organization's (WHO) has, through the Innovative Care for Chronic Conditions: Building Blocks for Action project, urged countries to implement strategies that promote integrated management of chronic conditions.

1.2 The National Department of Health has since developed an Integrated Chronic Disease Management (ICDM) implementation guide for health professionals, which is based on a public health approach to empower patients to take responsibility for their own health.

1.3 Chronic diseases are the most challenging health conditions of modern times, causing intense debates and discussions in the fields of medicine, ethics, law, sociology, politics, and economics.

1.4 South Africa has one of the most rapidly progressing burden of chronic diseases in the world, inclusive of HIV/AIDS, which is undoubtedly placing a huge burden of disease facing the country and poses a major challenge to health and social services and to the economy of the country.

1.5 Health practitioners are committed to maximising health outcomes and well-being. They do so through promoting access to the best possible preventive, promotive curative, and rehabilitative care for chronic conditions in order to attain optimal health outcomes for patients.

1.6 At a professional conduct inquiry, the professional board concerned shall be guided by the ethical rules, ethical rulings, these ethical guidelines, as well as any other Board's policies and directives.

2. MANAGEMENT OF CHRONIC DISEASES

2.1 ICDM promotes a multi-disciplinary approach in managing chronic conditions to achieve optimal health and clinical outcomes for patients with both communicable and non-communicable chronic diseases.

2.2 Communicable diseases such as Human Immunodeficiency Virus (HIV), Tuberculosis (TB), including Multi Drug Resistant TB (MDR-TB) and Extremely-Drug Resistant TB (XDR) as well as the non-communicable diseases, which may include but not limited to hypertension, diabetes, chronic obstructive pulmonary disease, asthma, epilepsy, mental health illnesses etc., are both applicable to these guidelines.

2.3 Presently, most chronic diseases can be managed. Understanding the impact of these diseases in communities and ensuring the effective management of interventions against them will improve the quality of life.

2.4 The ICDM model emphasizes the need for collaboration between health professionals, appropriate referrals, providing support and strengthening self-care for patients, and promoting continuity of care to ensure optimal care with improved health outcomes for patients with chronic conditions.

3. MODES OF TRANSMISSION

3.1 Transmission of diseases depend on people, the environment, and/or medical equipment/s.

3.2 Communicable diseases are transmitted primarily in four listed ways:

3.2.1 Direct contact by touch (example: Methicillin-resistant Staphylococcus aureus - MRSA). Health practitioner may become contaminated by touching pathogens present on medical equipment or high touch surfaces and then spread them to susceptible persons, especially when proper hand hygiene is not performed.

3.2.2 Sprays and splashes occur when an infected person coughs or sneezes, creating droplets which carry diseases. These pathogens can land on a susceptible person's eyes, nose, or mouth, thereby, causing infection.

3.2.3 Inhalation occurs when pathogens are aerosolised in tiny particles that survive on air currents over long distances and time and may reach susceptible persons. Airborne transmission can occur when infected patients cough, talk, or sneeze pathogens into the air (example: TB), or when pathogens are aerosolised by medical equipment.

3.2.4 Sharps injuries can lead to infections when bloodborne pathogens (such as HIV, for example) to enter a person, for example through a skin puncture by a used needle or sharp instrument or through infected blood (e.g. in drug addicts who share needles, occupational needle stick injuries or exposure to infected blood and blood transfusions).

3.2.5 Other common ways in which transmission can occur is through unprotected sexual intercourse, during pregnancy or at birth from the infected pregnant woman to the foetus or infant.

3.2 The modes of transmission referred to above may be effectively prevented, and health care practitioners can play and important role in this regard.

3.3 It is recommended that the health practitioner treat all patients the same and avoid the so called 'high risk groups or individuals' in terms of human relationships, and sexuality generalisation, especially around the issue of communicable diseases management, especially HIV in particular.

4. COLLABORATION WITH OTHER HEALTH PROFESSIONALS AND THE RIGHT TO CONTINUITY OF CARE

4.1 The primary responsibility of health practitioners is to ensure that the patient's best interests are realised.

4.2 Every patient has a right to receive continuous and appropriate care for their health condition, and no one should be abandoned by a health care professional who or a health facility which initially took responsibility for her/his health without appropriate referral or hand-over.

