



# Life Esidimeni psychiatric patients in Gauteng Province, South Africa: Clinicians' voices and activism – an ongoing, but submerged narrative

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After the first 45 days and beyond, the Life Esidimeni (LE) debacle may be slipping from public awareness. Despite ample evidence of clinicians' attempts to communicate their concern about this, as well as active steps to try to prevent it prior to the termination of the contract with LE, the question to South African doctors of 'What have you been doing about this?' has again been raised by some role players. This made it necessary to consider the notion of a 'submerged clinicians' narrative' in terms of the facts regarding: (i) the actual involvement of individual clinicians and professional societies collectively; (ii) individual doctors' responsibility as clinical decision-makers; (iii) other examples of clinicians' ongoing and repeating narrative; and (iv) possible conflict of interest between clinicians' relationships with their patients, and as employees, with a third party, whether a state or private employer or funder. Considering the evidence available, it does seem that despite a sustained level of communication and action by clinicians, and in particular by psychiatrists, on this matter, their communication and activism largely remained submerged, and as such, outside of public awareness and acknowledgement by politicians and managers, who were in all instances the final decision-makers on clinical matters pertaining to these patients.

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Having passed the first 45-day benchmark, as well as the extended period granted to the end of May 2017, after the release of the health ombudsperson's report,<sup>[1]</sup> the Life Esidimeni (LE) debacle may be slipping from public awareness. The report included several recommendations, including numbers 11 and 13 (pages 54 - 55),<sup>[1]</sup> which required that all patients still residing in listed illegal non-governmental organisations (NGOs) must be moved back to suitable locations.

When this process started early in February 2017, one of the psychiatrists attending the meeting was asked what she, as a clinician, had personally done to prevent the moving of these patients from LE. What made this question unexpectedly ironical was that it was asked of the doctor who, as the convener of the public sector group of the South African Society of Psychiatrists (SASOP), had in April 2015 already actually focused the initial communication between clinicians and decision-makers on possible alternatives to the decision to terminate the LE contract. She had also, as a director of SASOP's board, supported the uniform decision in December 2015 that SASOP should engage, with others and led by Section 27, in the legal action against the Gauteng Department of Health (GDoH). This was unusual, as it represented the first incident where this body of professionals took a state department, as its employer, to court, in order to oppose such a unilateral decision.

The first court hearing resulted in a recommendation to settle differences outside of court by the end of January 2016, with the GDoH agreeing that the same level of care would be ensured for LE patients, if moved. This settlement did not happen though, owing

to failure by the GDoH to produce additional information on the process. However, when it was realised that the first patients were being moved, Section 27 returned to court in March 2016, to apply for an interdict to prevent this. The GDoH was, however, able to convince the court that they were still honouring the original agreement, and the application was dismissed.

The GDoH proceeded with their now infamous 'marathon project' in arrogance, and in particular, with specific disregard for the opinions of individual and collective clinicians, several of whom were also employed by the GDoH. This included the doctor referred to above, faced with the question about her personal involvement. This same doctor was subsequently invited to join the health ombud's expert panel, appointed in October 2016, to investigate the first reported deaths of patients, and as a main contributor, she concluded the panel's reporting back to the ombud in November 2016.

The final component of the irony of this question being asked of this doctor was that it was in fact posed by the national minister of health, Dr Aaron Motsoaledi himself, who also appointed her on departmental task teams to remove the LE patients from NGOs, but apparently was not aware of either this colleague's particular personal track record, or of SASOP's collective involvement in the whole LE saga since its beginning.

## Discussion

To consider the notion that the clinicians' narrative regularly remains 'submerged' in this and similar situations, it is important to look at

the facts regarding: (i) the actual involvement in the LE incident of individual clinicians and professional societies collectively; (ii) individual doctors' responsibility as clinical decision-makers; (iii) other examples of clinicians' ongoing and repeating narratives; and (iv) possible conflict of interest in clinicians' relationships with their patients as employees of a third party, be it in the state or private healthcare system.

