

Laws and ethics pertaining to anaesthetic practice in South Africa: case-based narrative

HJ Moutlana,¹ ME Sethusa,² KS Matlala³

¹Department of Anaesthesiology, School of Clinical Medicine, Faculty of Health Sciences, Charlotte Maxeke Johannesburg Academic Hospital, University of the Witwatersrand, South Africa

²Private Practice, South Africa

³Department of Health, Waterberg District, Mokopane Hospital, University of Limpopo, South Africa

Corresponding author, email: hlamatsi@yahoo.com

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Introduction

Anaesthetists require knowledge of the laws and ethics in order to be able to deal with ethicolegal dilemmas that may arise in their practice. A study by Mamoojee and Alli¹ done at a major academic centre in South Africa (SA) concluded that anaesthetists have suboptimal knowledge of the law, with specific reference to informed consent for surgery, which is pivotal to their work. Another study performed in the same centre also reported an inadequate knowledge of the medicolegal process following an anaesthetic-related incident,² furthermore highlighting the gap in knowledge with regards to laws and ethics pertaining to anaesthetic practice. An attempt is made in this paper to fill this gap. This narrative employs the use of case scenarios to present possible ethicolegal dilemmas and the application of the relevant laws and ethical principles pertaining to the practice of anaesthesia in SA, to answer questions arising from the presented scenarios.

Choice on Termination of Pregnancy Act No. 92 of 1996 and the Children's Act No. 63 of 2003

A 14-year-old pregnant patient at 10 weeks gestation presents to the gynaecology outpatients department requesting termination of pregnancy (TOP). Your gynaecology colleague contacts you later to book her for evacuation of the uterus for incomplete abortion. She is a Jehovah's Witness Church member. You counsel her extensively prior to the procedure about the possible need for blood transfusion, and she agrees to blood transfusion if lifesaving. Her parents disagree with her regarding blood transfusion based on religious grounds.

Is the consent for TOP given by the patient herself valid?

The circumstances and conditions under which a pregnancy may be terminated are provided for in the Choice on Termination of Pregnancy Act No. 92 of 1996.³ An attempt to thoroughly answer the question presented above will be outlined by applying the Act. A female person regardless of age is classified as a "woman" in section 1 of the act.³ A pregnant woman may request TOP

during the first 12 weeks of the gestational period with no reasons required, as provided for in section 2(1)(a).³ This patient's gestational period falls within the stipulated 12 weeks, meaning that the Act allows her to request for the TOP if she wishes.

The informed consent of the pregnant woman is required prior to the TOP, and the consent required is none other than that of the pregnant individual regardless of their age.³ The Act defines a minor in section 1, as "any female person under the age of 18 years";³ thus the patient in this scenario will be considered a minor. It is, however, important to note that although the Choice on Termination of Pregnancy Act provides for a female of any age to consent for TOP, the patient would need to have the capacity to give a valid informed consent.⁴

In the case of minors, the capacity to consent is provided for in the Children's Act No. 38 of 2005.⁵ The capacity to consent, according to section 129 of the Act, refers to children of sufficient maturity, with the mental capacity to understand the benefits, risks, social and other implications of the procedure undertaken.^{4,5} The sufficient maturity provided for in the Children's Act provides a useful guideline that one can use to determine the capacity of a minor to consent for a TOP.⁴ Therefore, the consent given by this patient for the TOP will be considered valid according to the Act, despite the patient being a minor, if she fulfils the capacity to consent as described above. If there are sufficient grounds suggesting that this patient is not capable of giving consent for a TOP, she will then be informed that her parent's or guardian's consent will be required. If a parent or guardian cannot be contacted and/or the situation is an emergency as a result of TOP, consent can be sought from the medical superintendent of a hospital.⁴

Additionally, the Choice on Termination of Pregnancy Act encourages the medical practitioner to advise pregnant minors to consult with their parents, family members, guardian or friend prior to the TOP. However, if she chooses not to consult any of the abovementioned persons, the act provides that the TOP shall not be denied on such grounds.³

Can this patient consent for evacuation of the uterus herself?