4.3 It is against all ethical and professional rules for a health care practitioner to refuse to treat a patient solely on the grounds of the latter's perceived or actual disease status. Treatment should never be suboptimal because of a perceived potential risk to the health practitioner. Unilateral decisions not to resuscitate patients that may require such, is a violation of fundamental human right to life.

4.4 It is ethically and legally mandatory to get informed consent before a health practitioner conducts medical tests on a patient – by law this always applies, except in a medical emergency, or in the case of a child where a parent or guardian is required to give such consent.

4.5. The differential/provisional diagnosis of diseases, without further examination and investigation provides only the most basic information about a person's prognosis or actual state of health. It is imperative that the health practitioner continues to conduct further investigations, where necessary in terms of acceptable protocols of management.

4.6 In the management of chronic diseases, it is important that the health practitioner afford consideration to other health professionals who are also involved in the management of the health condition and related secondary manifestations.

4.7 Healthcare practitioner should:

4.7.1 Act in their patients' best interests when making referrals and providing or arranging treatment or care.

4.7.2 Work with and respect other health professionals in pursuit of the best healthcare outcomes for all patients.

4.7.3 Not service a patient in more than one capacity or charge fees based on more than one consultation where health practitioners are registered with more than one

statutory council or professional board or in one or more categories within the same professional board.

5. PROVIDING INFORMATION TO ENABLE SELF CARE

5.1 Health practitioner must offer sufficient and scientifically sound information to patients that is aimed at empowering them to increase treatment compliance and improve health outcomes. Such measures may include appropriate education regarding lifestyle behaviours that may lead to chronic non-communicable diseases, practices that may lead to chronic communicable diseases and improved management of predisposing and aggravating factors (including sexually transmitted diseases). Mobilising support from the community and disseminating information regarding preventive measures are also important.

5.2 The test results and diagnostic health information of patients should be treated with the highest possible level of confidentiality to align with provisions of the Protection of Personal Information Act (POPIA).

5.3 Confidentiality regarding a patient's diseases status extends to non-healthcare team or non-registered persons. Other health practitioners may be informed of a patient's disease status without a patient's informed consent. For treatment and care to be in the best interests of the patient, the need for disclosure of clinical and medical data to other health practitioners directly involved in the care of the patient, is necessary, and may be discussed with the patient.

5.4 The decision to divulge health information relating to the disease status of a patient, outside of a team of health practitioners providing care to a patient must always be done in consultation with the patient and must be in line with the statutory requirements.

5.5 A breach of confidentiality is more likely to occur in the ward, hospital, or health practitioner's reception area than in the laboratory. It is, therefore, advisable that health institutions, pathologists, and other health practitioners and specialists formulate a clear policy as to how such information will be communicated and how confidentiality of the results will be maintained.

6. COMMUNICATING DIAGNOSTIC INFORMATION

6.1 All communications between a health practitioner and a patient concerning her/his diseases and/or health status should be conducted in a language that is easily understood by the patient.

6.2 The patient must clearly understand the information provided, so that he or she may be able to provide consent. The importance of the patient's ability to understand the information

means that if posters are displayed in an attempt to inform patients about the diseases, these must be supplemented by necessary verbal explanation by the health practitioner.

6.3 Where necessary, a health practitioner must ensure that a patient is directed to appropriate facilities that will oversee his or her further care and, where relevant, counsel close family members.

7. KNOWLEDGE OF DISEASE STATUS OF PATIENTS

7.1 Health practitioner should be aware that there are factors that make it unrealistic to rely solely on testing either in everyday practise or when dealing with a person who has been occupationally exposed.

7.2 There is no evidence that knowledge of the communicable disease status of patients protects health practitioners, for example, by reducing the risk of needle stick injuries. However, given the high incidence of infections, in all instances, health care establishments should ensure that universal precautions are used to provide protection against infections.

7.3 Healthcare establishments should ensure that universal infection control precautions are adhered to regardless of the known or unknown communicable disease status of a patient.

7.3 Where certain well-defined high risk or exposure-prone procedures are contemplated, the patient should be informed of the concerns adequately and consent should be sought. All patients have a right to refuse, but the patient may not be declined treatment on this basis. Should a patient decline to be tested for a communicable disease such a patient, management of such patient should involve adherence to universal infection control practices regardless of the known or unknown communicable disease status of a patient.