### **Clinicians' voices in the LE incident, individually and collectively**

Judged from this individual psychiatrist's quoted experience, it appears as if the role that clinicians in general, and psychiatrists in particular, played in the LE matter has indeed been submerged throughout this ongoing process of more than 18 months, and therefore has also escaped the awareness of other role players. Despite documented evidence of clinicians' attempts to communicate their concern, as referred to by the health ombud's report,<sup>[1]</sup> the question to South African (SA) clinicians as to 'What have you been doing?' has indeed also been asked by SASOP's own members, by the World Psychiatric Association (WPA), as well as possibly by the public and others.

### **SASOP's involvement: Psychiatry's and psychiatrists' social contract**

SASOP's involvement in the LE incident included alerting the South African Depression and Anxiety Group (SADAG) and requesting their involvement in September 2015; arranging consultative meetings with role players in SASOP's adopted programme of the psychiatry and psychiatrists' social contract,<sup>[2,3]</sup> including different advocacy groups, in August 2015, and professional societies involved in the multidisciplinary team in October 2015; issuing a position statement on the closure of LE in December 2015, prior to being a respondent in the court action undertaken to prevent the transfer of patients without a proper plan, in March 2016; several individual SASOP and SASOP board members' personal participation in the health ombud's investigation in October and November 2016; and individual members' efforts, in a line-function capacity, to deal with the daily increased demand on additional services.

### **The South African Medical Association (SAMA)**

SAMA released two media statements, one in September 2016 following input from its Human Rights, Law and Ethics Committee before the SAMA National Council,<sup>[4,5]</sup> and the second in February 2017 following the release of the health ombud's report. SAMA condemned the GDoH for ignoring the concerns that had been expressed by representatives of the medical and psychiatric fraternity, and in particular, by SASOP, South African Depression and Anxiety Group (SADAG) and the South African Mental Health Federation (SAMHF).

### **Other professional groups**

In a letter dated 18 January 2016, the Psychological Society of South Africa (PsySSA) forwarded written concerns to the then-Gauteng Member of the Executive Council (MEC) for health about the planned closure of the LE facilities.

Other groups of concerned clinicians, represented by Rural Rehab South Africa, People's Health Movement SA, the Treatment Action Campaign (TAC), the Public Health Association of SA's Mental Health Special Interest Group and SAMA's Junior Doctors Association of SA (JUDASA) also issued statements of concern and open letters during September and October 2016, insisting on answers from the Gauteng MEC at the time.<sup>[6,7]</sup>

### **Gauteng clinicians' communication through line-function channels**

During April 2015, through a memorandum to the director of the Gauteng Directorate of Mental Health, the different clinical heads of the three specialised hospitals in Gauteng, more than 10 heads of psychiatric departments and units in other Gauteng hospitals, as well as the academic heads of psychiatry departments at the University of the Witwatersrand, the University of Pretoria and Sefako Makgatho University sought an appointment with the Gauteng MEC to express concern about the plan. Several GDoH managers were copied in this letter, including the chief director for planning and the chief financial officer.

During July 2015, clinicians reported on the state of affairs regarding mental-healthcare services in the Charlotte Maxeke Johannesburg Academic-Hospitals (CMJAH) cluster.<sup>[8]</sup>

Subsequently, ongoing problems have been pointed out in communications between clinicians and their respective executive managers at different hospitals, such as South Rand, Helen Joseph, Chris Hani-Baragwanath Academic and CMJAH. There seems to be a specific manner in which communication by clinicians through the line-function channels available to them gets submerged – by inadvertently dropping mental-healthcare issues from agendas, priority lists and funding, and omitting them from forums where opportunities might arise to resolve these challenges in a systematic way.