Evacuation of the uterus in this scenario is related to the termination of pregnancy and the consent by this patient, who is a minor, would be appropriate under the umbrella of the Choice on Termination of Pregnancy Act 92 of 1996.³ According to section 129 of the Children's Act No. 63 of 2003, a child of sufficient maturity aged 12 years or older may consent to surgical procedures with the parent's assent.⁵ However, the Children's Act would not be applicable in this scenario, as the Choice on Termination of Pregnancy Act would be undermined.⁴ The patient could, therefore, consent for the evacuation of the uterus herself, if she demonstrates the capacity or sufficient maturity to consent as outlined earlier.

She bleeds profusely in theatre during the evacuation of the uterus and requires blood transfusion. How would you address the disparity between the patient and her parents' stance with regards to transfusion of blood products?

The Bill of Rights of the Constitution of South Africa

The Constitution of the Republic of South Africa is the supreme law of the country. For any law or conduct to be valid, it must be consistent with the Constitution. Section 15(1) of the Constitution provides for individual's right to freedom of religion of their choice. The right for people to belong to a religious community and to practise their religion is further provided for in section 31(1)(a) of the Constitution.⁶ In this scenario, the sections described will protect the rights of this patient's parents to belong to and practise the Jehovah Witness's religion. However, the Constitution further provides in section 31(2) that the right to practise a religion may not be realised inconsistent with any other provision of the Bill of Rights.⁶

There are various sections of the Constitution that provide guidance to this patient's rights. The Constitution provides for everyone's right to life, the right to access health care and the right not to be refused emergency medical treatment in section 11, section 27(1) and section 27(3) respectively. With specific reference to children, section 28(1)(c) of the Constitution provides that they have the right to basic healthcare services. The Constitution also provides that in all matters concerning the child, it is paramount to consider the 'best interest' of the child according to section 28(2).⁶

When addressing the disparity between the patient and her parents' consent regarding blood transfusion, one needs to consider the constitutional rights of both parties. The right to life is a non-derogable right, according to the Bill of Rights.⁶ The patient in this scenario consents to blood transfusion if lifesaving. Blood transfusion for extensive bleeding at this moment is an emergency lifesaving intervention. In order to avoid the infringement of the patient's constitutional right to access health care, the right not to be refused emergency medical treatment and the right to life according to section 27(1), section 27(3) and section 11 respectively as mentioned earlier, the patient's wish

with regards to blood transfusion will need to be respected and her parents' right to freedom of religion may not undermine this patient's rights.⁷

The Children's Act No. 63 of 2005

The parents' refusal for their child to get a blood transfusion is addressed in section 129(10) of the Children's Act 38 of 2005. The Act provides that parents or guardians may not refuse or withhold consent based only on religious beliefs, unless they can demonstrate that there is a medically acceptable alternative choice to the medical treatment concerned or blood transfusion in this scenario.⁵ If the alternative therapies to blood transfusion and the resources for their application, are not suitable, available and/or cannot be offered when blood transfusion is required in a medical emergency setting, the parents may not refuse their child this potentially lifesaving intervention. The refusal will be violating the child's constitutional rights.⁷

The National Health Act 61 of 2003

The National Health Act 61 of 2003 requires that healthcare providers may not refuse a person emergency medical treatment (section 5).⁸ The administration of a potentially lifesaving blood transfusion in an emergency setting will also be provided for in this section of the Act.

Futility of care, autonomy, beneficence, nonmaleficence, justice

A 30-year-old male was assaulted and subsequently found unconscious by passers-by. Paramedics were called to the scene, whereby he was subsequently resuscitated and intubated. He was then transferred to a central hospital and has been in intensive care unit (ICU) on mechanical ventilation for five days. His Glasgow Coma Scale (GCS) has remained 2T/10 since admission with no improvement. The computerised tomography (CT) scan shows extensive intracerebral haemorrhages with herniation. His inotropic requirements have been increasing since admission and he is currently on 1 mcg/kg/min adrenaline. He has acute kidney failure requiring dialysis. A multidisciplinary team of medical practitioners managing him assessed his condition and concluded that the medical treatment offered to him is futile. The family was contacted to discuss the decision to withhold treatment, however, the family insists that he is still young and has a fighting chance; therefore, they would like the medical team to continue treatment.

