ELECTIVE REPORT

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INTRODUCTION

This essay attempts to fulfil three broad aims. Firstly, I will describe the social and cultural norms of South African medical practice – particularly the clinical teams responsible for caring for HIV positive patients with whom I worked during my elective period. Secondly, I intend to explore the nature of the physician-patient relationships that developed, both in terms of the degree of trust between agents and also in terms of where the ultimate decision making power tended to lie. Lastly, I will consider to what extent my observations can be generalised to South African practice, and what problems this may pose for the South African HIV patient.

To fulfil these aims I will emulate the publication style of what was described by Kon as a 'lay of the land study'. This is a study that "seeks to define current practices, opinions, beliefs, or other aspects that may be considered the status quo. Such studies may be descriptive or explanatory in nature, and may or may not be hypothesis-driven."[1] My study is not hypothesis driven, and intends to have both descriptive and explanatory elements. I will be using Kolb's experiential learning cycle of experiencing, reflecting, conceptualising and testing[2] to structure my reflections. I will begin by outlining who I worked with and the unique challenges that affect the South African health industry.

THE ELECTIVE EXPERIENCE IN SOUTH AFRICA

My first aim was to understand the working of the clinical teams responsible for patients with HIV. I was assigned to internal medicine at a state-run facility called Tygerberg Hospital just outside of Cape Town. One day a week was spent on call in the medical assessment unit (MAU). I would accept patients to the MAU and then I would be responsible for their care until they were discharged. The other days of the week were spent investigating, treating and discharging patients.

THE SOUTH AFRICAN POPULATION

South Africa has a population of just over 50 million people – half of which live below the poverty line. Life expectancy is around 50 years – one of the lowest values in the world.[3] The estimated HIV prevalence rate for South Africa in 2010 was 10.5%.[4] This equates to over 5 million people, with 40,000 new paediatric cases in 2010.[4] Due to the history of apartheid, there is a wide socio-economic and cultural gulf between the wealthy (predominantly white and coloured[a]) and poor (predominantly native African) neighbourhoods. In the area of Cape Town where I was working, the native language was Xhosa, though most patients also spoke at least some English.

THE SOUTH AFRICAN MEDICAL ESTABLISHMENT

MEDICAL STUDENT TRAINING

Undergraduate medical students in South Africa have six years of training which is broadly similar to that in the UK. The main difference is that the 6th year in South Africa consists of an intensive clinical training post which is in many ways similar to the Foundation Year 1 post in the UK. Medical ethics teaching was introduced to students at Stellenbosch University (which is attached to Tygerberg hospital) only in 1999, following a recommendation that all medical schools should have medical ethics as part of their syllabus.[5] This was after a government review into events during the apartheid years, which found that healthcare professionals were complicit in human rights abuses.

HEALTHCARE PROVISION AND THE GOVERNMENT

South Africa has a large private healthcare system which serves the richest 20% of the population.[6] Most South Africans receive much less comprehensive treatment at the hands of the public health system. There also exists a large industry of traditional

[a] This is not a racial grouping familiar to the UK: it refers to a diverse ethnic group made up of Indian and Indonesian immigrants to South Africa.

healers known as sangomas (there are six times more sangomas in South Africa than there are medical doctors).[7]

Much tension exists between traditional healers and doctors of evidence-based medicine about how to treat patients with HIV. It is said that "the traditional healer, in addition to using herbs, also works on the spiritual level, which is an essential part of the African healing process that Western medicine does not address."[8] The difficulties that doctors face when treating HIV patients extends further than contending with sangomas – politicians have had a detrimental role in educating about HIV and providing access to anti-retroviral drugs.

In 2006, the South African health minister Manto Tshabalala-Msimang promoted garlic, lemons and potatoes as a natural remedy to HIV infection.[9] During this time, the president of South Africa was a man called Thabo Mbeki. He publicly denied that the HIV virus caused AIDS, and endorsed the belief that the chief cause of AIDS was actually social-deprivation.[10] This lead to the delayed implementation of a national anti-retroviral programme which is estimated to have cost the lives of over 330,000 people.[11]

UNIQUE CULTURAL CONSIDERATIONS

South Africa is an interesting country to consider from a medical ethics perspective. There is a small, rich population which receives excellent medical care. There is a much poorer majority who receive medical care from traditional healers and from an over-burdened national health system. HIV/AIDS is a devastating economic and social burden on a country which is still recovering culturally from years of apartheid rule. Finally, government officials have made matters worse with poorly-construed HIV policy. All of these factors contribute to a physician-patient relationship that is very different to that encountered in the United Kingdom.

THE PHYSICIAN-PATIENT RELATIONSHIP

TRUST AND THE PHYSICIAN-PATIENT RELATIONSHIP

The Health Professionals Council of South Africa (HPCSA) publishes guidelines for good practice in the health care profession, similar to the role that the GMC's Good Medical Practice plays in the United Kingdom.[12] The opening line of this document reads; "practice as a health care professional is based upon a relationship of mutual trust between patients and health care practitioners".[12] Trust is central to effective medical care, and yet trust can be misplaced when the physician does not have the patient's best interests at heart.

