GUIDING NEWS FOR SOUTH AFRICA’S HEALTHCARE PROFESSIONALS

EUTHENASIA
WE EXPLORE ETHICS AROUND THE RIGHT TO DIE

TRADITIONAL HEALERS
ABOVE ALL, DO NO HARM

PRIVATE HEALTHCARE MARKET
COMPETITION COMISSION INQUIRY

GUIDELINES FOR INFORMED CONSENT

VOLUNTEERS Responding to emergencies

FIND OUT MORE: NEW BOARDS | NHI EXPLAINED | WONDERLAND OF HEALTH APPS | NEW TECHNOLOGY
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The Bulletin provides a voice to the healthcare professions in South Africa, tackling topical issues and providing a platform for engagement.

2016

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FROM THE EDITOR

Dear Practitioners,

Each year, South Africa makes great strides in improving the health status of the nation. Often working under stressful conditions and in challenging situations, South Africa’s healthcare practitioners are known for their professional conduct and compassion. We salute those who go above and beyond the call of duty each day to serve the people whose health has been entrusted to them.

Not only are our healthcare professionals working to save lives in South Africa each day, but they are also engaged in international missions to some of the most dangerous regions in the world. In this issue we tell the story of the Gift of the Givers Foundation and its evolution into Africa’s most effective disaster response agency founded Imtiaaz’s blow-by-blow account of the Foundation and its evolution into Africa’s most effective disaster response agency.

It’s been an eventful year at the HPCSA as the organisation strives to fulfill its mandate to protect the public by establishing a solid policy framework to ensure that healthcare professionals have quality training to practise competently and ethically. In this issue, we discuss how the newly established Inspectorate Office can assist practitioners to understand how this function is critical to maintaining the reputation of the entire profession.

We are committed to building a future for all healthcare professionals. We are committed to building a future for all healthcare practitioners and ensuring that all newly qualified practitioners are registered at the beginning of each year before embarking on their new careers. This campaign also assists with reducing the traffic flow to the HPCSA office. HPCSA is currently investigating ways of developing an online registration system that will ensure an efficient and effective registration process.

Amongst others, Council’s responsibility is to ensure that the education and training standards of accredited institutions within the country are of high quality. HPCSA is delighted to have been part of the process of accrediting the newly established Sefako Makgatho Health Sciences University. The University, provides an excellent opportunity for the development and training of a new generation of health professionals who will make a positive impact on the lives and livelihoods of many South Africans.

We bid farewell to the outgoing Professional Board members, whose term of Office was for the period 2010 to 2015. We welcome the appointment of new board members, new Committees and Council members. I am also delighted to inform you of the new President, Dr Kgosietsile Letlape and his Vice-President, Mr Arnold Malotana. I believe together we will steer HPCSA to great heights.

I take this opportunity to thank the outgoing board members for their sterling job and valuable contribution they have made in ensuring that the HPCSA achieves its mandate. To the new board members, I extend a warm welcome. I hope that this will be a fruitful tenure and I wish you all the best.

Connie Parasuraman
EDITOR’S SECRETARY

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THE BULLETIN

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To the right patient, at the right time, placed right, at the right time.

Why queue for your medication when Medipost can deliver it free of charge?

GET YOUR CHRONIC MEDICATION NOW

Get your chronic medication in 4 easy steps!

1. Fax your prescription and contact details to 0866 488 446 or contact us on 012 426 4000.
2. A friendly pharmacist will contact you to confirm your delivery date and delivery address.
3. Your medication is delivered free of charge to your address of choice!
4. Sit back, relax and enjoy the good life - because with Medipost there are no long pharmacy queues!
Digital technology creates an ever-changing landscape in healthcare with exciting possibilities.

By Mari Hudson

ew apps and other digital advances can now easily unlock access to information for both healthcare provider and patient. For a brief moment, imagine yourself to be Alice, and we’ll give you a peep into Digital Wonderland.

In this digital age, the keys to a new view on healthcare are often as magical as in Alice’s Wonderland; it’s really at the tip of your fingers: the downloading of an app, the press of a button on your keyboard, your fingers on a touchscreen.

Let’s show you what’s hiding behind four doors to illustrate new ways new technology can make your life a bit easier. This is merely to inspire you to explore further.

**DOOR ONE:** Find and book an appointment with a healthcare practitioner online.

**RecoMed** is the leading online platform dedicated to helping patients easily find and book healthcare practitioners online.

RecoMed works closely with practitioners to create an online profile, much like a website, that includes all the information a patient needs to make an informed healthcare decision. To date, hundreds of practitioners and thousands of patients are enjoying increased access to healthcare by using www.recomed.co.za.

**DOOR TWO:** When you don’t know who to call, **mySOS** can help.

One of the unfortunate realities of life is that emergencies do happen—and the sooner help arrives, the better.

Locally developed emergency mobile app, **mySOS**, has partnered with **myStroke** and EP24 in a new initiative to give patients with suspected strokes the best help available in the quickest amount of time possible.

The **myStroke** initiative, funded by Boehringer Ingelheim and endorsed by the South African Stroke Society, has successfully supported the establishment of stroke units throughout South Africa, 61 of which have registered on www.myStroke.co.za as facilities that are able to provide specialist stroke care.

A further 40 hospitals are setting up the system and are due to go live within the next six months. This is how **mySOS** can help you.

One-button emergency activation—On starting **mySOS** an automatic countdown timer starts, if this is not cleared, **mySOS** will automatically notify your emergency contacts with details of the emergency and location.

Emergency—This function offers a list of contact details for the closest and most appropriate emergency service-providers based on the nature of your emergency (medical, police, fire, sea rescue or roadside assistance). **mySOS** also notifies your emergency contacts about the incident and your location.

Find Near Me—This helps you find and navigate to the nearest service-provider for the service you need. This includes hospitals, doctors, pharmacies, dentists, police stations and also veterinary services for your four-legged friends.

**DOOR THREE:** An app to reduce unnecessary visual impairment and streamline eye care referrals. **Vula Mobile** is a medical referral platform that allows health workers and medical specialists to communicate directly and instantly, which speeds up the referral process while ensuring accuracy and privacy when sharing patient health information.

In a world where 60% of all visual impairment can be prevented or cured, getting patients quality assessment and the service you need. This includes hospitals, doctors, pharmacies, dentists, police stations and also veterinary services for your four-legged friends.

**DOOR FOUR:** Help HIV clinicians to provide excellent quality of care. **Aviro HIV Mentor** is built for clinicians. This ART treatment mentor is a decision support tool for HIV clinicians. Using the recommended South African HIV Guidelines, the **Aviro HIV Mentor** provides real-time, immediate feedback and guidance for the clinician so that excellent and reliable care can be delivered to every patient.

Built and designed by a team of experts, the **Aviro HIV Mentor** provides step-by-step guidance as clinicians interact with patients. This allows them to follow the correct guidelines and provides them with a procedural checklist that ensures quality of care.

The app includes input for adults, paediatrics and pregnant mothers, and provides information on antiretrovirals, viral loads and drug interactions. The app also has calculators for螳
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THE NHI MODEL EXPLAINED

The White Paper on the National Health Insurance (NHI) scheme presented to Cabinet looks set to overhaul the South African health system. The NHI White Paper details plans about the provision of universal healthcare to all South Africans by 2030.

by Dr Aquina Thulare

Although some sectors remain sceptical about NHI, Health Minister Aaron Motsoaledi is adamant it’s the only way to provide equitable healthcare to rich and poor -- making valuable contributions to the country’s economic and political stability. But how will it work?

Pillar 1 interrogates the descriptive framework, policy objectives, health financing policy analysis and viable options for reform. It asks the question: where are we starting from? And it analyses the consequences of inequity in the distribution of healthcare services.

Pillar 2 interrogates health financing policy analysis and viable options for reform. It asks: where should we go? Using the NDP 2030 as a framework, it aims to determine the impact of universal healthcare coverage on the population.

Pillar 3 interrogates the stewardship of financing, governance, regulation and provision of information. It asks what kind of vehicle can we afford to get us there? How far and how fast?

The National Development Plan (NDP) 2030 envisions a health system that works for everyone and produces positive health outcomes, and is accessible to all.

The NDP Vision says that by 2030, South Africa should have:

• Significantly reduced the social determinants of disease and adverse environmental factors.
• Achieved universal coverage.
• Produced a generation of universal healthcare for all citizens.

The scheme will be implemented in three phases, to see free quality healthcare become effective by 2030. Motsoaledi said South Africa’s public and private healthcare systems required reorganisation in order to ensure access affordable care for all citizens.

Motsoaledi said the private healthcare sector was “simply unaffordable” and that the public health sector was struggling to provide quality services.

To view the document, visit the HPCSA website at http://www.hpcsa-blogs.co.za/nhi-white-paper/

WHITE PAPER FOR PUBLIC COMMENT

The National Health Insurance (NHI) is a health financing system designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status. NHI is intended to ensure that the use of health services does not result in financial hardships for individuals and their families.

NHI is aimed at ensuring that:
• All South Africans have access to quality healthcare irrespective of their socio-economic status.
• From each according to ability to each according to need.
• Health services are delivered equitably.
• The population does not pay for accessing health services at the point of use.
• The population has financial risk protection against catastrophic health expenditure.

WHAT WILL A NATIONAL HEALTH INSURANCE MEAN FOR SOUTH AFRICA?

The National Health Insurance (NHI) was approved by Cabinet looks set to overhaul the South African health system.

The White Paper on the National Health Insurance (NHI) scheme presented to Cabinet looks set to overhaul the South African health system. The NHI White Paper details plans about the provision of universal healthcare to all South Africans by 2030.

by Dr Aquina Thulare

The White Paper on the National Health Insurance (NHI) scheme presented to Cabinet looks set to overhaul the South African health system. The NHI White Paper details plans about the provision of universal healthcare to all South Africans by 2030.
The design of a NHI is based on the following guiding principles:

- **Right to access healthcare in line with Section 27 of the Bill of Rights of the Constitution**
- **Social solidarity**
- **Equity**
- **Health care as a public good**
- **Affordability**
- **Efficiency**
- **Effectiveness**
- ** Appropriateness.**

The equity and solidarity principles in pooling finances and risks result in the affluent subsidising the poor and the young and healthy subsidising the old and sick. This is the most equitable system, since the entire population is at risk of experiencing the need for healthcare at some stage of their lives.

The NHI will establish entitlements and obligations for the population: entitlements—services available to covered population; and obligations—responsibilities to be met by the covered persons in order to obtain the benefits (e.g. referral, treatment protocols and clinical guidelines as well as other rules governing rational use of health services).

NHI will cover a comprehensive list of services, including:

- Preventive, community outreach and promotion
- Reproductive health
- Maternal health
- Paediatric and child health
- HIV/AIDS and tuberculosis
- Health counselling and testing
- Chronic disease management
- Optometry
- Speech and hearing
- Mental health including substance abuse
- Oral health
- Emergency medical services
- Prescriptions medicines
- Rehabilitation care
- Palliative services
- Diagnostic radiology and pathology.

Hospital service coverage must include:

- Emergency medicine
- Internal medicine
- Family medicine
- Psychiatry
- Obstetrics and gynaecology
- Paediatrics and neonatology
- Surgery
- Anaesthesia
- Urology
- Orthopaedics
- Oncology
- Ophthalmology
- Radiology
- Pathology
- All sub-specialties.

**PURCHASING OF HEALTHCARE SERVICES**

The NHI will have public and private healthcare providers accredited according to clearly stipulated criteria.

Active purchasing of healthcare services are focused on the following:

- Ensuring that all personal health services are free at the point of care and that the population is guaranteed financial risk protection at all times.
- Giving incentives to providers for performance on efficiency, health outcomes and quality.
- Gatekeeping at primary and higher levels of care will be implemented in the following way:
  - Upward and downward referral system
  - Leverage economies of scale and use purchasing power to ensure affordability and long-term sustainability
  - Centralised procurement of key resources.

The ultimate aim of the NHI is to provide the population of South Africa with free healthcare when they need it, to encourage the expansion of primary healthcare services, to create fairness in the sharing of skilled healthcare professionals, healthcare finances and other resources. The government aims to achieve a healthier nation, where people live longer and are economically and socially productive.

When it comes to financing, we should not get caught up in terminology. Worldwide universal health systems are classified according to functions and policies for collection, pooling, purchasing, and delivery capacities.