### **Faculties of health sciences**

While the Faculty of Health Sciences at the University of the Witwatersrand (Wits) only discussed the matter internally at their faculty board meeting in February 2017, the Faculty of Medicine and Health Sciences of SU issued a public press statement, signed by several members of the deanery and executive HODs.<sup>[9]</sup>

Similarly to the previous Gauteng health MEC, who denied that she had ever received the letter from SASOP, or a follow-up letter in October 2015, it was also reported that the premier of Gauteng, Mr David Makhura, stated that he was unaware of a letter from the Wits class of 2016 occupational therapy students, appealing to authorities not to close Waverley Care Centre.<sup>[10,11]</sup>

### **Individual doctors' responsibilities as clinical decision-makers**

There are two matters regarding individual doctors' actions and responsibilities reported on in the health ombud's report that must also be further explored. The first is the content included in paragraph 4.1.5 of the report as 'The voices of LE staff' (pages 8 - 9), and the second pertains to a statement made by the Gauteng MEC of Health at the time, with regard to advice she received from psychiatrists (pages 15 -16).<sup>[11]</sup>

### LE staff

From their statements to the health ombud, the medical practitioners employed by LE at the time noted that they were 'not comfortable' with the decision: one doctor resigned out of conscience; the others were 'trying their best under trying circumstances and against their consciences and better judgements', while 'not having a choice'. They also referred to the chaotic transfer process.

The question as to whether doctors at LE discharged or transferred patients alludes back to a dismissed interdict application in March 2016, where the presiding judge commented on the distinction that must be drawn between the 'discharge' and 'placement' of mental healthcare users. He noted that users are only 'discharged' once they have been assessed by a 'qualified professional', deemed fit to be cared for by their family and no longer in need of services, while mental health care users are transferred as a 'placement', on the basis of a determination that they remain in need of services.<sup>[12]</sup>

It can be concluded that it is very unlikely that these doctors would have thought that all these long-term patients' mental-health status had suddenly changed from requiring 'assisted' mental healthcare for several years, to that of 'voluntary' healthcare users, who have somehow overnight regained their capacity to make informed decisions. Also, any 'discharging' of patients that might have happened only occurred with the assurance from GDoH officials that they would be transferred to equivalent care facilities.

### Advising psychiatrists

The previous health MEC reported to the health ombud that she was advised 'by Dr Sokudela and Dr Madigoe' that 'patients need to be discharged in phases' (page 15).<sup>[11]</sup> She also argued that 'in all meetings none of the psychiatrists raised these concerns (about moving patients too rapidly) with her' (page 16).<sup>[11]</sup> One has to assume that she still referred here to Drs Sokudela and Madigoe, as she never met with SASOP during this period. She only requested a meeting with SASOP after critical reports were received about her not meeting with professionals with opposing views. It may therefore be necessary to further explore how these named colleagues actually advised the MEC and others of the GDoH at the time.

### Other examples of clinicians' ongoing, repeating narratives and tasks

Reflecting on other historic examples of where clinicians' voices and activism might have been ongoing, but submerged, the following come to mind:

- **The apartheid era and Steve Biko:** In this first example, the submerging of clinicians' narratives required the irrational component of white supremacy as an ingredient, with the official and public approach acquiring a specific denialist and delusional quality.<sup>[13,14]</sup>
- **The AIDS and antiretroviral denial period during the 1990s:** In a similarly irrational manner, in this instance an African traditional alternative approach, flying in the face of medical knowledge, was opposed by many groups of clinicians at the time. Overy<sup>[15]</sup> describes the different strategies that the TAC followed in its ongoing campaigns for access to antiretroviral (ARV)-treatment, including litigation via the courts. One such case was about the right of access to public health services, and children's right to be afforded special protection,<sup>[16]</sup> as considered by the

Constitutional Court.<sup>[17,18]</sup> Jobson<sup>[19]</sup> refers to Dr Colin Pfaff who, in 2007, implemented the knowledge that dual therapy is superior to monotherapy in prevention of mother-to-child transmission of HIV in reducing viral transmission rates, in mothers 28 weeks pregnant in rural KwaZulu-Natal, prior to its subsequent acceptance as a treatment guideline. He was charged at the time with misconduct and acting unlawfully, despite of support by the Rural Doctors' Association of SA and the SA HIV Clinicians' Society.