7.4 "High risk" procedures may require the use of "extended" universal precautions such as special gloves, clothing and face masks. "High risk" procedures include, for example, the penetration of a needle-tip in a body cavity; the simultaneous presence of the health care practitioner's fingers and a needle or other sharp object in a poorly visualised or highly confined anatomic cavity; and orthopaedic and other procedures where there is an aerosol of blood, bone fragments or bloody fluids.

7.5 It should be emphasised that permitting pre-operative or pre-treatment testing with informed consent where high-risk procedures are contemplated, or under specific circumstances, does not justify routine testing of all patients.

8. PATIENTS' REFUSAL TO BE TREATED

8.1 It is not justifiable to provide medical intervention without the patient's consent, except in special circumstances such as emergencies.

8.2 Where a health practitioner has sustained a risk-bearing incident, such as a needle stick injury, immediate post-exposure measures should be instituted, including the provision of information as to the communicable disease status of the source patient as follows:

8.2.1 Testing any existing specimen from the source patient. This should be done with the source patient's consent, but if consent is withheld, the specimen may nevertheless still be tested, with the patient alerted to this. The source patient must be given the option of knowing the test results.

8.2.2 relating to HIV, if there is no existing specimen and the patient still refuses to consent to a test, the patient should be treated as HIV positive, and prophylaxis should be initiated in respect of the health care practitioner who has been placed at risk of HIV infection.

8.2.3 If the patient is unable to give informed consent and is likely to remain unable to do so for a significant length of time, every reasonable attempt should be made to obtain appropriate proxy consent. Proxy consent means consent by a person legally able to give such consent in terms of the National Health Act, 2003 (Act No. 61 of 2003) – i.e. in order of precedence, a spouse or partner, a parent, a grandparent, an adult child or a brother or sister of the patient, or in the case of a child, a clinical manager (or equivalent) as provided for in f the Children's Act, 2005 (Act No. 38 of 2005).

8.3 It must be emphasised that regarding uncomplicating chronic disease management, except in emergency, ordinary protocols shall apply.

9. DISCLOSURES

9.1 Health practitioners should try to counsel their patients to disclose their communicable disease status to their partners to encourage them to undergo necessary testing and access treatment, if necessary. This is consistent with good clinical practice.

9.2 If a patient refuses consent, the health practitioner should use his or her discretion when deciding whether or not to divulge the information to the patient's immediate and known partner, taking into account the possible risk of transmission and the risks to the patient

(e.g. violence) that may follow such disclosure. The decision must be made with great care, and consideration must be given to the rights of all the parties concerned. If the health practitioner decides to make the disclosure against the patient's wishes, the practitioner must do so after explaining the situation to the patient and always accept full responsibility. The following steps are recommended – the health practitioner must: -

9.2.1 Counsel the patient on the importance of disclosing to his or her partner and on taking other measures to prevent transmission.

9.2.2 Provide support to the patient to make the disclosure.

9.2.3 If the patient still refuses to disclose his or her disease status or refuses to consider other measures to prevent infection, counsel the patient on the health practitioner's ethical obligation to disclose such information.

9.2.4 If the patient still refuses, disclose information on the patient's disease status to the known partner and assist them to access treatment if necessary.

9.2.5 After disclosure, follow up with the patient and the patient's partner to see if disclosure has resulted in adverse consequences or violence for the patient, and, if so, intervene to assist the patient appropriately.

9.3 Health practitioner must recognise major ethical dilemmas that may arise when confronted with a person with communicable diseases, such as people with HIV, and who refuse to disclose their status to their partner/s, despite counselling. Legislations prohibit the disclosure of any information contemplated in health status, treatment or stay in a health establishment, unless if such non-disclosure of the information presents a serious threat to public health.

9.4 When health practitioner record diagnostic information for patients on medical insurance for the purpose of processing claims, or in line with the rules of the medical scheme, the patient must give informed consent for such information to be placed on the account.