- To better and more effectively mobilise and control the key financial resources in the health sector so as to adequately and sustainably enhance the strengthening of the under-resourced and strained public sector. This is directly linked to the State’s irresponsibility to proactively realise the right of all to access affordable healthcare services and the need for improved efficiency in the delivery of healthcare.
- To enhance the role of the health sector in improving the social and economic welfare of the population.

NHI seeks to transform the financing of the health system in pursuit of the goal of universal health coverage. Implementation of NHI will be based on the principle of the right of all citizens to have access to quality health services that are delivered equitably, affordably, efficiently, effectively and appropriately based on social solidarity and health as a public good. In moving towards universal health coverage, NHI will extend population coverage, improve the quality and quantity of services that the covered population will be entitled to, as well as reducing the direct costs that the population will be exposed to when accessing healthcare. This will protect individuals and households from out-of-pocket expenses and financial catastrophe related to healthcare. NHI will provide cover to co-entitlement health services that are delivered comprehensively and based on scientific evidence.

While there are many challenges in the road ahead, the rewards will be well worth it. In the sinews of the new health system, we will see the inefficiencies of the old system fall away, and at the same time, we will see the health of the nation improve as we take ownership of our own health and make the necessary sacrifices to ensure that every South African has access to quality healthcare from cradle to grave.
The Gift of the Givers organisation initially began as a medical supply facility in 1992. Today it provides much more as volunteers respond to global emergencies writes Dr Imitiaz Sooliman

**SOUTH AFRICA’S GIFT OF MERCY AND COMPASSION**

The Gift of the Givers organisation initially began as a medical supply facility in 1992. Today it provides much more as volunteers respond to global emergencies writes Dr Imitiaz Sooliman.

It was a hot summer’s afternoon in July 2011. A temporary outdoor clinic was hastily set up. Medical teams avoid patient registration 30 metres away. But with a difference; they were being checked to identify possible suicide bombers. We were in Mogadishu, reputedly the most violent city on Earth, wrote Imtiaaz Sooliman, founder of the Gift of the Givers Foundation.

This was just one of the challenging situations faced by the volunteers of Africa’s most effective disaster response agency.

Friday afternoon on 19 April 2013, theatre teams took cover under the operating table as surgeons frantically tried to “close” the patient to the sound of gunshots inside Darouss Hospital and a staccato of gunfire in the street outside. Missiles have struck the mountain above the hospital, bombs have fallen around the hospital. This is Syria, hell on Earth.

November 2013, a paramedic search-and-rescue team braves choppy seas and shark-infested waters at great risk to themselves, to rush to the island of Palompon, almost destroyed by Typhoon Hayan. Time is of the essence. These are South African medical and search-and-rescue professionals, highly skilled, brave, disciplined and charged with the spirit of ubuntu.

Gift of the Givers missions are about faith, commitment, dedication and unconditional service. We believe in professionalism, discipline, quality care and the annihilation of all ego. “Nobody is better than the next person, the team is our first priority. There is no hierarchy system. There is leadership, but everyone pulls their weight. Flexibility, adaptability, a cool temperament, calmness and respect of the religious values of the others are all core ingredients possessed by our volunteers.”

“Humility is a virtue possessed by all our team members. We carry the flag, we represent South Africa, we represent the African continent, we carry the spirit of ubuntu. This is more than just medicine; this is humanity and spirituality combined. This is about our honour as South Africans and Africans.”

It all started in Turkey on 6 August 1992. On a Thursday night after a “zikr” – a chanting of the Names of the Almighty - a spiritual teacher and a suf master looked me in the eye and said: “My son, I’m not asking you, I’m instructing you. You will form an organisation, the name will be Gift of the Givers. You will serve all people of all races, of all religions, of all colours, of all classes, of all cultures, of any geographical location and of any political affiliation, and you will serve them unconditionally. You will not expect anything in return, not even a thank you.

“You will serve them with love, kindness, compassion, mercy and remember the dignity of man is foremost. Feed the hungry, quench the thirsty, clothe the naked, wipe the tear of the grieving, caress the head of the orphan and say words of good counsel to the widow. In whatever you do, be the best you can be, not because of ego but because you are dealing with human life.”

This was the beginning of a...
mission that has resulted in a most amazing journey. Disaster response is our speciality, but in a period of 23 years, we have established 21 categories of projects and have delivered R4.1 billion in aid to 42 countries, South Africa included. The medical missions commenced initially with the supply of medicines, medical disposables and medical equipment only. Then came the first innovation. In collaboration with a South African company, we designed the world’s first containerised mobile hospital. A unique facility, this product of South African engineering ingenuity, developed, designed and built in Pretoria, was deployed in Bosnia in 1993. This saw an African team assisting Europe through a feat of South African engineering prowess. The CNN commentator, on 1 February 1994, stated that the container hospital was equal to any of the best hospitals in Europe. In 1994, came another innovation, the world’s first containerised primary healthcare units.

It was only in 2004 that we introduced medical teams. This was in response to the tsunami in Thailand. Then they were later deployed in Hatun, a coastal village on the east coast of Somalia. This was a primary health team comprising of paediatricians, general practitioners and nurses. In 2005, came a further development, the deployment of a trauma team, including orthopaedic and general surgeons, anaesthetists, ICU doctors and nurses, in response to the massive earthquake in Pakistan.

Our South African medical team converted a decommissioned hospital into a 400-bed emergency hospital in 24 hours, performing 75 operations each day. We followed this up with post-op rehabilitation by deploying logistic and medical teams to the tsunami-affected areas in Sri Lanka, Thailand, Indonesia, India, Pakistan, and for South Africa.

In the months to follow, two more floors were added to our Ar Rahmah Hospital in Darkoush, Syria, where we now have 180 personnel servicing the hospital. This has become the largest and most effective search-and-rescue team in all North Syria. Recently, we received 1 700 casualties in 10 days. In Palompon, Philippines, the paramedic team, “saved” a hospital by renovating the entire top floor, which had been destroyed. They replaced 1 000m2 of roof in just four days.

All credit goes to the medical and paramedic teams, medical equipment, medical supplies, medicines, vaccines, anti-malarial medication, high energy and protein supplements, food and water to millions of people in 31 countries.

Gift of the Givers has delivered life-saving aid in the form of Search and Rescue teams, medical personnel, medical equipment, medical supplies, medicines, vaccines, anti-malarial medication, high energy and protein supplements, food and water to millions of people in 31 countries.

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Katmandu, Nepal. Dr Sooliman as part of the team responding to the magnitude 7.8 earthquake in April 2015.
The Competition Commission (CC) started a market inquiry into the private healthcare sector in September 2013. Now focusing on further information gathering and assessment, the inquiry is well under way. The Commission is at pains to state that “the market inquiry is a general investigation into the state, nature and form of competition in a market, rather than a narrow investigation of a specific conduct by any particular firm. The Commission has initiated an inquiry into the private healthcare sector because it has reason to believe that there are features of the sector that prevent, distort or restrict competition.”

“The Commission further believes that conducting this inquiry will assist in understanding how it may promote competition in the healthcare sector, in furtherance of the purpose of the Act.”

The key areas of the inquiry relates to the hospital market, the provider market, the funder market and the patients’ perspective. Medical technology and medicines are also within scope. The three listed hospital groups have said to dominate the private hospital market, although none has a market share of more than 35%. Health Minister Aaron Motsoaledi contends each is able to exercise dominant market power at provincial or district level. The inquiry began in May 2014, and two sets of formal written submissions have been called for, with deadlines set for in October 2014 and in March 2015. Following the submissions and responses received, were sent further information requests to over 160 stakeholders in the private healthcare sector. This was to allow the team to conduct detailed inquiries into the potential healthcare access and competition concerns highlighted in submissions and the Statement of Issues (SoI).

On 16 October 2015, the Commission published, in the Government Gazette, the amended Terms of Reference (ToR) for the completion of the market inquiry into private healthcare. The Commission has also published a revised administrative timetable on its website. The inquiry has to date received large volumes of data and information from stakeholders and the team has spent significant time meticulously analysing the data and information. However, in light of the extent of this inquiry and delays experienced in accessing information from certain stakeholders, the Commission has decided to amend the completion date. In terms of the amendment, the final report, which may include recommendations, will be completed by 15 December 2016. The scope of the inquiry remains unchanged. The inquiry intends to publish further details on the venues and subject matter of the public hearings scheduled for 1 February 2016 to 31 May 2016 in due course.

Further details regarding the revised administrative phases are available on the Commission’s website: http://www.compcom.co.za/healthcare-inquiry

The inquiry intends to publish further details on the venues and subject matter of the public hearings scheduled for 1 February 2016 to 31 May 2016 in due course.

Registration NOW Open

It gives us great pleasure to invite you to attend the ICEM 2016 on 18-21 April 2016 in Cape Town, South Africa.

To Register, Please Visit: www.icem2016.org
The re-use of single-use devices is both dangerous and unethical. Practitioners should adhere to the manufacturer’s instructions and the intended number of use to safeguard their patients.

SAMED strongly advocates that users of SUDs adhere to the manufacturer instructions and intended number of uses to safeguard the patient and healthcare practitioner during use of these products. Failure to adhere to manufacturer’s instructions will result in liability resting with the third party who disregards these manufacturer’s instructions for use. Any service provider using single use devices in contravention of a manufacturer’s or supplier’s recommendations do so at their own risk. The practice of re-using a single use device is not condoned by SAMED in any way.

References:
http://www.fda.gov/MedicalDevic es/DeviceRegulationandGuidance/ Reprocessing/ucm2025268.htm
I nternationally, a number of medical device companies along with healthcare professionals (HCPs) have been implicated in unethical behaviour and/or unscrupulous business dealings. To this effect, the South African Medical Device Industry Association (SAMED) relies on its Code of Business Practice (the Code) to guide the unique and complex interactions between medical device companies and HCPs. The Code attempts to address the complexity of medical technology and the importance of having HCPs understand how to use the technology safely and effectively. Medical devices are often highly dependent upon hands-on HCP interaction from beginning to end – unlike drugs and biology, which act on the human body by pharmacological, immunological or metabolic means.

Surgical medical devices often serve as extensions of a physician’s hands. In other circumstances, medical devices are non-invasive magnets, instrumentation and/or software to aid in the diagnosis, monitoring and treatment decisions made by healthcare professionals. Many medical devices require technical support during and after deployment.

In this regard the Code states that a company representative may not touch a patient under any circumstances even if demonstrating or training on a product. Surgical representatives are also not permitted to assist with surgery. In addition, it is up to the doctor to obtain patient consent for the representative to be present. SAMED has developed a world-first online training course entitled ‘Company Representative In the Clinical Environment (CRICE)’ for company representatives dealing with what is allowable in the clinical environment.

The Code seeks to provide guidance on the interactions of SAMED members with individuals (clinical or non-clinical, including but not limited to physicians, nurses, technicians and research co-ordinators) or entities (such as hospitals or group purchasing bodies) that directly or indirectly purchase, lease, recommend, use, arrange for the purchase or lease of, or prescribe Companies’ medical devices. Another business practice covered in the Code is that of the prohibition of rebates, i.e. SAMED member companies must practice transparent invoicing and may not offer an off-invoice discount, free goods or other incentive schemes deemed to be perverse, to an HCP. Other areas covered include that of loan or placement of equipment with an HCP, where the contract between the SAMED member company and the HCP includes the purchase of consumables or disposables associated with the equipment, are subject to the following provisions:

- HCPs shall not use technological equipment, healthcare products or devices for profiteering and must refrain from charging patients fees for the use of such products or devices that are not market related.
- The consumables are used to cross-merchandise the capital equipment in a manner which is defensible and fair.
- The consumables relate to the specific piece of capital equipment being financed by means of the purchase of the consumables and is defensible in terms of, for example, the provisions of the National Credit Act.
- The placement of equipment agreement should be in writing and, in cases of valid complaints, made available in terms of the Code’s process for dealing with Infringements of the Code.

This is in line with the HPCSA’s Guidelines for Good Practice – Booklet 5, item 3.6 Technological Equipment as applicable to HCPs, explains Tanya Vogt, SAMED executive officer.