How can the ethical principles be applied to guide the medical practitioners managing this dilemma?

Prior to applying the ethical principles to cases of futility, the definition of futility will need to be outlined. Futility can be classified into four types:

- Physiological futility – where a medical intervention cannot result in the physiological effect it is intended to achieve.^{9,10}
- Imminent demise futility – where regardless of the medical intervention, the patient will die in the near future.^{9,10}

- Lethal condition futility – where a medical intervention is applied in the presence of an underlying lethal condition and the intervention has no effect towards such a condition, and the patient will die from that lethal condition despite the intervention.^{9,10}
- Qualitative futility – the medical intervention does not result in an acceptable quality of life for the patient.^{9,10}

When a decision regarding futile treatment is being considered, such a decision should be guided by the ethical principles of autonomy, beneficence, nonmaleficence and justice.¹⁰ The principle of autonomy refers to acknowledging the right of autonomous agents to hold views, make their own choices and act based on what they value and believe.¹¹ This would mean that the family's wishes in respect to the medical treatment of their loved one would need to be respected, if this principle is applied.

Autonomy must be applied together with other principles outlined above. The principle of beneficence encompasses three actions according to Beauchamp and Childress: "preventing harm, removing harm, and promoting good", whereas nonmaleficence requires the "avoidance of actions that cause harm".¹¹ To apply the principle of beneficence and nonmaleficence, it would need to be demonstrated that the medical interventions undertaken in the case above, such as ICU care, ventilation, inotropic support and dialysis, would prevent harm, remove harm, promote good and avoid harm.¹¹ Assuming the medical team assessed the medical interventions as futile, considering that despite such interventions, the patient will die from the brain herniation soon. As such, a classification of imminent demise futility was made.

A balance between benefits and burdens such as immediate detriment, risk of harm and other costs must be determined. If it can be argued that the pain endured by the patient is so severe and the physical condition is so burdensome, to such an extent that it outweighs the limited or no anticipated benefits, then it would be considered inhumane to prolong life.¹⁰

The principle of justice encompasses a "fair, equitable, and appropriate distribution of benefits and burdens" according to Beauchamp and Childress.¹¹ The continuation of treatment, especially in ICU, plus commencement of dialysis in a context where it is deemed futile, would not constitute a fair and equitable distribution of resources.

When considering terminating treatment because of futility against the patient proxy's wishes, the medical practitioners must apply the ethical principles of beneficence and nonmaleficence. The discussion should be centred on whether there are benefits; if the treatment is in the patient's best interest and whether the treatment will prevent further harm to the patient. Palliative care must always be offered where treatment that is deemed to be futile is being withheld.¹⁰ In addition to the principles of beneficence and nonmaleficence, a consideration should be afforded as to whether the withholding of treatment would lead to distributive justice for others who might or are in need of the same resources.¹⁰

In summary, when decisions to consider discontinuing or withholding futile treatment must be made, the following must be considered:

- A decision whether or not the treatment in question is futile must be made in consultation with the specialists in the field.¹⁰ In the scenario above, opinions of an intensivist, a neurosurgeon and a renal physician may need to be considered.
- The principle of autonomy to consider the family's wishes must be applied.¹⁰
- The ethical principles of beneficence and nonmaleficence must be applied, to determine whether it would be ethical to provide such treatment, based on the determination whether benefits or harm will be achieved by that treatment.¹⁰
- The justice principle must be used to decide whether it will be equitable and fair to continue such treatment. It must be determined whether such treatment will divert resources away from patients with positive prognosis.¹⁰
- Once it is concluded that the treatment is futile and that it is ethically justified to discontinue, the reasons must be explained to the patient and/or their family.¹⁰
- Ensure that palliative care is provided if the treatment is discontinued.¹⁰
- If the family still insists that they would like to continue with the futile treatment, transfer them to a facility that may be able to assist with their request.