10. OCCUPATIONAL TRANSMISSION OF CHRONIC DISEASES, COMPENSATION AND INSURANCE

10.1 There is a risk of transmission of communicable chronic disease's infection in the healthcare environment (e.g., from patient- to-patient, patient-to-health practitioner, and from health practitioner-to-patient) through the exchange of infected blood or other body fluids – although scientifically the risk has been shown to be small. The risk can be reduced to negligible levels by effective infection control and hygiene measures. Nonetheless health care practitioners need to remain vigilant regarding the risk of occupational exposure.

10.2 Universal precautions must always be practised by all health practitioners and health institutions in the health care environment.

10.3 Post-exposure treatment of a health practitioner or a patient must be available where the possibility of an exchange of blood or body fluids has taken place. All health institutions must have clear and concise policies on such treatment.

10.4 Health practitioner working in the health care industry must be involved and assist in the development and formulation of a comprehensive policies that covers prevention, treatment, and care, as well as non-discrimination and non-stigmatisation. In developing these policies, it should not be forgotten that several health practitioners may themselves be infected. This means that, such policies should also cover the needs of health practitioners – the ethos of a caring profession should apply to fellow health professionals. It is also imperative for employers in the health care industry to familiarise themselves with their constitutional, legal and ethical obligations when dealing with patients.

10.5 Students in faculties of health sciences, who are not legally recognised employees, and who face the possibility of occupational exposure should ideally be insured - either by their training institution where they are registered or by the training facilities where they are undergoing training.

10.6 There is consensus that adherence to universal precautions is the most important preventative action that will significantly protect health practitioners against infection.

10.7 For the above reasons the following must be in place: -

10.7.1 All employers must make available to health practitioners the tools and systems necessary for the latter to practise universal precautions.

10.7.2. The necessary universal precaution tools and systems must also be provided to paramedical personnel, auxiliary and unskilled workers

who handle patients (or could be exposed to contaminated materials), and health science students.

11. HEALTH CARE PRACTITIONERS INFECTED WITH COMMUNICABLE DISEASES

11.1 Health practitioner cannot be obliged to disclose their disease status to an employer. Also, no health practitioner must be unfairly discriminated against or dismissed as a result of his or her condition.

11.2 Restrictions that cannot be scientifically justified should not be imposed on infected health practitioners.

11.3 Universal precautions should always be used when undertaking invasive procedures in order to minimise transmission from health practitioners to patients.

11.4 Patients should be made aware by health practitioners that disease infection can affect everybody including health practitioners.

These guidelines must be read in conjunction with other ethical booklets of the HPCSA which include but are not limited to: -

Booklet No 1: General ethical guidelines for healthcare professions.

Booklet No 4: Seeking patients' informed consent: The ethical considerations.

Booklet No 5: Confidentiality: Protecting and providing information.

Booklet No 9: Keeping of patient records.

ANNEXURE 1

1. BASIC ELEMENTS OF PRACTICALLY APPLICABLE AND UNIVERSAL PRECAUTIONS

1.1 Universal precautions are designed to prevent:

1.1.1 Penetration of the skin by contaminated sharp objects; and

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

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

2. BODY FLUIDS WHICH SHOULD BE HANDLED WITH THE SAME PRECAUTIONS AS SPECIMENS

2.1 The following specimens should be handled with the same precautions as blood (the list is not exhaustive):

2.1.1Cerebrospinal fluid

2.1.2 Peritoneal fluid

2.1.3 Pleural fluid

2.1.4 Pericardial fluid

2.1.5 Synovial fluid

2.1.6 Amniotic fluid

2.1.7 Semen

2.1.8 Vaginal secretions

2.1.9 Breast milk

2.1.10 Follicular fluid

2.2. The following other body fluids and tissues should also be treated like blood specimen:

2.2.1 Any other body fluid which is blood stained.

2.2.2 Saliva in association with dentistry.

2.2.3 Unfixed tissues and organs.

3. BODY FLUIDS SUCH AS URINE, SWEAT AND SALIVA

Body fluids such as urine, sweat and saliva do not pose any risk.

4. AVOIDANCE OF INJURIES WITH "SHARPS"

Health practitioners should avoid injuries with "sharps" by: -

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

4.2 Never allowing a sharp object, especially a contaminated one, to come near one's fingers (e.g. they should not re-sheath needles and should use instruments to load and unload scalpel blades, etc.)