“The fundamental purpose of the Code is to promote and encourage, ethical principles and practices.” SAMED recognises that an HCP’s first duty is to act in the best interests of patients. Companies can serve the interests of patients through beneficial collaborations with HCPs. To ensure that these collaborative relationships meet high ethical standards, they must be conducted with appropriate transparency and in compliance with applicable laws and regulations.

SAMED recognises the obligation to facilitate ethical interactions between companies and HCPs to ensure that medical decisions are based on clinical evidence and in the best interests of the patient. The code also covers patient registries, royalty arrangements, reimbursement for information such as marketing data, formulary, managed care and similar fees. SAMED recognises that all South Africans have a right to access to healthcare and that right should be progressively realised through co-operation and shared responsibility between the SA medical device industry and the SA healthcare profession.


The purpose of the Code is to promote ethical principles and practices.”
A recent study found that a total of R12.2 billion was paid out of pocket by members of medical aid schemes during 2013, writes Charlton Murove, senior researcher, Research and Monitoring Unit at the Council for Medical Schemes (CMS).

One of the questions which lingers within the medical schemes industry is how much do medical scheme members take out of their own pockets towards healthcare? A recent CMS study determined that during 2013, medical scheme members spent a total of R12.2 billion on what is known as out-of-pocket payments (OOP).

OOP refers to healthcare costs that members pay themselves over and above the monthly contributions. This is obviously owing to healthcare needs not being covered in full by medical schemes.

There are several reasons why medical scheme members have to pay for benefits themselves:
- Members have exhausted their benefits
- Medical schemes do not cover all healthcare needs, therefore some healthcare requirements fall outside the benefit offering
- Incorrect benefit option choice by members
- Members may have used providers outside the networks as per the rules
- The providers of healthcare services have charged fees above the tariffs prescribed by the scheme.

OOP USING ANNUAL RETURNS DATA

The study, Out of Pocket Payments by Medical Scheme Members, was somewhat constrained by the availability of data. During 2013, a total of R12.2 billion was paid by members. This amount was calculated as the difference between amount claimed and the amounts paid by the schemes (from both savings and risk pools).

The distribution of the OOP is consistent with our expectations. Most of these payments were for day-to-day benefits, i.e. specialists, medicines, support health professionals, dentists and GPs.

THE EXTENT OF OOP FOR INDIVIDUALS

For individuals, the OOP may present very significant financial challenges. The source of data for investigating this was the CMS complaints data. During the 2013 financial year, there were 5 743 valid complaints received, of which 56.2% were technical or clinical complaints. These relate to the short-payment and non-payment of Prescribed Minimum Benefits claims. An analysis of the complaints data showed that, in some instances, individuals had to pay in excess of R100 000 out-of-pocket. The consequences of short payments may have dire financial implications for individuals.

The CMS is concerned about the levels of OOP. Further research will be carried out to understand the extent of, and factors leading to, excessive out-of-pocket payments. As highlighted, this research was based on limited data. In future CMS will collect claims data by benefit option and this will help inform how benefit design impacts OOP. Recommendations have also been put forward that future EISs should indicate which respondents belong to medical schemes.

Reducing OOP is a collective responsibility which requires all stakeholders to work together. Some avenues that have been identified as curbing out-of-pocket payments include improving member education to deepen understanding on benefit content and/or entitlements, exclusions and/or limitations within the entitlements and how to avoid co-payments.

Improved efficiencies will also be made through initiatives such as managed care, patient channeling, especially within options requiring the use of designated service providers, and a network of doctors. Further limitation of the extent of OOP can be achieved with the proper co-ordination of care at registration of rules, reducing penalties by medical schemes to members for not following set procedures such as pre-authorisations and none use of designated service providers.
It is important for healthcare professionals to understand and gain clarity on certain aspects of the implementation of ICD-10 coding.

The Council for Medical Schemes (CMS) has noticed that healthcare professionals experience challenges in coding, specifically after the implementation of the ICD-10 in phases 3 and 4.1 were implemented with effect 1 July 2014. This article will attempt to provide clarity on certain aspects of the implementation while addressing areas of concern.

Allocation of certain ICD-10 codes to specific disciplines
Some medical schemes informed certain healthcare professionals that some ICD-10 codes are reserved for use on accounts by specific practice types and may thus not be used by other professionals.

No ICD-10 code may be allocated or reserved for a specific healthcare discipline or practice. Any healthcare professional who renders a service within his/her scope of practice may use any of the clinically correct ICD-10 code(s) indicated on the 2014 ICD-10 Master Industry Table (MIT) as Valid_ICD-10_Clinical Use and Valid_ICD-10_Primary.

Recording of clinical information
Clinical documentation at hospitals is often insufficient for accurate coding, resulting in the assignment of sign and symptom codes and over-utilisation of default codes, which impacts negatively on health data collection and incorrect payment of benefits. As per the National Health Act (NHA), all medical practitioners are required to complete the discharge summary which reflects the patient’s diagnoses, treatments and health education provided on discharge. Furthermore, proper documentation of patient health records, which must be available to all clinical staff involved in the treatment of a patient, is a legal requirement as per the Health Professionals Act no. 56 of 1974. Professionals requesting ICD-10 codes from hospital case managers and call centres
Implementation of the ICD-10 continues requesting ICD-10 codes from case managers in hospitals, call centres at medical schemes and other entities, who may not do so as it is out of their scope of practice to diagnose a patient and provide ICD-10 codes. Several healthcare professionals have indicated that certain medical schemes require their codes to match that of the hospitals.

The ICD-10 codes for different healthcare professionals treating a patient within the same episode of care can differ and claims may not be rejected where codes between claims do not match.

Professionals not providing referral codes or diagnosis
Diagnosing professionals must supply the diagnosis, chief complaint and/or symptom and where possible ICD-10 code(s) to the non-diagnosing professionals especially pharmacists and pathologists as referral information. All diagnosing professionals to add the diagnosis and if possible the ICD-10 code to each medication item on a prescription. Pharmacists may not make a medical diagnosis and assign ICD-10 codes to a claim hence members of medical schemes experience severe difficulty in having their scripts funded correctly if a default ICD-10 code is used by pharmacists.

Professionals changing ICD-10 codes to avoid secondary codes
It was reported that accounts are amended by healthcare professionals who are unable to refuse to adhere to the secondary coding rules. They also refuse to add an External Cause Code (ECC) in the secondary position (SDX) when an injury/poisoning (chapter XIX 56 of 1974) has been coded. This results in medical schemes not being able to reimburse the member as the provision of the ECC is compulsory with all injury/poisoning codes. Instances have been reported where the primary (PDX) ICD-10 code has been changed from an ‘S’ injury code to an ‘M’ musculoskeletal code to avoid having to add the ECC in the secondary position.

Healthcare professionals should take special note of the fact that changing the ICD-10 code to a code that is not a true reflection of the member’s condition hinders quality health data collection and is fraudulent, leading to incorrect identification of PMB conditions. This may result in non-payment or incorrect payment of accounts.

Professionals changing ICD-10 codes to ensure PMB payment
It is of grave concern to the CMS that certain healthcare professionals change the diagnostic code to an ICD-10 code that is included in the PMB-coded list. Healthcare professionals should be aware that this is fraudulent and may lead to non-payment of claims.

The CMS further noticed that healthcare providers often inform the member that a condition is included in the PMB regulations when it is not. The CMS advises healthcare providers to ensure that they provide the correct information to members and do not ‘upcode’ in order to ensure that schemes will fund a claim as a PMB. As per the PMB Code of Conduct medical schemes are entitled to request all clinical records including pathology and radiology reports to ensure that a PMB condition is correctly identified.

CREDIT

By Ronelle Smit, Clinical Analyst, the Council for Medical Schemes, who serves on the National Department of Health’s former ICD-10 Task Team.

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THE BULLETIN 22

CODING CHALLENGES & CONCERNS

THE BULLETIN 23
The aim of informed consent is to keep patients fully informed whilst minimising the risk of patient complaints and lawsuits. Here are practical steps practitioners can take when obtaining informed consent from patients and useful guidelines in keeping suitable and acceptable records.

**KEEPING THE RECORD STRAIGHT – A PRACTICAL GUIDE**

The HPCSA has guidelines to assist medical practitioners with the rules and regulations pertaining to record keeping. These guidelines include (but are not limited to) the following:

**MAINTAIN AT LEAST THE FOLLOWING INFORMATION FOR EACH PATIENT CONSULTED:**

1. Personal (identifying) particulars of the patient.
2. Bio-psychosocial history including allergies and idiosyncrasies.
3. Time, date and place of every consultation.
4. Assessment of the patient's condition.
5. Proposed clinical management of the patient.
6. Medication and dosage prescribed.
7. Details of referrals to specialists, if any.
8. Patient's reaction to treatment or medication, including adverse effects.
9. Test results.
10. Imaging investigation results.
11. Information on the times that the patient was booked off from work and the relevant reasons.
12. Written proof of informed consent.

With time constraints putting pressure on the clock and patient care the priority, record keeping might be relegated to second place. If the maxim, “if it’s not written down, it didn’t happen” is to be believed, a practitioner may treat the patient with the best intentions but only have the records to rely on in the event of a complaint or legal case.

**HAVING A SYSTEM IN PLACE**

With this in mind it is best to develop a system that will streamline the process and alleviate the pressure of having to record absolutely everything. The most practical way in which this can be achieved is to standardise the forms used each time a patient is seen, starting with the first form completed by the patient while sitting in the rooms during the consult. Once the identifying particulars and bio-psychosocial history has been obtained, the patient’s current medical status should be recorded during each visit. The detail and accuracy is important in the event of the treating practitioner, or another medical practitioner, needing to refer back to the notes at a later stage to understand the patient’s medical history.

**IF IT IS ILLEGBLE, IT CANNOT BE RELIED UPON**

Another issue of concern, especially in a court of law, is that of illegible handwriting. Again, pressed for time, the practitioner writes faster with resulting deterioration in handwriting. With records being important in complaints and lawsuits, poor handwriting puts practitioners at risk.

A practical way to overcome this is with the aid of technology. A patient’s consent can be obtained to record the consultation on a recording device. Thereafter, the recording can be transcribed by a staff member in the practice and this can be used to augment and support the notes the practitioner is still advised to take during the consultation. The process of the voice recording and subsequent transcript will make record keeping easier and legible.

**CONSENT**

An informed consent form can go a long way to assisting with you being able to prove what the patient was aware of in and during the consultation. A court takes cognisance of the documents signed by the patient and, should it be alleged by the patient that they didn’t know or weren’t made aware of any aspect of treatment, the informed consent will assist in disproving this allegation.

An informed consent form will assist in showing that a patient was made aware of the aspects of their treatment. A court of law takes cognisance of the documents signed by a patient when they allege they were not made aware of aspects of their treatment.

Again, the most practical answer is to have standardised forms developed specifically for your practice which cover the procedures that patients will undergo. On signing these forms patients acknowledge that they have read and understood the contents of the informed consent, protecting the practitioner and focusing the patient’s attention on ensuring the really do understand their treatment.

“Patients need as much data as possible to make an informed decision about what treatment is best” - BEN GOLDACRE
The HPCSA affords healthcare professionals with the privilege to own shares in their field of practice, but they must remain ethical and compliant.

**OWNERSHIP OF PRACTICES**

The following are guidelines to ethical and legal behaviour and rules on ownership of practices, shareholding in hospitals and in medical device companies.

**WHO CAN OWN A MEDICAL PRACTICE?**

Only practitioners registered at the HPCSA must own shares or be partners or associates in either the form of a solo practice, partnerships, associations or incorporated practices. It is, however, permissible to outsource the administration of the practice or establish a legal entity to do so, provided that the practitioner does not permit such entity to operate in violation of the established ethical rules of the HPCSA.

Even if the ownership structure is correct, the Undesirable Business Practices Policy prohibits the following actions, whether undertaken directly or indirectly (such as by means of a spouse or life partner or other company/firm), all based on the general principle that the profits or income of the practice may not be shared with any third-party entity:

- Transferring income or profits from professional practice to a service provider through payment of a fee that is more than a market-related fee for the services rendered by the service provider;
- Paying or providing a service provider with some or other benefit that is intended or has the effect of allowing the service provider or persons holding an interest in such a service provider to share, directly or indirectly, in the profits or income of such a professional practice or to have an interest in such a professional practice.