Births and Deaths Registration Act, Inquest Act, Health Professions Act and Health Professions Amendment Act

A 52-year-old male patient is admitted to ICU after undergoing a Whipple's procedure. Three days after surgery, his condition deteriorates, and an assessment of an anastomotic leak is made. He dies in ICU before the scheduled re-look laparotomy.

Is this a natural or unnatural death?

Unnatural deaths are defined according to the Regulations Regarding the Rendering of Forensic Pathology Service¹² of the National Health Act No. 61 of 2003⁸ which defines them as:

- "Any death due to physical or chemical influence, direct or indirect, or related complications;
- Any death, including those deaths which would be considered to be a death due to natural causes, which may have been the result of an act of commission or omission which may be criminal in nature,
- Any death as contemplated in section 56 of the Health Professions Act, 1974 (Act No. 56 of 1974); and
- Any death which is sudden and unexpected, or unexplained, or where the cause of death is not apparent."¹²

Furthermore, unnatural deaths related to anaesthesia used to be stated in the Health Professions Act No. 56 of 1974¹³ as: "The death of a person whilst under the influence of a general

anaesthetic or local anaesthetic, or of which the administration of an anaesthetic has been a contributory cause, shall not be deemed to be a death from natural causes as contemplated in the Inquests Act, 1959 (Act 58 of 1959), or the Births and Deaths Registration Act, 1992 (Act 51 of 1992)". This section of the Health Professions Act No. 56 of 1974¹³ included patients dying as a result of anaesthetic factors such as drug effects, machine or equipment malfunction and procedural errors such as high spinal anaesthesia. Surgical procedures not requiring anaesthesia were excluded by this section of the act.¹⁴

Section 48 of the Health Professions Amendment Act No. 29 of 2007,¹⁵ substituted section 56 of the Health Professions Act No. 56 of 1974.¹³ The section brought about the definition of a procedure-related death as: "The death of a person undergoing, or as a result of, procedure of a therapeutic, diagnostic or palliative nature, or of which aspect of such a procedure has been a contributory cause, shall not be deemed to be a death from natural causes as contemplated in the Inquests Act, 1959 (Act 58 of 1959), or the Births and Deaths Registration Act, 1992 (Act 51 of 1992)."¹⁵ This amendment does not specify the type of procedure, therefore, the death in the scenario can be classified as unnatural since it is a procedure-related death according to section 48 of the Health Professions Amendment Act.¹⁵ The old section would not provide a clear direction with regards to the classification of this death as it is related to the procedure.

How should this death be handled according to the relevant SA laws?

The processes for handling unnatural deaths in SA is provided for by various acts. The Births and Deaths Registration Act No. 51 of 1992,¹⁶ provides that if a medical practitioner thinks that the death is due to unnatural causes, a death certificate normally issued in case of natural deaths will not be issued and a police officer is informed (section 15(3)).¹⁴ The Inquest Act No. 58 of 1959¹⁷ requires that deaths due to unnatural causes must be reported to the police (section 2(1)) and provides for the medicolegal investigation (an inquest and postmortem examination) of unnatural deaths (section 3).¹⁴ In the case of the scenario mentioned above, a medicolegal investigation would need to be undertaken.

Impaired physicians and the Health Professions Act

You notice that an anaesthetic colleague has been acting strangely for the past few months. He is rude and sometimes gets aggressive towards the nursing staff and surgeons. There have been multiple complaints from patients about his rude behaviour. He has also been absent from work more frequently and you are of the opinion that he has reported on duty under the influence of alcohol on multiple occasions. There are growing concerns that he is a danger to himself, his colleagues and patients.

How can the relevant SA law be applied to guide the concerned colleagues about managing this situation?