4.3 Being personally responsible for the immediate safe disposal of all "sharps" that they use into an approved container.

4.4 Never handling a "sharp" without looking at it.

4.5 Never putting down a "sharp" except in an agreed neutral area.

4.6 Using the safest "sharp" that will do the job (e.g. knives and sharp needles only for skin; scissors and blunt (round-nosed) needles for tissues).

4.7 Never feeling for a needle point (or other sharp object) with their fingers.

4.8 Never putting their fingers in an area or wound where someone else is using a "'sharp".

4.9 Avoiding the use of wire sutures.

4.10 Using heavy-duty gloves (ring-link or similar) in dangerous situations (e.g. where there are broken bones, sharp foreign bodies).

4.11 Handle all sharp instruments with care.

4.12 Discard sharp objects immediately after use (in a “Sharps bin”)

4.13 Never recap any needle.

4.14 Never discard any needle/sharp into a bin or box – use a dedicated and appropriate “sharps” container (“Sharps bin”).

4.15 Never detach a needle from a syringe – discard as a unit.

4.16 Never force any sharp into a container. A sharps container is full when ¾ filled.

5. AVOIDANCE OF SKIN AND MUCOUS MEMBRANE CONTAMINATION

5.1 Three risks have been identified regarding skin and mucous membrane contamination, namely from:

5.1.1 Blood or body fluid on the hands;

5.1.2 Spillage of blood or body fluid on the health care practitioner’s body;

5.1.3 Spray-aerosol of blood or body fluid to eyes and face.

5.2 Health practitioners should never have contact with patients’ soiled linen, etc. if the skin of their hands is not intact (e.g. from cuts, eczema, etc.) unless the lesions can be completely isolated by impermeable adhesive tape.

5.3 Health practitioners should use make careful use of gloves:

5.3.1 Suitable gloves should be used by every health care provider handling blood or body fluid.

5.3.2 Torn gloves should be removed immediately, and contamination washed away.

5.3.3 Double gloving reduces skin contamination during operations by 80% and may reduce the risk associated with “sharps” injuries.

5.4. In respect of spillage health care practitioners should:

5.4.1 Use plastic aprons and impermeable boots where the risk of spillage exists,

5.4.2 Ensure that all spillage is immediately cleaned.

5.4.3 Double seal all containers of blood and body fluid.

5.5 Health establishments should have standard operating procedures for decontamination of infected arears.

5.5 In respect of spray-aerosol health care practitioners should:

5.5.1 Use face or eye protection (e.g. face shields, eye-goggles) where the risk of spray-aerosol contamination exists.

5.5.2 Should continuously aspirate laser and fulguration smoke by suction.

NOTE: Routine implementation of these simple, logical measures, that are not time consuming, nor significantly expensive, by all members of the health care team, should reduce the risk of infection of health care practitioners by patients, and of patients by health practitioners to very nearly zero.

Ethical guidelines for good practice in the healthcare professions

The following Booklets are separately available:

Booklet 1: *General ethical guidelines for health care professions.*

Booklet 2: *Ethical and professional rules of the health professions council of South Africa as promulgated in government gazette R717/2006.*

Booklet 3: *National Patients' Rights Charter.*

Booklet 4: *Seeking patients' informed consent: The ethical considerations.*

Booklet 5: *Confidentiality: Protecting and providing information.*

Booklet 6: *Guidelines for the management of patients with chronic diseases.*

Booklet 7: *Guidelines withholding and withdrawing treatment.*

Booklet 8: *Guidelines on Reproductive Health management.*

Booklet 9: *Guidelines on Patient Health Records.*

Booklet 10: *Guidelines for the practice of Telehealth.*

Booklet 11: *Guidelines on over servicing, perverse incentives and related matters.*

Booklet 12: *Guidelines for the management of healthcare waste.*

Booklet 13: *General ethical guidelines for health researchers.*

Booklet 14: *Ethical Guidelines for Biotechnology Research in South Africa.*

Booklet 15: *Research, development, and the use of the chemical, biological and nuclear weapons.*

Booklet 16: *Ethical Guidelines on Social Media.*

Booklet 17: *Ethical Guidelines on Palliative Care*