**shares or an interest similar to a share in the professional practice to such a person**

- Transferring income or profits to a professional practice to a service provider through payment of a fee that is more than a market-related fee for the services rendered by the service provider;
- Paying or providing a service provider with some or other benefit that is intended or has the effect of allowing the service provider or persons holding an interest in such a service provider to share, directly or indirectly, in the profits or income of such a professional practice or to have an interest in such a professional practice.

**over-charging of patients**

- Fee-splitting, i.e. a practitioner may not share fees with any person who has not ‘taken a commensurate part in the services for which such fees are charged’.
- Fees may only be charged for services personally rendered.

The arrangements where fees are shared and/or commissions paid could also constitute violations of ethical rules 27A (conflicts of interest), 23 (involvement in medical devices and medicines supply chains) and/or 18 (professional appointments or subcontracting of professional services by non-healthcare professional entities).

**CAN PRACTITIONERS OWN SHARES IN OTHER ENTITIES?**

Shareholding in private hospitals is explicitly permitted under ethical rule 23A, provided that a number of conditions are met. In contrast, shareholding in medical devices and pharmaceutical companies is not permitted. This is owing to the direct influence that a practitioner could have in generating a direct income stream from product utilisation, which is more remote and less likely to influence the case of private hospitals. Practitioners may, however, have shares in pharmaceutical or device companies that are publicly listed, but this must be disclosed to patients prior to prescription of products from companies.

**Ethical rule 23 states:** ‘A practitioner shall not participate in the management or control of a business. For example, if the practitioner does not own or control the business or a shareholding in the business is not permitted, this business cannot be used as a place to hide fees (e.g., marketing fees to device companies) that would otherwise not be permissible to be levied by the practice.

- In line with the ethical rule on fees and the rulings of the HPCSA, “No provision is made for hiding off fees to a corporate entity.” This means that working out fees on a percentage of income from patients is unacceptable, with no or limited relation to the actual costs of the specific services rendered by the corporate entity.

- As far as a practitioner may be involved in a corporate such as a pharmaceutical or medical device company is concerned, ethical rule 23 states that where a practitioner is in any contractual relationship with such an entity such as being on an advisory board, doing presentations for, or consulting to the company, such practitioner must obtain the patient’s written consent prior to prescribing a medicine or device of the company.

**WHAT PRACTITIONERS SHOULD DO**

Apart from ensuring that the manner in which their practices are owned is in line with the HPCSA’s provisions, practitioners have to investigate the ownership of corporations, professional appointments or other entities that they have or that they are associated with.

**WHAT PRACTITIONERS SHOULD NOT DO**

- The practitioner does not engage in or advocate the preferential use of such hospital or healthcare institution.

In addition, the HPCSA must approve the purchase agreement and the practitioner must annually submit a report to the HPCSA on the number of patients referred by him or his associates or partners to such hospital, and the numbers referred to other hospitals.

**THE RELATIONSHIPS BETWEEN PRACTITIONERS AND OTHER CORPORATE ENTITIES:**

Corporate involvement entails non-practitioners providing services like financing, investment, administration or rental to a professional practice on an arm’s length basis and for remuneration on a market-related, pre-determined fee.

Corporate involvement is, according to the Undesirable Business Practices Policy, only permissible if:

- Ethical rules and policies of HPCSA are complied with.

This would include adherence to ethical rule 7 on fees, ethical rule 18 on professional appointments (subcontracting), ethical rule 22 on exploitation and the policy on perverse incentives, for example.

- “Practitioners take responsibility for the compliance of the corporate unregistered partner with the ethical rules and policies of the Council.” For example, if the unregistered entity is overcharging patients on consumables the practitioner will be held responsible by the HPCSA.
- Practitioners are not able to hide behind the corporate veil or take individual responsibility for all business transactions and operations of the business.

For example, when it comes to the contract involving third parties, on behalf of the practitioner or practitioners, the corporate entity cannot be given free reign. The corporate entity cannot be used as a place to hide fees (e.g., marketing fees to device companies) that would otherwise not be permissible to be levied by the practice.

- In line with the ethical rule on fees and the rulings of the HPCSA, “No provision is made for hiding off fees to a corporate entity.” This means that working out fees on a percentage of income from patients is unacceptable, with no or limited relation to the actual costs of the specific services rendered by the corporate entity.
It is natural to feel anxious and apprehensive ahead of a surgical procedure. Much of this fear is based on feeling out of control and not knowing what is going to happen to you. Information can empower you and allow you to make the most informed choices and help you understand the procedure.

**TEN THINGS YOU SHOULD CONSIDER BEFORE UNDERGOING SURGERY:**

1. **Meet your anaesthesiologist and raise any concerns**
   - Find out from your surgeon who your anaesthesiologist will be. Make contact before the surgery to ask any questions you may have about your anaesthesiologist. 
   - Anaesthesiologists are highly qualified, specialist doctors who play a critical role before, during and after surgery by providing the anaesthetic and constantly observing and monitoring the status of each patient.
   - Many anaesthetic practices offer a pre-anesthetic consultation service. Should you suffer from any significant illness that could affect the outcome of your surgery, request that your surgeon refers you for a consultation with the anaesthesiologist.
   - At this consultation you will be assessed in terms of anaesthetic risk and may be sent for special investigations, such as chest X-rays, an ECG or blood tests. This will prevent your operation from being cancelled or delayed on the day of surgery.
   - If you are in any doubt about the chosen anaesthetic or pre-scribed surgical procedure advised, get a second opinion from a specialist in the field. This is your right as an individual and you should not feel guilty about “second-guessing” your doctor. Bear in mind though, that the second opinion may very well confirm the first.

2. **Anaesthesia options**
   - The anaesthesiologist’s creed is always to put the patient’s safety first. As a patient you should never be afraid to ask your anaesthesiologist about the different anaesthetic options available to you. Generally, local anaesthesia numbs a specific location on the body, regional anaesthesia affects a larger area, while general anaesthesia affects the entire body and you are unaware of proceedings.
   - The manner in which anaesthesia is administered also differs. Some forms are inhaled while others are administered intravenously. Generally speaking, people react better to some options than others. It is important to notify your surgeon if you or anyone in your family has had an adverse reaction to anaesthesia.
   - These anaesthesiologists are members of the surgical team, and are qualified to provide quality and compassionate care when you are unable to look after yourself.
   - The South African Society of Anaesthesiologists (SASA) has as its mission: “Leading the science and practice of safe anaesthesia at the highest standard and ensuring the sustainability of anaesthesiology services.”

3. **Pre-existing medical conditions**
   - Advise your doctor and anaesthesiologist about any health issues, as these may affect your surgery and treatment. Those of highest concern include heart- or lung-related disease, diabetes, high blood pressure, dental fittings, arthritis or drug allergies.
   - Be open and honest about any recreational drug use, as this may have a significant impact on surgery and your anaesthesiologist needs to be prepared for possible complications as a result.
   - Drinking alcohol may also have unpredictable effects on anaesthesia. Under certain circumstances you may be asked to postpone your operation in order to avoid any possible side effects. Conferring with your doctor about any supplements that you may be taking is advisable. Generally, you are advised to stop taking these one to two weeks prior to surgery.

4. **Current medication**
   - Be sure to inform your anaesthesiologist of ALL the medication you are taking, including the dosing and timing. This would include over-the-counter medications and supplements.
   - Certain supplements may increase the risk during surgery. Ginkgo biloba, ginseng, garlic, Echinacea, fish oils and vitamins may raise the chance of heart problems or bleeding.
   - Others may exaggerate the effects of anaesthesia or cause an adverse reaction with other medications, causing unexpected side effects. Confer with your doctor about any supplements that you may be taking. Generally, you are advised to stop taking these one to two weeks prior to surgery.

5. **Confirm surgical instructions**
   - To avoid surgical error, your doctor or a nurse may indicate with an X the spot on your body where the surgery is to take place. Other methods may include the wearing of coloured plastic armbands that inform both surgeon and anaesthesiologist of your operation details.
   - Patient allergies and other relevant information is entitiled to check these yourself for added peace of mind.
   - The anaesthesiologist is responsible for maintaining sterility in the surgical environment, but it won’t do any harm to take a look to make sure that your doctors and nurses wash or sanitize their hands before they treat you. Although it should be common practice, a reminder could help prevent infections such as Methicillin-Resistant Staphylococcus Aureus (MRSA), a bacteria that causes a number of treatable-resistant infections.

6. **Pain management**
   - Post-operative pain is a burning sensation to be expected after a surgical procedure. You might also experience aching muscles and a dry throat.
   - Post-operative pain management is the responsibility of your anaesthesiologist.
   - Keep him or her informed of any symptoms and ask for painkillers to continue using at home according to prescription.
   - During your recovery, you might also experience nausea and vomiting which may result in dehydration and feeling unwell. Those at high risk of nausea and vomiting may benefit from receiving anti-emetics pre-operatively to reduce the symptoms.

7. **Nausea and vomiting**
   - Do not eat anything for at least six hours before your anaesthetic. Under certain circumstances you may drink small volumes of water up to two hours before your anaesthetic.
   - Should you have mistakenly eaten less than six hours before surgery, you must advise your anaesthesiologist who may have to postpone your operation in the interests of your safety. If you have had a child or infant that has had an anaesthetic, you need to discuss this with your anaesthesiologist.

8. **Follow doctor’s orders**
   - In the lead-up to your operation take extra care of yourself and follow your doctor’s advice. Surgery puts the body under significant stress, so the stronger you are in the lead-up, the better you will be able to cope. Make sure you get sufficient sleep, eat a healthy diet and could consider taking directions on starting or stopping medication before your operation.
New research suggests an increased risk of below normal BMI for children with odontogenic infections

Dental caries (tooth decay) is the most common childhood disease and the most frequent non-communicable disease worldwide. In South Africa, as in the rest of the world, most of the dental decay remains untreated with significant impact on general health, quality of life, development and educational performance of children. Despite the pandemic character of dental decay, particularly in children, there are only a few studies that have examined the relationship between the severity of dental decay and the body mass index (BMI). Previous research concluded that children with early childhood caries (ECC) who needed tooth extraction had lower mean weights than those without treatment need. In larger surveys among 1 to 6-year-olds, non-hospital visitors, the relationship between caries and underweight remained inconclusive.

A recent large population-based prospective cohort study conducted in the United Kingdom among 5-year-olds, reported that children with tooth decay had slightly higher increases in weight and height in the previous years than children without tooth decay. Morse and colleagues developed the PUFAs index to measure the clinical consequences of untreated caries. PUFAs is an index used to assess the presence of oral conditions and infections resulting from untreated caries in the permanent and primary dentition. The index is separated separately from the decayed, missing and filled teeth. There is one index which is the most common methods in oral epidemiology for assessing dental caries prevalence as well as dental treatment needs among primary included in the sample. The overall prevalence of caries (DMFT + dmft >0) was 79.2%. The overall prevalence of odontogenic infections due to caries could not be calculated because the index represents the number of children with caries. The PUFAs index per child is calculated in the same cumulative way as the DMFT index and represents the number of teeth meeting the PUFAs diagnostic criteria. The purpose of the study was to determine the association between untreated dental caries and BMI among 8 to 10-year-old children in the Dlamini district of Mpumalanga.

The results of Figure 1 show that children with a BMI have significantly higher levels of PUFAs than children with a normal BMI (p<0.05). The results also suggest that children with a low BMI have less caries (total caries) than children with a normal BMI. This result was however not statistically significant (p>0.05).

The odds ratios (OR) (adj. adjusted) from logistic regression model with low BMI as the dependent variable are shown in Table 1.

The regression co-efficient between BMI and PUFAs was significant, p = 0.01. Children with odontogenic infections (PUFA+pufa >0) had a 2.99 times higher risk of below normal BMI as compared to those without odontogenic infections. Although boys in large families in which the breadwinner was employed versus unemployed had a 1.38 times higher risk of below normal BMI compared to children in small families, boys versus girls had a 1.12 times higher risk of below normal BMI. The results suggest that children from large families may have significantly higher levels of caries (total caries) than children in small families. The results of the current study show that children with odontogenic infections have an increased risk of below normal BMI as compared to those without odontogenic infections. According to Benazet et al there are three possible pathways for this association:

1. Pain and discomfort result in reduced food intake
2. Reduced quality of life affects children’s growth and development through restricted activity, reduced sleep, concentration deficits etc; and
3. Odontogenic infections may result in cytokine release which might impact on growth.