The Health Professions Council of South Africa (HPCSA) defines the impairment of a practitioner as "any mental or physical condition which affects the competence, attitude, judgement or performance of professional acts by a registered practitioner".¹⁸ The regulations relating to the investigations of impaired practitioners are provided for in section 51 of the Health Professions Act No. 56 of 1974.¹³

The ethical and professional rules of the HPCSA require that practitioners shall:

- "(a) report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired;
- (b) report his or her own impairment or suspected impairment to the board concerned...;
- (c) report any unprofessional, illegal or unethical conduct on the part of another student, intern or practitioner".¹⁹

In the scenario above, the anaesthetist will be required by the HPCSA to report the colleague to the HPCSA and the process that will ensue is outlined in the next paragraph.

Complaints pertaining to alleged practitioner impairment are lodged with the Health Committee Secretariat of the HPCSA.²⁰ An informal investigation is conducted, the practitioner is informed of the complaint and is requested to undergo an assessment to determine if they are impaired or not. Should the committee determine that the impairment exists, the practitioner will be declared impaired, and the impairment is processed on the HPCSA administration system against that practitioner's name. Conditions of practice, for example, supervision, prescription restriction or limited scope of practice, will be imposed, monitored and enforced by the committee.²⁰

Mental Health Care Act

A 32-year-old mental healthcare user is booked by the psychiatrists for electroconvulsive therapy (ECT) under general anaesthesia. The patient is reported to be suicidal and previously attempted to commit suicide without success. The psychiatrist would like to continue with the ECT without the patient's consent.

Would it be appropriate to continue with the procedure under the circumstances?

Consent for treatment of mental healthcare user is provided for in the Mental Health Care Act No. 17 of 2002.²¹ The Act provides in section 9(1) that "A healthcare provider or a health establishment may provide care, treatment and rehabilitation services to or admit a mental health user only if –

- (a) the user has consented to the care, treatment and rehabilitation services or to admission;
- (b) authorised by a court order or a Review board; or

(c) due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the –

- i. death or irreversible harm to the health of the user,
- ii. user inflicting serious harm to himself or herself or others.²¹

The patient presented in the scenario above has not consented to treatment, however, since the patient is reported to be suicidal and if it can be proven that a delay in providing the ECT may result in his death, the Act would allow for the continuation of ECT without his consent, as provided for in section 9(1)(c)(i).²¹ Consent will be sought from the family members according to the hierarchy for obtaining consent.

Consumer Protection Act and anaesthetic practice

Mr X is unhappy about a huge anaesthetic bill he got from the anaesthetist. He claims the anaesthetist overcharged him and that he was not told about the excessive bill he would incur.

Can the Consumer Protection Act be applied to analyse Mr X's unhappiness?

The Consumer Protection Act No. 68 of 2008²² defines a consumer in respect of any particular goods or services, as:

- “a person to whom those particular services are marketed in the ordinary course of the supplier's business” section 1(a).²²
- “person who has entered into a transaction with a supplier in the ordinary course of the supplier's business...”²²

Patients from a legal perspective are regarded as consumers. Patients benefit from services supplied by healthcare professionals and when the definitions described above are applied, would be seen as consumers in the healthcare industry with similar rights that apply to other industries provided for in the Act.²³ Similarly, healthcare professionals will be considered suppliers.²³

Section 23 of the Act provides for the disclosure of price of goods or services. The Act provides in section 23(5) that the price must be “adequately displayed to a consumer, if in relation to any particular goods, a written indication of the price, expressed in the currency of the Republic...”²² The purpose of the Act is “to promote and advance the social and economic welfare of consumers in South Africa.”²² Written, informed consent is important in the healthcare industry, as it provides the healthcare professional with a form of protection. Therefore, all agreements, including billing policies, should be outlined in the informed consent.²³ The practitioners need to ensure that patients are fully informed of the fees regarding the service to be rendered. With regards to the scenario above, the Act requires for the anaesthetist to have informed Mr X about the fees he would be charged for the services provided.

Occupational Health and Safety Act

The management of a hospital decided that due to budgetary constraints the hospital will only provide one set of personal protective equipment (PPE) per month for anaesthetists. There

are huge concerns among anaesthetists regarding the risk of contracting a contagious respiratory disease.