I witnessed several instances in Tygerberg Hospital where doctors abused the trust that their patients placed in them. I will use Kolb's experiential learning cycle of experiencing, reflecting, conceptualising and testing hypotheses to analyse these situations and identify why these abuses of trust occurred and what impact they had on patient care.[13]

INCIDENT ONE: "THERE WAS A PROBLEM"

The first incident occurred on the renal ward on the 16th of April 2012. A patient was hospitalised for kidney failure. He had been in hospital almost two weeks awaiting a biopsy when the following exchange took place:

> PATIENT: YOU SAID THAT I WOULD BE SEEN YESTERDAY BY THE KIDNEY TEAM, DOCTOR.
>
> DOCTOR: THERE WAS A PROBLEM.
>
> PATIENT: WILL I BE SEEN TODAY, DOCTOR?
>
> DOCTOR: YES.
>
> PATIENT: OK. THANK YOU DOCTOR.

Reflecting on this incident, I have identified the reasons why this interaction shocked me:

- The doctor failed to offer either an explanation or an apology for why the patient has still not been seen by the renal team.
- The patient was satisfied with the doctor's response.

Perhaps the most surprising thing for me was that the patient accepted this exchange as a normal conversation between a doctor and a patient. When I quizzed one of the senior medical students on this patient's response, he replied "this is typical of the patients we get here. They are completely passive – like lambs."

The doctor was not in the least bit concerned that he had broken a promise to a patient, and felt no obligation to apologise. This was a fundamental failure to treat a patient with dignity. The patient felt that he was in no position to make a complaint. - he just had to accept whatever the doctor decided to do. Whilst this incident was not hugely damaging to patient care, it is symbolic of the power-relationships that existed in the hospital and the helplessness of the patients who felt it normal to take a totally passive and submissive role in their healthcare. This next incident explores what happens when this passive role that patients adopt is combined with doctors who fail to act in the best interests of their patients.

INCIDENT TWO: FEMORAL STAB

The second incident happened on the 25th April 2012 in the Emergency Room. A twelve year old girl was brought in after collapsing at school. It was the opinion of the registrar that she had no physical ailment and that the collapse was related to a psychological condition, but nevertheless it was important to run some routine blood tests to rule out unlikely but potentially serious illness. The registrar told the girl that we needed to take some blood and, without drawing the curtains, lifted up her skirt to expose her upper thighs. It became clear to me that the registrar was about to attempt to take blood from the girl's femoral vein. This procedure carries considerably more risk of infection or complication than taking blood from the arms, and is much more painful for the patient.[14] It is generally only attempted after two failed attempts at taking blood from the arms – and even then in children it is

prudent to obtain expert help before proceeding to the more invasive 'femoral stab', which is often considered a last resort.[15]

It was at this point that I stopped the registrar and asked her to explain to me what she was going to do, and asked why she hadn't attempted to take blood from the arms first. She replied that it was easier to take blood from the femoral vein than from the arms. I protested that it has a higher complication rate and that we should attempt to take blood from the arm first. We managed to take blood from the arm easily and the patient avoided having to undergo a more painful procedure.

Reflecting on this incident, the core ethical problem was fundamentally a failure act in the best interests of the child, but the doctor also failed to treat the patient with dignity. Her parents were unable to leave work to be with her in hospital, and she was not mature enough to make her own decisions about care. In these circumstances, it is expected that doctors will identify and act in the patient's best interests – something that this registrar actively failed to do, instead choosing to take blood in a manner which made her job easier but which exposed the patient to unnecessary pain and risk of infection.

WHAT CAN WE LEARN FROM THESE ANECDOTES?

I chose these two stories because they exemplified the two major differences that I noticed between the English and South African approaches to medical ethics in practice. Firstly, there is generally less respect for the dignity of patients in South Africa. Secondly, despite paying lip-service to the tenets of patient autonomy and consent, there is a feeling that these ethical obligations are merely legal requirements that must be dealt with before the actual business of practising medicine can begin. There can be no justification for this behaviour on the part of these doctors - the previously mentioned ethical guidance from the HPCSA cites autonomy and respect for the dignity of persons as core ethical values.[16] The above case studies highlight abuses of two human rights fundamental to medical ethics – the right of autonomy and the right to dignity.[17] In the final part of this essay I will

determine how widespread these human rights abuses are South African practice, why this is a problem, and some suggestions for how to work towards a solution.

THE EXTENT OF THE PROBLEM, AND POSSIBLE SOLUTIONS

I have discussed above how my own experiences led me to suspect that patient rights abuses, in particular a lack of respect for patient autonomy compounded by misplaced trust in doctors, were widespread in Cape Town. My suspicions are supported by a bioethics paper published in 2011. Research was conducted on 223 medical students in Cape Town into the type of patient rights abuses that they had witnessed.[18] The researchers had a response rate in excess of 80% and of the respondents, 71% claimed to have witnessed an abuse of patient rights.