According to the authors the latter has a highly speculative. However, it is also possible that under-nutrition which will impact negatively on the BMI could result in increased susceptibility to dental caries. Under-nutrition refers to the insufficient intake of energy and nutrients that support growth and development as well as the maintenance of health. Under-nutrition may also affect the development and integrity of the oral cavity as well as the progression of oral diseases. There are four possible mechanisms to explain the relationship between under-nutrition and more specifically protein-energy maltnutrition (PEM) and den- tal caries. Potier et al (2005) indicated that one of the local effects of under-nutrition was enamel hypoplasia, which, in turn, has been associated with caries development. Another local change associated with under-nutrition is salivary gland hypofunction which may increase caries risk via decreased salivary flow rate, decreased buffering capacity, and decreased salivary constituents, particularly proteins. The same authors also argued that under-nutrition may cause altered eruption timing of the teeth and that an advanced or delayed eruption would increase or decrease, respectively, the age-specific exposure time to cariogenic conditions, so age-specific caries rates may be confounded by altered eruption. A fourth possible mechanism was provided by Cunningham-Rundles et al (2005), under-nutrition results in immunological deficiencies (inflammatory) which play an essential role in the pathogenesis of chronic inflammatory diseases, including dental caries.

CONCLUSION

The results of this study show that children with odontogenic infections (PUFA+pufa >0) had an increased risk of below normal BMI, but that there was no significant association between the low BMI and categories of caries.

Fig 1. Mean experience of dental caries and the mean experience of odontogenic infections due to caries in the 2 categories of BMI.

Table 1: Odds ratios obtained from the logistic regression model.
The Oxford Dictionary defines “euthanasia” as “the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma”. But there are many kinds of euthanasia, including active euthanasia, when death is directly and deliberately caused, and assisted suicide, when the patient who wants to die needs help to kill themselves, asks for it and receives it. Euthanasia also includes the administration of specific pain-killers that will hasten the death of the person.

In South Africa, euthanasia is illegal. The position of the Health Professions Council is that the act of euthanasia is morally and ethically unprofessional. Since euthanasia has not been legally sanctioned in South Africa, it is incumbent upon the HPCSA to guide professionals on the matter.

The position of the HPCSA is based on the fact that medical professionals take the Hippocratic Oath, pledging to preserve life at all costs and to do nothing that will intentionally harm the patient or result in the death of a patient. The HPCSA views assisted suicide as a contempt of this Hippocratic Oath.

The HPCSA ethics guidelines state the following: “Council finds active euthanasia or the willful act by a healthcare professional to cause the death of a patient unacceptable, notwithstanding whether or not such an act is performed at the request of the patient or his or her closest relatives or of any other person.”

“The healthcare professional may alleviate the suffering of a terminally ill patient by with- holding treatment - allowing the natural process of death to fol- low its course, provided there is consultation with another healthcare practitioner who is an expert in the field, and where available, discussions with the closest relatives. “The withholding of treatment does not exempt the healthcare professional from the duty to as- sist the dying person by providing him or her with the necessary medication in order to alleviate the terminal phase of illness. The healthcare professional shall refrain from employing unusual methods of treatment which are of no benefit to the patient.”

South Africa is not alone in its condemnation of euthanasia and assisted suicide. In 2014, Britain’s Supreme Court upheld the ban on doctors helping pa- tients to end their lives, but ruled that judges do have the “consti- tutional authority” to intervene in the debate. The ruling chal- lenged parliament to re-examine the predicament of those who are severely ill and wish to die, but cannot do so without medi- cal assistance.

In September, 2015, members of the British parliament voted against a bill to allow people with terminal illnesses to end their lives with medical supervi- sion. The debate is emotionally fraught and philosophical debate, according to the Finan- cial Times – reflected the strik- ing differences of opinion among British people.

In South Africa, an organisa- tion called DignitySA is fighting for the benefit of the sick or terminally ill patients. Out of more than 278 000 ballots cast, the ini- tiative to ban assisted suicide was rejected by 85% of voters and the initiative to outlaw it for physical and mental illnesses to die, assisted by qualified doc- tors and nurses. They have helped over 1 000 people die in clinics in Zurich after an in-depth medical report prepared by a psychiatrist has established the patient’s condition, as required by Swiss courts.

In a referendum on 15 May 2011, voters in the Canton of Zurich overwhelmingly rejected calls to ban assisted suicide or euthanasia for non-residents. Out of more than 278 000 ballots cast, the initiative to ban assisted suicide was rejected by 85% of voters and the initiative to outlaw it for people of Zimbabwe, consider euthanasia to be “kuroya” – practicing witchcraft.

Studying cases in pre-colo- nial Shona society, oral literature attests to the fact that the idea of killing to alleviate suffering was in existence, these scholars found that case of killing for the benefit of the sick or the terminally ill were common in pre-colonial Shona society. They also found that the concept of eutha- nasia in Shona society was even broader in scope than the Western conception of it. These case studies cite

Each day health professionals make life or death decisions affecting the patients in their care. The question of whether euthanasia is an ethical choice has always been a matter of debate.

In 2013, Ezra Chitando and Faison Mangena of the Depart- ment of Religious Studies, Class- sics and Philosophy at the Uni- versity of Zimbabwe, published an insightful paper interrogating African thought. The paper emphasises close consultation with family physicians over many years. The termination of life was supposed to be limited to those with “unbearable and hopeless suffering” whose mental facul- ties were not impaired and who had no other hope of relief.

Under current Zimbabwean law, euthanasia is illegal. Promi- nent Zimbabwean sociologist, Claude Marariki, believes that “Africans value life because they are afraid of the menacing ngozi (avenging spirits) which may come back to haunt them in the long run.” He argues that Africans, particularly the Shona people, ask for it and receive it.

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AVOIDING DISCONTENT WITH CONSENT

The HPCSA guides health practitioners through the informed consent to costs process.

Patients have a right to information about their condition and the treatment options available to them. The amount of information given to each patient will vary according to factors such as the nature of the condition, the complexity of the treatment, the risk or side effects associated with the treatment or procedure, and the patient’s own wishes. This is legislated under the National Health Act, the National Patients’ Rights Charter; the Health Professions Act; the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act; and the ethical and philosophical principles, such as the right to individual autonomy and self-determination.

These legislations require that practitioners inform patients about the cost of services or treatment provided as part of seeking consent from patients. The majority of complaints against practitioners received by Council are related to the fees and most of these complaints arise because patients were not informed about the costs of treatment or services rendered by practitioners. As a result, the Council offers some guidance to practitioners on obtaining consent from their patients.

Informed consent on cost of services is a process by which a practitioner informs their patients about the costs and out-of-pocket expenses associated with the services, treatment or procedure before it commences.

The Council’s view is that informing patients about the cost of services should not be separated from clinical decision-making processes as it may impact upon decisions made on available treatment options. The information should be contextualised within a clinical consultation and be an interactive process between a practitioner and the patient, especially where clinical decisions may impact upon financial decisions.

From the analysis of complaints it appears that patients want to receive the details of all procedures associated with their treatment and their costs, including both certain and likely services. These include costs of other practitioners to be involved in their care; for example, anaesthetists in surgical procedures, paediatricians in deliveries, and medical technologists in cardiothoracic procedures. Patients want to know the overall costs co-payments for private hospital treatment, and how much of this would be covered by their medical aid. In order to assist patients with making informed decisions, patients should be advised about the costs of alternative treatments or procedures, such as hospital treatment versus day clinic treatment.

The Council acknowledges that it is not the responsibility of practitioners to know about the out-of-pocket expenses or co-payments related to their services or that of the hospital, but they should assist their patients in obtaining such information from their medical schemes. Practitioners are advised that in cases where they obtain authorisations on behalf of their patients, they should exercise caution in establishing what has been authorised before commencing with treatment that may attract co-payments which the patient cannot afford. This is relevant for some novel treatment options that should be contextualised within a clinical consultation and be an interactive process between a practitioner and the patient, especially where clinical decisions may impact upon financial decisions.

The Council acknowledges that there are categories of practitioners who are not primary caregivers and this will pose a challenge for these practitioners obtaining consent. These practitioners who are secondary caregivers include anaesthetists and assistant surgeons working with surgeons; paediatricians working with obstetricians in emergency caesarean sections; pathologists and radiologists providing diagnostic services; and other professionals providing therapeutic and rehabilitation services. Although it is not the responsibility of the primary practitioner to provide specific information about the fees for other practitioners involved in the treatment of the patient, Council advises them to at least inform the patient that there may be fees associated with other practitioners and even inform the patient who those practitioners are, where possible. It would be wise to provide patients with names and contact details of practitioners who will be involved in treatment of the patient and notify the relevant practitioners of the patient details to facilitate the exchange of relevant information.

Information about fees and costs for services and treatment should be provided in writing and the patient should acknowledge receipt in writing as acceptance of the fees disclosed. The information provided should be in a way that practitioners and patients refrain from using the terminology such as: private rates, medical aid rates, contracted in, or contracted out as this nomenclature is not recognised by Council. In addition to providing specific information on fees and charges, practitioners should document their fee-changing and billing policies which includes the following:

When payment will be required
- Any discounts available for early payment (or charges for late payment)
- Acceptable forms of payment
- Contact for discussion of payment issues and problems.

Council acknowledges that there will be circumstances where it will not be possible to obtain consent related to costs before the treatment is provided (emergency cases or admissions). In these cases information should be provided to the patient as soon as possible after treatment. Where it is not feasible to provide information directly to the patient either before or after treatment (e.g. because the patient is not conscious or otherwise incapable of receiving or understanding the information), it may be appropriate to provide the information to a close relative or representative acting in the patient’s interests.

In order to assist practitioners to provide adequate information and obtain informed consent, Council has developed cost estimate forms that practitioners can customise which is available for download on the HPCSA website.
ACCOUNTS AND MEDICAL REPORTS TO PATIENTS BY HEALTH PRACTITIONERS

The management of information, whether paper based or computerised, is central to the effective running for any organisation.

Dr Munyadziwa Kwinda of the HPCSA looks at key issues around accounts and medical reports to patients.

The HPCSA acknowledges that healthcare practitioners are required to provide patients with detailed accounts for services rendered and the Act provides the following guidelines:

According to Section 59(1) of the Medical Schemes Act: “A healthcare professional who claims payment from a patient is required to furnish the patient with a detailed account. The HPCSA provides guidelines for the details to be provided to the patient.”

ACOUNTS TO PATIENTS BY HEALTH PRACTITIONERS

The HPCSA requires healthcare practitioners to provide patients with detailed accounts for services rendered and the Act provides the following guidelines:

According to Section 59(1) of the Medical Schemes Act: “A supplier of a service who has rendered any service to a member or to a dependant of such a member in terms of which an account has been rendered shall, notwithstanding the provisions of any other law, furnish the member concerned an account or statement reflecting such particulars as may be prescribed”. In terms of Regulation 5 of this Act, the account or statement mentioned above should contain the following:

- The date on which each relevant health service was rendered.
- The nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine.

The Health Professions Act in section 53(2) makes it a requirement for any practitioner who, in respect of any professional services rendered, claims payment from the patient to furnish the patient with a detailed account. Patients who settle their account out of pocket may not require a detailed statement as stipulated above, but practitioners are encouraged to include as much information as possible in the statement of account using the above information as a guide. For patients covered by medical schemes, the details in the account should be as stipulated above. Practitioners are further advised that statement of accounts should reflect all the fees charged to the patient inclusive of co-payments, where applicable.

CO-PAYMENTS RELATED TO THE PRACTITIONERS’ CHOICE OF TREATMENT OPTION/ALTERNATIVE

Currently, the HPCSA has not increased an account in the number of complaints from patients related to co-payments attributed to their hospital accounts due to the treatment option/alternative decided upon by healthcare practitioners. Council supports the use of evidence-based medicine but further advises practitioners to discuss potential out-of-pocket costs before ordering diagnostic tests or making treatment decisions to prevent patients from facing daunting and potentially avoidable healthcare bills. Practitioners should consider financial discussions of their duties.