How can the anaesthetists apply the Occupational Health and Safety Act to notify the hospital management that the hospital is obligated to provide PPE for the employees?

The Occupational Health and Safety Amendment Act No. 181 of 1993²⁴ provides that the employer must “identify the hazards and evaluate the risks associated with such work constituting a hazard to the health of such employees, and the steps that need to be taken to comply with the provisions of this Act”. The employer is required by the Act to evaluate the risks associated with the anaesthetists contracting a contagious respiratory disease at work. The Act further requires that the employer must “as far as is reasonably practicable, prevent the exposure of such employees to the hazards concerned or, where prevention is not reasonably practicable, minimise such exposure.”²⁴ With regards to the scenario above, the PPE would be considered a reasonable measure to prevent or minimise the employee's exposure to the respiratory disease, and therefore, the hospital has an obligation to provide such PPE.

Protection of Personal Information (POPI) Act

Mrs A is shocked to see her pictures in a medical journal she was sent by her cousin who is a doctor. She realises that the pictures could have been taken when she went for a surgical procedure two months ago. She remembers the doctors in her care talking about publishing an article about her condition. However, none of the doctors had asked her for permission to obtain her photographs nor to use them in a publication.

How can the POPI Act be applied to outline Mrs A's rights in this situation?

Section 11 (1)(a) of the POPI Act²⁵ requires that “personal information may only be processed” if the person consents to the processing of such information. In the scenario above, consent was not obtained from Mrs A, therefore, the inclusion of Mrs A's pictures in the journal is an infringement of the POPI Act. The POPI Act²⁵ further provides guidance with regards to the lawfulness of processing personal information. The Act provides in section 9(b) that “Personal information must be processed in a reasonable manner that does not infringe the privacy of the data subject.”²⁵ Mrs A's pictures published in the journal could be identified by her cousin, meaning that her information was processed in a manner that violated her privacy.

The POPI Act²⁵ further provides in section 8, for the party responsible for the processing of personal information, to ensure the conditions for lawful processing as provided in the Act are upheld. The party responsible for handling Mrs A's pictures should have taken measures to ensure that conditions set out in the Act are complied with at the time of the determination of the purpose (in this case publication) and during the processing itself.²⁵ The responsible party should have ensured that a consent is obtained from Mrs A, the purpose of the pictures is explained

to her and that measures to ensure her privacy are undertaken. Section 13(1) of the Act provides that “personal information must be collected for a specific, explicitly defined and lawful purpose related to a function or activity of the responsible party”.²⁵ The Act further specifies in section 13(2) that “Steps must be taken in accordance with section 18(1) to ensure that the data subject is aware of the purpose of the collection of the information...”²⁵ In the case of Mrs A, she was not made aware of the specific purpose of the collection of her pictures.

Section 18(1) of the Act provides that “If personal information is collected, the responsible party must take reasonably practicable steps to ensure that the data subject is aware of...(a) the information being collected...” and (c) “the purpose for which the information is collected”.²⁵ Mrs A was not notified by the responsible party that her pictures were collected for a publication, and therefore, her rights were infringed.

Conclusion

The law and ethics have an influence on the practice of anaesthesia, as it does all other departments of medical practice. Knowledge of the law and ethical principles pertaining to anaesthesia is important. This article attempted to provide a brief application of the laws affecting anaesthetic practice in SA, using cases to apply the law in a practical manner. Clinical scenarios such as consent, death, wellness and occupational safety, which may be influenced by the law, were analysed. Ethical dilemmas such as futility of treatment and an impaired colleague were also analysed. It is important for anaesthetists to familiarise themselves with ethicolegal aspects that may have an influence on their practice.

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ORCID

HJ Moutlana  <https://orcid.org/0000-0002-7944-5613>

ME Sethusa  <https://orcid.org/0000-0002-9857-164X>

KS Matlala  <https://orcid.org/0000-0003-1995-8713>

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