Of the respondents, one quarter claim to have witnessed an interaction where there was no respect for patient dignity. The same percentage claim to have witnessed patients receiving so little health information from their care teams that it would be classed as a patient rights abuse. Finally, 15% reported that no attempt was made to gain informed consent before initiating treatment. These figures are worryingly high - and perhaps even more concerning was that one of the vulnerable groups identified in this study was teenage patients. The danger of paternalism in medical practice was explained by Onora O'Neill, "traditional doctor-patient relationships… [are] based on asymmetric knowledge and power. They institutionalise opportunities for abuse of trust".[19] If individual doctors are abusing patient rights, what reaction would we expect the institutions surrounding them – the medical schools and hospitals – to have?

INSTITUTIONALISATION OF THE ABUSE OF TRUST

Two important points emerge from the above mentioned paper regarding the role that institutions play in these abuses of trust. Firstly, ten per cent of the medical students who refused to participate in the study claimed that they feared reprisals by the medical establishment if they reported patient rights abuses. Secondly, some

students took the brave step of formally reporting the abuses that they witnessed, only for them to receive no official response whatsoever – "we gave all the grievances that we had. And we named specific patients, sisters, everything and incidences… but nothing was done".[18]

Doctors and other healthcare professionals are getting away with these patient rights abuses because nothing is being done when abuses are reported. This can only inculcate a feeling of helplessness in those students who want to do the right thing, and embolden those who feel that ethical concepts such as consent and patient autonomy simply get in the way of their medical practice. If the healthcare practitioners are getting away with it, then why are the patients allowing it? I will now attempt to conceptualise these failings of the medical profession within the context of the demographic and cultural environment in which they occurred.

CONCEPTUALISING ABUSES OF TRUST IN SOUTH AFRICAN MEDICINE

When we look at the demographics of the patient population that requires state medical care in Cape Town we begin to understand why patients allow these institutionalised abuses of patient rights to occur. This population is generally poorly-educated and relies heavily on sangomas in addition to hospital – especially for HIV/AIDS treatment. In traditional African culture the hospital is strongly associated with death.[8] These attitudes need to be modified if we are to be successful in getting patients to fully engage with Western medicine – which would necessitate educating about patient rights as part of this engagement. It is problematic that in many parts of South Africa, "western medicine is accepted only superficially, and many patients routinely consult traditional healers after hospitalisation".[20]

As well as being poorly-educated about their own rights, patients were reluctant to have them enforced for fear that they would be making a nuisance of themselves. A study into patient abuse by South African nurses cited "an underpinning ideology of patient inferiority" as one of the root causes of the abuse. They "were engaged in a

continuous struggle to assert their professional and middle class identity".[21] This socio-economic struggle should not be allowed to play out in hospitals, and it should be up to the management of these hospitals to ensure this.

WHAT NEEDS TO CHANGE?

When analysing the potential causes of these abuses of trust, it is useful to divide the causes into patient factors, medical practitioner factors and healthcare system factors.

In terms of patient factors, there is good evidence that involving and educating patients improves the clinical outcome of their illness. Treating patients with dignity and involving them in decisions about their own medical care are two factors that are independently associated with positive health outcomes.[22] When considering HIV in particular, we know that when medical decisions are made jointly between patients and physicians the patient has better health outcomes.[23] This suggests that the South African patient cannot afford to simply trust in the benevolence of his physician – but rather must, for the benefit of his health, engage in a sincere and mutual partnership with him. It is therefore recommended that the South African government embarks upon a campaign to educate all citizens about the benefits of Western medicine in addition to traditional medicine, and especially emphasises the active role that the patient is expected to play in the physician-patient relationship.

Regarding the medical practitioner factors, frustration and stress have been cited as two major factors which lead to patients abusing the trust that patients put in them.[18] It must be made clear to doctors during training and beyond that these are unacceptable justifications for abusing trust and acting paternalistically in modern medicine.

Finally, the healthcare institutions themselves must look at their own whistle-blowing protocols and support services for those who do make complaints about patient rights abuses. They must undertake to seriously consider and respond to

every complaint made against doctors and other staff. They must also do more to discipline staff who violate the ethical principles surrounding treating patients with dignity and gaining informed consent.

My elective in South Africa provided me with a wonderful opportunity to experience how the same ethical principles of Western medicine are approached in a country that is not England, and that has very different pressures on its healthcare resources. I found a country where the relationship between patient and doctor was very different than that in the UK, for a number of complicated reasons. Nevertheless, there is no scope for cultural relativism when it comes to simple ethical principles that both English and South African medical establishments fully subscribe to, and South Africa still has some way to come in terms of how medical ethical principles such as patient autonomy and respecting the dignity of patients are reflected in clinical practice.

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