Patients have concerns about the costs of their care despite having a medical scheme because although medical schemes are obliged to pay in full without co-payment or the use of deductibles, the diagnosis, treatment and care costs of Prescribed Minimum Benefit conditions, their coverage of diagnostic or treatment options/alternatives still depends on the policy determined that an individual patient has purchased with the medical scheme. Discussing the potential out-of-pocket costs to the practitioner or hospital of a diagnostic or treatment procedure is beneficial to patients in that it helps them to choose lower-cost diagnostic and treatment options/alternatives; the discussion helps those patients who want to make an informed decision about trading potential medical benefit for less financial distress; and it allows them to prepare themselves financially for an expensive procedure.

The HPCSA acknowledges that health practitioners are not responsible for the fees related to the hospitals and that patients have a duty to obtain authorisation from their medical aids, but Council is of the view that practitioners are in a better position to assist patients to obtain information about the potential out-of-pocket expenses related to diagnostic and/or treatment option/alternative that suits the patient’s interest best and, where not possible, practitioners should at least inform patients that there will be hospital fees which may also include co-payments and further provide them with contact names and details where possible.

ISSUING OF MEDICAL REPORTS TO PATIENTS

From time to time, patients require that their treating practitioners write or complete medical reports related to their illnesses. According to Ethical Rule 16 of the Ethical Rules of Conduct for practitioners Registered under the Health Professions Act, 1974, “A practitioner shall issue a factual report to a patient where such patient requires information concerning him or herself. The reasons for these reports vary and include among others: [a] certificate of illness (medical certificate), medical reports related to injury on duty, medical reports for temporary incapacity (short term or long term), medical report related to road accident (RAI), etc.” The HPCSA has noted that some practitioners have developed policies and standard operating procedures about the completion or writing of medical reports when requested by their patients. Unfortunately, some of these policies are applied strictly without looking at the needs of individual patients. For example, a policy that states that the turnaround time for the completion of a medical report is 90 days may not be relevant for a patient who requires the completion of a temporary incapacity leave application form when he or she has exhausted his or her sick leave days.

Practitioners are reminded that the core ethical values and standards of good practice which should inform the development of policies and standards and operating procedures for their practices. These core ethical values and standards include the following:

- Best interest or well-being: Health practitioners should act in the best interests of patients even when the interests of the latter conflict with their own self-interest.
- Compassion: Healthcare practitioners should be sensitive to, and empathise with, the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.
- The “best interest of the patient” should be the backdrop against which all the policies and standard operating procedures related to medical reports are applied. Practitioners and these policies or procedures should accommodate the needs of individual patients.
By Professor Dan J Ncayiyana

How many traditional healers are there in South Africa?

The figure of 200 000 has long been bandied about in the literature, with little or no evidence to support it. The truth is that no one really knows. Given the bewildering array of would-be traditional practitioners, including herbalists, nyangas, sangomas, faith healers, diviners, those who murder for muti or use body parts for their concoctions, and those who smell out witches to be burned, there is not a single all-inclusive definition for a traditional healer.

The Traditional Health Practitioners Act of 2007 (which became effective on 1 May 2014) sought to address this conundrum through a process of certification and registration. It created a Traditional Health Practitioners Council to assume responsibility for setting the training requirements, establishing a register and regulating the practice of traditional medicine. Only those with “qualifications” – obtained by virtue of examinations conducted by an accredited institution, educational authority or other examining authority in the Republic – would be eligible for registration. Although an interim council has been set up, no practitioners have yet been registered, no doubt because there are as yet no accredited institutions and no graduates.

Another enduring yet dubious assertion is the claim that traditional healers are the first health providers to be consulted in over 80% of cases of illness. In fact, population-based studies and national demographic health surveys have shown a declining trend in the use of traditional healers as primary healthcare clinics. In addition, hospitals have become more physically accessible and allopathic medicine has gained greater cultural acceptability.

This trend is not unique to South Africa. Chinese traditional medicine, long the bedrock of the healthcare system in China, is reported to be contracting dramatically at the same time that it is blossoming in South Africa and elsewhere in the world as a result of dramatic Western-style healthcare reforms and changing cultural values in China.

But traditional healing practice remains a dominant facet of life in South Africa, and traditional healers remain ubiquitous across the country, with their clients being more likely to be poor, unemployed, living in rural areas, aged between 25 and 49 years, with a history of low health status. There is a high rate of consumption of traditional herbal medicine which has placed some botanical species on the endangered list. Every year 1 500 tons of traditional medicines are sold in medicine markets in Durban alone.

Ancient traditional healing customs are not unique to South Africa or indeed the African continent. They are to be found in virtually every society, from Ayurveda in India to acupuncture in China to the Shamans and indigenous health systems of Latin America and the Caribbean.

These health systems, like their largely Western counterparts of homeopathy, chiropractic, reflexology and the like, distinguish themselves from orthodox biomedicine in not being founded on evidence from scientific inquiry. This is underscored in the Traditional Health Practitioners Act, which defines the philosophy underpinning traditional health practice in South Africa as “indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines, communicated from ancestor to descendants or from generations to generations, with or without written documentation, whether supported by science or not”.

It is clear from this definition that conventional health practitioners and traditional healers operate from vastly irreconcilable knowledge domains and language systems, making it highly improbable that biomedically trained health professionals and traditional healers can form a viable working partnership in the health system. Therefore, the integration of traditional healers into the mainstream of healthcare presents many complexities.

The South African medical and allied health professions are not indiscriminately antagonistic to traditional healers per se. They recognise and acknowledge the cultural significance of traditional healing which is embedded in our society. Their primary concern is with the safety and well-being of the patient subjected to mysterious diagnoses and unproven and sometimes harmful remedies.

There is, no doubt, a class of traditional healers whose conduct conforms to the dictum primum non nocere – above all, do no harm, and to the Hippocratic injunction to “cure sometimes, relieve often and comfort always”. That most traditional healers comfort always is not in doubt. Indeed, many patients receiving conventional medical care will concurrently consult traditional healers for emotional support and succour, and for an explanation of the patient’s illness in the context of his or her worldview and belief system – all the things the patients perceive to be lacking in allopathic care.

Unfortunately, there are some very good reasons for health >
and medical professionals to be concerned about the safety and welfare of sick patients in the care of traditional health practitioners. There are no official codes of ethics or other enforceable rules of conduct to protect these patients, leaving them vulnerable to deception and exploitation.

Harmful treatments are all too often prescribed, such as enemas for children with diarrhea; patients have often been dissuaded from taking or using effective treatment for medical conditions such as epilepsy, TB and HIV/AIDS; and patients with serious but treatable conditions have frequently delayed seeking conventional medical assistance until too late, on account of the promise of unfounded claims of a cure with traditional remedies.

True, all traditional healers cannot be painted with the same brush. There is a class of ethical and even well-educated traditional healers potentially capable of playing a positive collaborative role in the country’s healthcare system as envisioned by national policy. For this to happen, these healers must be given sufficient training that enables them to conduct an elementary assessment to identify cases that merit referral to a conventional doctor. For this to happen, these healers must be given sufficient training that enables them to conduct an elementary assessment to identify cases that merit referral to a conventional doctor. The authorities in these countries have chosen to look for a way to integrates traditional healers as kindred with Western medical practices and to harness the traditional practitioners who are held in high esteem in their communities.

Ayurvedic medicine in India has been practised for over 5,000 years and it will never be replaced by Western medicine. India has 180 colleges that offer degrees in Ayurveda and thousands of evidence-based studies in esteemed universities like Harvard Medical School and Massachusetts General Hospital have proved the benefits of ancient medicinal practices. The increasing use of brain imaging technology in the West has given the proponents of purely evidence-based medicine, proof that these techniques have value.

South Africa is not alone in its struggle to find a place for traditional healers under the umbrella of a formal healthcare system. India, Bangladesh, Peru, China, Colombia, Uganda and other countries with strong shamanic and ethnomedical traditions are in the throes of trying to find systems to integrate traditional with allopathic medicine.

These countries are grappling with the very same issues as South Africa: not just the widespread use of traditional healers and the harm that they do, but also that fact that they daub in areas of psychology, mental well-being and spirituality, which biomedical sees as unscientific and unproven.

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What is your reputation worth? According to a study by the World Economic Forum, on average more than 25 percent of a company’s market value is directly attributable to its reputation. This same dictum can be applied to a professional, especially in the healthcare field, where reputation is directly correlated with trust. The importance of managing your reputation cannot be underestimated—just not to keep the trust of your patients and clients, but also to keep the confidence and support of industry and legislative role players.

As is clearly stated in the revised Inspectorate Office is aimed at assisting practitioners to understand the consequences of unethical behaviour and to enforce accountability and compliance with the Act. The Inspectorate Office was founded by the HPCSA in 2014 to enforce compliance with the Act, regulations and rules governing the health care professions. Operated within the legal department, the office is headed by a senior manager supported by five inspectors and a secretary.

Currently regional offices are being set up in Gauteng, Western Cape (Cape Town), Kwa-Zulu-Natal (Durban) and Eastern Cape (East London). There will eventually be a foot print in each major city in order to speed up the process and make it easier for all involved.

Responsibilities and Duties
The main responsibilities of the Inspectorate Office are:
- To enforce compliance with the law, rules and sanctions imposed by the professional conduct committees through conducting inspections on the premises of suspended and removed healthcare practitioners.
- To attend to criminal matters pertaining to registered persons practising healthcare professions.
- To be effective and efficient in enforcing compliance, the office has embarked on a process to engage stakeholders and other regulatory institutions to foster collaboration and improve working relationships.

The mission of the office is to promote voluntary compliance by all employees of the HPCSA and registered healthcare practitioners. Managing patient information is of utmost importance to maintain the trust of all stakeholders, including patients and clients, as well as maintaining the confidentiality and support of industry and legislative role players.

In the spirit of the HPCSA motto and the mandate of the HPCSA – that of protecting the public and guiding the profession – the council believes that all registered healthcare practitioners are responsible professionals who are committed to the ethical values of the profession and the regulations and rules of the Health Professions Act, regulations and other rules. The office, therefore, plans to attend to all matters concerning complaints around a compliance framework for the staff, practitioners and members of the public. While focusing on improving compliance, the office also aims to eradicate unregistered practitioners and members of the council, members of the public and other law enforcement agencies.

The office receives complaints from members of the public and referrals from departments and committees of the professional conduct boards, as well as criminal protection authorities. The office is developing an Integrated Compliance Strategy to bring about a significant reduction in the number of complaints and ensure that the Board is burdened unnecessarily and practitioners be subject to complaints that cannot be sustained.

**Prelim Decision (There are grounds for Inquiry)**
- If a preliminary inquiry decides that the respondent acted unprofessionally, or that an inquiry into the conduct of the respondent is impracticable or dishonest or dishonourable or unworthy, the committee may be composed of at least two public representatives, one of whom must be the chairperson; two persons registered in the profession in which the respondent is registered, at least one of whom registered in the same discipline as the respondent; one member of the Board; and one legal advisor.
- A Prelim decision cannot serve at PCC for the same matter.

**Legal Representation and Procedure at PCC**
- In the event of an appeal against a decision of the PCC, the respondent or the person aggrieved may appeal to the High Court in terms of section 42(8) of the Act.
- The PCC is entitled to appoint a professional conduct committee. Reg. 9 (23).
- The PCC procedure is similar to the civil procedure.
- A compulsory period of professional conduct committee. Reg. 9 (23).
- If it is found that the conduct of the respondent, it must direct that an inquiry be held or a complaint be referred to a professional conduct committee for an inquiry to be held or to a complaint to be investigated.
- The penalty that has been imposed.

**Prelim Decision (There are grounds for Inquiry)**
- If a preliminary inquiry decides that the respondent acted unprofessionally, but the committee finds that the matter is of minor transgression, the committee may impose a minor transgression penalty. Reg. 9 (23).
- In this case a charge gets formulated and communicated to the respondent who has 14 days to accept or reject the same.
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**Appeal against Preliminary Decision**
- The finding made and the penalty imposed by the preliminary committee of inquiry in terms of sub-section (4) or (5) is of immediate force and effect, but may be set aside by the High Court if the respondent appeals to the Court in terms of section 20 of the Act.
- At the end of the inquiry the PCC reaches a verdict (guilty/not guilty).
- Mitigation and aggravation followed by a penalty.