- **Stigma and poor prioritisation of mental healthcare:** Ahmedani<sup>[20]</sup> comments that mental-health stigma operates in society, is internalised by individuals and is contributed to by health professionals, while Sartorius<sup>[21]</sup> notes that stigma makes even community and health decision-makers hold people with mental illness in low regard, resulting in their reluctance to invest resources into mental healthcare. The stated core incentive of the GDoH to move patients from LE to 'save money' has been pursued with such disregard for the basic needs and human rights of mental healthcare users that it can be regarded as having assumed a similar irrational quality to the two historical examples above, where contact was indeed lost with what should have been a reasonable approach to mental healthcare prioritisation.

### Dual loyalties and human rights

On the question of whether clinicians' voices and activism have become a submerged narrative as far the LE psychiatric patients are concerned, one is reminded of the group Physicians for Human Rights and the School of Public Health and Primary Health Care at the University of Cape Town (PHR, and SPH and PHC). They have produced a comprehensive report and guide on the need for clinicians to take decisive action in cases of human-rights abuses of their patients.<sup>[22]</sup> In Chapter V<sup>[22]</sup> of their guide, they identify several institutional mechanisms through which to promote human rights by stakeholders, including national professional organisations (e.g. SASOP); international professional organisations (e.g. WPA); statutory bodies; civil society; government itself; and training and research institutions.<sup>[22]</sup> With regard to the proposed activities that national professional organisations should be considering, PHR, and SPH and PHC list a number of actions to be taken.

Considering this list in the context of the LE experience, and noting the pre-empting at the time of the subsequently appointed health ombudsperson, several of these were pursued in this matter by different individual clinicians and professional groups.

### Institutional mechanisms to promote human rights that national professional organisations should undertake to implement<sup>[22]</sup>

'(1) Establish professional practice standards that address the problem of dual loyalty and human rights for across a wide spectrum of practice settings and situations; (2) Where violations of professional standards take place, hold members accountable to these standards through appropriate disciplinary action; (3) Facilitate adoption of self-audits by health services to complement application of standards. Special audits can be commissioned in various settings; (4) Make available advisers and counsellors skilled in human rights and ethics to health professionals practising in circumstances where problems of dual loyalty and human rights arise; (5) Provide direct support for health professionals in high-risk situations, (e.g. prison healthcare,

occupational health, military medicine) under the auspices of the professional association; (6) Establish or facilitate an independent oversight and reporting structure to play a monitoring and/or ombudsman role; (7) Issue newsletters and create websites to raise awareness in the professions and the public, and conduct ongoing debate on dual-loyalty problems in a range of vehicles, such as journals and professional meetings; (8) Initiate and support ongoing ethical and human-rights training that addresses the problem of dual loyalty and human rights; (9) Ensure that constitutions of national professional organisations establish the organisation as independent of the state and of state policy; (10) Submit shadow reports on national reports to United Nations treaty-monitoring bodies for human-rights treaties such as the Convention Against Torture and the Covenants on Civil and Political Rights and Economic, Social and Cultural Rights on issues concerning dual loyalty and human rights; (11) Advocate for legal, administrative and social changes that will enable health professionals to respect, protect and fulfil the human rights of their patients; (12) To implement many of the above mechanisms, national associations may have to develop plans and invest resources to increase members' support for these organisational actions.<sup>1(22)</sup>

## Conclusion

Despite an unprecedented and sustained level of communication by clinicians on this matter, it still seems, however, that clinicians' communication and activism in this regard did remain largely submerged and, as such, stayed outside of public consciousness and of the official awareness of the politicians and managers, who were the final decision-makers on such clinical matters.

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