**Preemptive Guidelines for Conduct**
- The respondent or the person aggrieved may appeal to the High Court in terms of section 42(8) of the Act.
- A compulsory period of professional conduct committee. Reg. 9 (23).
- The PCC procedure is similar to the civil procedure.
- A prescribed fine.
- A caution or a reprimand and a caution or a prescribed fine.
- At the end of the inquiry the PCC reaches a verdict (guilty/not guilty).
- Mitigation and aggravation followed by a penalty.

**Preliminary Investigation**
- If a complaint is received by the Registrar, who then received by the Registrar, who then receives a complaint from the complainant and to present the complaint to the Professional Conduct Committee (PCC).
- The complaint must be submitted to the Committee of Inquiry which must be composed of at least two public representatives, one of whom must be the chairperson; two persons registered in the profession in which the respondent is registered, at least one of whom registered in the same discipline as the respondent; one member of the Board; and one legal advisor.
- The Prelim decision cannot serve at PCC for the same matter.

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**APPEAL AGAINST THE PRELIMINARY DECISION**
- The appeal to the High Court must be in force and effect from the date determined by the court and may be set aside by the court if the respondent is found guilty of a minor transgression penalty.
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Dr Letlape: Taking the HPCSA into a new era

The new president of the HPCSA is already bracing himself for the challenge. He insists no stone will remain unturned in bringing about positive change.

“We must be vigilant in setting and upholding the high standard of healthcare and training for which South Africa is known for. And that the South African public benefits from the services for which their taxes pay.”

That’s the message from newly appointed president of the Health Professions Council of South Africa, Dr Telogo Kgositeloe Solomon Letlape – experienced campaigner within the regulatory structures. Dr Letlape was appointed by the newly appointed executive council of the HPCSA and was recently inaugurated by Minister of Health, Dr Aaron Motsoaledi, along with the vice president, Mr Lesiba Arnold Mokotane. It is after much soul-searching that Dr Letlape accepted the challenge with humility and ever-changing healthcare realities.

Driven by a high regard for members of the healthcare profession and a passion for serving the patient population, Dr Letlape is perfectly placed to take the HPCSA into the future. Apart from a distinguished career as an ophthalmologist, Dr Letlape has also spent much of his time ensuring that the South African healthcare profession is held to the highest standards. Between 2001 and 2009, he served as the chairperson of the South African Medical Association, serving concurrently in the Council of the World Medical Association (from 2005 to 2006) as president of the World Medical Association and from 2003 to 2010 as a board member for the Professional Provident Society.

He has experience in a number of different roles at the HPCSA, giving him insight into the increasing demands facing practitioners in a dynamic and ever-changing healthcare milieu. His involvement with the HPCSA started in 2010, when he served as a member of the Medical and Dental Board from 2010-2013 and was part of the executive committee of council. From October 2011 to April 2012 he served as the acting registrar of the HPCSA. From 2010 to 2013, he served as a member of the ethics committee and the audit committee of the HPCSA, in addition to his duties he served as a member of the tariff committee of the Medical and Dental Board (MDB) and chair of the Prei Med2 Committee of the MDB between 2010 and 2015. He is acutely aware that South African practitioners have to operate in one of the most dynamic environments globally, but that it is the duty of the HPCSA to ensure that the working conditions of these practitioners “are conducive to better patient care.”

Dr Letlape qualified in 1981 with an MBBCh degree in Medicine at the University of Kwa-Zulu Natal. In 1988, he completed his FSC (OPHTH) degree in Ophthalmology at the College of Ophthalmology Medicine South Africa. In the same year, he obtained his FRCOphth degree in ophthalmology at the University of Edinburgh. His interest in primary healthcare for South Africans prompted him to participate in various boards and committees within and outside the HPCSA, including an affiliation to the College of Ophthalmology South Africa, Royal College of Ophthalmology in Edinburgh and the Ophthalmological Society of South Africa.

His responsibility is to take the HPCSA into a new realm, which he says, will be initiated within the next six months as the various health professional boards submit their strategic plans of all the boards and Council to the Minister. “These measures come as a response to a recent report in which the Minister of Health called into question the HPCSA’s governance, management and efficiency. Dr Letlape will be at the helm of the HPCSA for the next five years. “Self-regulation is an important part of the health profession and it is our collective responsibility to ensure that the council functions, because it is critical to the continued independence of the health professions. All parts of the organisation need to work together for the organisation to perform optimally.”

He has accepted the report as a call to action. Dr Letlape insists that no stone will remain unturned in looking into complaints and investigating incidents highlighted by the report. Demands on regulators have multiplied exponentially since the 1980s, and the structure providing oversight and guidance has simply not kept pace, he continues.

The more than 26 health professions regulated by Council has increased phenomenally. “In the past 35 years practitioner numbers have increased fourfold or more and we are now faced with a complex organisational matrix with an inadequate support structure,” he opines.

Dr Letlape says a thorough review of how the organisation functions to bring about the clarification of roles is critical to transforming the HPCSA into one that can fulfil its mandate. In addition, sufficient administrative support must be put in place. It is going to be necessary to balance the expectations and needs of the indifferent constituents in Council. “Healthcare practitioners across all the boards have an immense responsibility to society and it is the duty of the HPCSA to create a working environment that is conducive to ensuring that they can fulfil their oath.”

It is not only the welfare of patients that keeps Dr Letlape up at night; he is ever mindful of the fact that practitioners are required to put the needs of patients before their own. It is therefore incumbent upon Council to ensure that they don’t have to worry about paying rent or educating their children. Remuneration, continuing professional education, ethical and moral guidance, and vigilance in setting high standards are all areas which will receive attention.
As the outgoing president of the HPCSA, I thank the 2010/15 Council members for their endless support, guidance and perseverance in ensuring that HPCSA maintains its mission of “quality and equitable healthcare for all.”

Upon my appointment as president of the HPCSA, I knew that this would be a challenging position, but found that big challenges were accompanied by big rewards. A quote by Roger Crawford summarises my feelings: “Being challenged in life is inevitable, being defeated is optional.” Though we were challenged in many ways over the past years, we knew that failure or defeat was not an option.

My tenure was characterised by a lot of achievements during the past five years and I would like to highlight a few:

• In 2011 the HPCSA introduced a new era for psychology professionals by promulgating the amended scope of practice. The scope of practice was simplified for all psychologists, including clinical, counselling, educational, research, industrial, neuro-forensic and registered counsellors, as well as psychometrists.

• It is the responsibility of the HPCSA to ensure that it maintains the standard and quality of graduates in the country. In 2011 the scope of the professions of audiology and speech therapy reviewed the regulations to ensure that professionals were responsive to the needs of the country. We are now assured of their ability to be of service to all South Africans.

• In upholding its mandate, the HPCSA in 2012 and 2013, launched a massive media awareness campaign which emphasised health and human rights. These were the first ever national radio campaigns to reach the public who may have been unaware of the HPCSA’s role in the past. These campaigns also informed the public on how to lodge a complaint against a practitioner, in the event of their rights being breached by the practitioner.

• In conjunction with the radio campaigns, HPCSA embarked on nationwide roadshows throughout South Africa. The roadshows have become an important part of the HPCSA’s annual activities.

• I like to express my sincere gratitude to all members of the council members who provided a critical foundation for the achievements of the past five years. I acknowledge the input and guidance of the professional boards in executing their role in resolving problems and executing their duties.

• Last but not least, I express my gratitude to all members of the council members who provided a critical foundation for the achievements of the past five years. I acknowledge the input and guidance of the professional boards in executing their role in resolving problems and executing their duties.

• To the incoming council members, I wish you all the best. I have no doubt that you will continue to uphold the HPCSA mandate of protecting the public and guiding the professions.

Professor Mochichi Samuel Mokgokong.
At the end of their tenure, the respective boards report on the five years of serving the interests of healthcare practitioners and the public.

**PROFESSIONAL BOARD FOR DIETETICS AND NUTRITION**

1. The establishment of the register for nutritionists and the change of the name of the Board to the Professional Board for Dietetics and Nutrition in 2010.

2. The appointment of the Task Team on a situational analysis study to determine the extent of overlaps in the scopes of practice for the dietetic and nutrition professions. The purpose of the analysis was to define the roles and competencies of the Nutrition Professional (NP) in the well-being of the South African population. The purpose was to compare the skills and competencies of the nutrition professional as identified with the current skills and competencies for dietitians and nutritionists in terms of the SGB documents and to make a recommendation to the Board by the end of the term in terms of the scope of nutritionists.

3. The Board endorsed the Integrated Nutrition Programme (DoH, 1995), Roadmap for Nutrition in South Africa (DoH, 2010) and the Strategic Plan for Maternal, Newborn, Child and Women’s Health (MNCHW) and Nutrition in South Africa (DoH, 2012) and more recently tabled in parliament the National Development Plan 2012-2030. The Board recognised and accepts the obligations that improving the nutritional status of South Africans and in particular children is critical to their survival, health, growth and development. The mandate of ensuring that the implementation of the nutritional status of South Africans and in particular children is critical to their survival, health, growth and development is central to broader national development.

**PROFESSIONAL BOARD FOR DENTAL THERAPY AND ORAL HYGIENE**

A prominent task team, consisting of teaching staff from the educational institutions that trained the three categories of professionals, from the public and the private sector, and representatives of all the categories of oral health personnel, undertook the challenge of developing post graduate qualifications for dental assistants, dental therapists and oral hygienists. The Board also reviewed and improved key documents, such as the evaluation and accreditation guidelines and the ethical rules for the three professions and the development of guidelines for the accreditation of clinical sites. In line with the mandate of ensuring that the programmes offered at the institutions meet the minimum standards to ensure competent trained graduates, the Board has successfully completed the evaluations of the dental assisting programmes offered at the four universities of technology, as well as the evaluations of the dental therapy and oral hygiene programmes offered at the four traditional universities, the last one completed in April 2015.

Another milestone within the dental profession was the appointment of the Task Team on a situational analysis of theances of dental professionals and to make a determination of dentistry competencies for dietitians and nutritionists for the purpose of presenting a paper at The College of Paramedics Conference, United Kingdom. Many of the issues we are grappling within the South African context were the same as in other parts of the world, like USA, Canada, Switzerland, Australia and New Zealand.

4. The Board hosted a delegation of five officers from the Environmental Health Officers Registration Council of Nigeria. Best practices for efficient health programmes, conducted educational and accredited workshops in roadshows and the issuing of newsletters in order to enhance communications and stakeholder relations.

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6. The Board hosted a delegation of five officers from the Environmental Health Officers Registration Council of Nigeria. Best practices for efficient health programmes conducted educational and accredited workshops in roadshows and the issuing of newsletters in order to enhance communications and stakeholder relations.

7. The health promoters approached Council for consi-
The Board examinations
The Board examinations conducted by various universities on behalf of the Board continued to be effective and met the evaluation and assessment standards expected before qualified practitioners are registered. The Board has a responsibility to:
A) To determine and ensure maintenance of standards for professional practice and professions.
B) To determine and ensure upholding of standards for education and training.
C) To guide registration to students and to compliant practitioners to practice professions.
D) To register, where applicable, graduates for internship training.
E) To register, where applicable, graduates for community service.
F) To develop policy and formulate regulations and rules of conduct for professional practice.

The Scope of Practice for Clinical Associates was promulgated on 25 May 2015 for public comment. As part of the ongoing review processes, the Board has reviewed the current training ratios for education and training of specialists in Dentistry. On the other hand, the Board has signed an MOU on behalf of the Colleges of Medicine of South Africa (CMSA), to conduct community service training which will enable practitioners to be registered as specialists.

Accreditations
The Board also managed 93 accreditations ranging from training programmes and evaluation of training facilities which included internship evaluations, undergraduate education and training in medicine and dentistry, clinical education and examination, postgraduate education and training in medicine and dentistry and medical sciences.

Proposals for the different options/cases for articulation form the national diploma in medical technology to the BHS(P)-registration as well as the scope of the occupational therapy technician (OTT) and occupational therapy assistant (OTA) to be concluded.

The Board has been finalised at the roll-out of the evaluation of training laboratories which have applied to the Board for accreditation for training status. A schedule for this roll-out for all the regions has been compiled and issues such as roles, responsibilities and payment of fees were included in the MOU.

Outcomes for the new professional qualification were developed by the Board in consultation with heads of educational institutions in medical technology. The first application for accreditation of the BHS(P)-Medical Technologist and Therapist qualification to the Bachelor of Science qualification implemented to the profession. A career ladder was developed by the laboratory assistant qualification to the Bachelor of Health Science, medical laboratory science qualification implemented to the profession. The Board has largely been focusing on the evaluation and postgraduate education and training.

For the evaluation of universities of technology institutions the evaluation of minimum standards for medical orthotists and prosthetists was satisfactorily. The Board has finalised the draft regulations for the training of medical orthotists and prosthetists which recently applied for accreditation. The work of this task team is in progress and the draft proposals will be considered at the next meeting of the Board.

The Board undertook the following initiatives:
A) Proposed Standards of Practice documents of all professions.
B) Developed processes and procedures to evaluate professions registered to the Board andPagoza qualification to the Bachelor of Science qualification implemented to the profession.
C) Developed Standards of Practice.
D) Increased awareness and improved efficacy of clients/ patients to the benefit of the profession.
E) Developed competencies to the benefit of the profession.
rights for optometrists for per- sons practising the profession of optometry. However, the as- sociated essential drug list is missed and thus, the Board is still engaging with the MCC on it.

Promoting the health sector

In pursing the Board’s enda- vour to improve its open lines of communication with stake- holders, the Board held annual meetings with the heads of departments of optometry/dis- pensing opticiany, the National Optometry Forum (in public sec- tor optometry group) and the professional association to ad- dress matters of common inte- rest pertaining to education and eye care service delivery. These meetings have been very be- neficial in that all the stakeholders involved understood the Board objectives against developments and also the Board received use- ful feedback on how to improve in carrying out its mandates. The matter of community ser- vice is still with the Department of Health. However, the Board continued to engage the depart- ment and made further submis- sions. Approval by the depart- ment is, however, still pending. Volunteer optometry services being provided mainly by international practitioners/organisations has been a great concern for the Board. The Board thus pro- posed that Council tightens the regulation of these services to ensure the communities receive high-quality services.

Board performance survey tool

The Education, Training and Quality Assurance (ETQA) department has developed a tool to be used to collect data from professional boards for the purpose of monitoring their performances in areas of mandate. The ETQA Standing Committee resolved that the Boards should be requested to contribute to the basis that the tool is developed for this purpose. Subsequently, the ETQA Standing Committee resolved that the Board’s performance survey tool should be revised in line with the strategic objectives of the Boards to in- clude the development of stra- tegic plans, communication with stakeholders, financial matters and registration matters.

The Board submitted input re- garding the proposed tool. The tool has been used by the Board to evaluate its activities and objectives over a 12-month period. This en- abled the Board to identify areas where there was a need for im- provements as well as areas of excellence.

Roadshow meetings

The Board conducted two suc- cessful roadshows between 2014 and 2015. The roadshow events focused on the Board’s communication strategy of cre- ating a cohesive and effective communication environment.

The success of some of the Board members of the Board delivered presentations on a number of important matters including: the role and functions of HCPOA and the Board; strategic initiatives and objects of the Board; education, training and evaluation of facili- ties; and continuous professional de- velopment.

The Board saw the value and the importance of attending roadshows as it creates an op- portunity for engagements and building relationships with practi- tioners while encouraging a satis- factory attendance of all catego- ries of registration.

PROFESSIONAL BOARD FOR PSYCHOLOGY

During the past five years the Pro- fessional Board for Psychology focused on issues of communicat- ion with all stakeholders and to raise an awareness of the roles and responsibilities of the Board and HPCSA. Dialogue and align- ment of strategies with the public and professionals were also priorit- ised.

The Board participated in con- ferences by means of panel or open discussion slots and exhi- bition tables at the SIOPSA and Psychology Forum Conferences and EAPPSA conferences during this term. The International Test Commission (ITC) Conferences were all attend- ed by representatives of the Board and were held in Amster- dam, the Netherlands in 2012, Stockholm, Sweden in 2013 and San Francisco in 2014.

Some of the key achievements include the review of policies and guidelines such as:

A) Internship guidelines for Psy- chologists
B) Examination guidelines for Psy- chology practitioners
C) Guidelines pertaining to the educ- ation, training, registration and scope of registered counselors
D) Guidelines pertaining to the educa- tion, training, registration, and scope of psychologists
E) Guidelines for the evaluation of education, training and registration and training facilities
F) The scope of practice was fi- nally promulgated by the Minister of Health on 2 September 2011. However, a need was identified to review the scope as there were numerous typographical and other editorial errors. It was agreed to be attended to in regulations defining the scope of practice for psychology practitioners. The regulations defining the scope of practice for psychology practitioners were revised in line with the strategic objectives of the Board. It also appeared that medical schemes have formu- lated their own interpretations of the scopes of practice and as a result led to some of the medical schemes not recognizing praction- ees for services which they were unable to claim for prior to the promulgation of the scope of practice. A scope task team was appointed to oversee the process and the work will continue in the next term.

4. Regulations relating to the registration of student psychome- trists and student registered counsellors were promulgated during the period of review in or- der to ensure that possible gaps were closed and that these were being trained under in the Board’s jurisdiction. Regulations relating to the registration of psychome- trists were Gazetted on 14 February 2013. In March 2013, the Board approved the registration of the first registry of psychome- trists and the Board and its Committee struc- ture. The National Health Mental Health Council of South Africa adopted the Framework and Strategic Plan when the National Health Coun- cil of South Africa adopted the Framework and Strategic Plan when the National Health Coun- cil of South Africa adopted the Framework and Strategic Plan for Psychology.

Due to the need and demand for increased output and production of radiographers, a meeting of the representatives of the four edu- cational institutions was called and facilitated by the Board. The focus of the meeting was to iden- tify the strategies to improve the situation. It was agreed to com- promise on the profession of radio- graphy and patient safety. It was decided that each institution would now have to comply with the registration requirements by enacting regulations and issuing licenses to manage the licensing of the profession.

The Board relaxed the number of hours available for students to complete their training at schools. The Board approved the registration of the first registry of psychome- trists and the Board and its Committee struc- ture. The National Health Mental Health Council of South Africa adopted the Framework and Strategic Plan when the National Health Coun- cil of South Africa adopted the Framework and Strategic Plan when the National Health Coun- cil of South Africa adopted the Framework and Strategic Plan when the National Health Coun- cil of South Africa adopted the Framework and Strategic Plan when the National Health Coun- cilor the Royal College of Radiologists (RCR) and the South African College of Radiologists and Biomedical Sciences (SACRBS). The Board resolved that the issue of the Board’s recognition of the qualifications of those who have completed the more rigorous路roadshow as this creates an op- portunity for engagements and building relationships with practi- tioners while encouraging a satis- factory attendance of all catego- ries of registration.

3. The scope of practice was fi- nally promulgated by the Minister of Health on 2 September 2011. However, a need was identified to review the scope as there were numerous typographical and other editorial errors. It was agreed to be attended to in regulations defining the scope of practice for psychology practitioners. The regulations defining the scope of practice for psychology practitioners were revised in line with the strategic objectives of the Board. It also appeared that medical schemes have formu- lated their own interpretations of the scopes of practice and as a result led to some of the medical schemes not recognizing praction- ees for services which they were unable to claim for prior to the promulgation of the scope of practice. A scope task team was appointed to oversee the process and the work will continue in the next term.

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1. Policy development or review
- Finalised regulations relating to the undergraduate curriculum and professional examinations in (i) audiology and (ii) speech language therapy
- Finalised regulations relating to the registration of (i) audiology and (ii) speech language therapy students
- Finalised scope of practice of (i) audiologists and (ii) speech language therapists
- Regulations relating to the curricula and examinations for hearing aid acousticians are being finalized by the task team
- Scope of practice of professional mid-level workers (MLW) is in the process of being developed for (i) audiology technician (AT), and (ii) speech language therapy technician (SLTT)
- Regulations relating to the curricula and examinations for (i) AT and (ii) SLTT are being developed by task teams
- Reviewed and revised policy on supervised practice

2. System improvements
- Devised and finalised comprehensive documentation and processes for the evaluation for accreditation of higher education institutions for speech language therapy and audiology

3. Education
- Supported development and implementation of revised SLT and audiology curricula in existing programmes
- Supported development of SLT and audiology curricula and initiation of a new programme at the University of Fort Hare
- Initiated the accreditation of the new programme for hearing aid acousticians.

4. Standards setting
- Developed the following guidelines for audiology practice
  (a) Draft diagnostic protocols for paediatric populations
  (b) Draft guidelines diagnostic audiology in adults
  (c) Draft guidelines for industrial audiology
  (d) Draft guidelines for hearing and vision and fitting for adults
  (e) Draft guidelines for hearing screening services in Schools
  (f) Draft guidelines for newborn and infant hearing screening in South Africa
- Guidelines on the fitting of hearing instruments for children
- Guidelines for adult audiological rehabilitation
- Note that all these guidelines can be downloaded from our website www.hpcsa.co.za

5. Task Teams
- The Board facilitated development of guidelines for hearing screening in the following contexts:
  (a) Task Team: Midlevel workers
  (b) Task Team: Hearing screening Schools
  (c) Task Team: Hearing screening Otology
  (d) Task Team: Hearing screening (HAC) Early Hearing Detection and Intervention
  (e) Task Team: Hearing screening (HAC) (SLT and AT) service delivery

6. Continuing Professional Development
- The Board endorsed the HPCSA’s Maintenance of Licence to Practice proposal.
- The Board appointed the CPO Accreditors and Accredited Services in 2011.

7. Stakeholder engagement
- The Chair person and/or deputy chair person represented the Board at the following meetings:
  (a) The annual inter-university heads of department
  (b) The National Speech Therapy and Audiology Forum/Rehabilitation Forum
  (c) The National Department of Health re: EHDI, Disability and Rehabilitation Task Team
  (d) The meeting of the Medical and Dental, and Radiography Boards relating to use and ownership of X-ray equipment
  (e) The SAA and SASLHA conference at Sun City for business practices, ethics, introduction of MLW cadre, and in Cape Town (re EHDI)
  (f) The Department of Labour regarding occupational hearing screening.
- The Board hosted a Hearing Aid Acoustician Stakeholder consultation meeting to canvass views regarding the scope and education and training in this profession.
- The Board took note of the findings of the above consultation meeting and developed a consultation paper.
- The Board initiated and chaired a meeting with the Department of Basic Education, Professional Boards for physiotherapy, occupational therapy and psychology regarding, norms and standards and human resource for implementation of rehabilitation services.
- The Board collaborated with the National Speech Therapy and Audiology Forum and University of Limpopo for the preparation of a position statement on supervised practice for hearing aid acousticians.
- The Board established task teams comprising members of the profession, and universities to develop guidelines for:
  (a) hearing acousticians; and
  (b) hearing screening: EHDI, schools, otology, and MLWs: SLT and AT.
- The Board consulted with the profession (via surveys from its task teams) regarding EHDI, school screening, MLWs.
- The Board liaised with the South African Language Hearing Association regarding the proposed Memorandum of Understanding pertaining to a mutual recognition agreement which would facilitate recognition of credentials among speech language therapy professional associations in six countries.

In terms of section 3 of the Health Professions Act, 1974 (Act No. 56 of 1974), all professions which are practised in South Africa are required to register with a professional council, and to abide by the rules and regulations thereof. The Health Professions Council of South Africa (HPCSA) is the sole body responsible for the regulation of the health care profession (via surveys from its task teams) regarding EHDI, school screening, MLWs.

8. Legislation
- The SAAA and SASLHA are working towards the establishment of a National Speech Therapy and Audiology (SLT) Board of Registration. The role of this Board will be to register and regulate speech-language therapists, speech-language pathologists, and audiology technician. This work is ongoing.
- The SAAA and SASLHA is in the process of being developed for (i) audiology technician (AT), and (ii) speech language therapy technician (SLTT)
- The Board liaised with the South African Language Hearing Association regarding the proposed Memorandum of Understanding pertaining to a mutual recognition agreement which would facilitate recognition of credentials among speech language therapy professional associations in six countries.

9. Consultation
- The Board collaborated with the National Speech Therapy and Audiology Forum and University of Limpopo for the preparation of a position statement on supervised practice for hearing aid acousticians.
- The Board established task teams comprising members of the profession, and universities to develop guidelines for:
  (a) hearing acousticians; and
  (b) hearing screening: EHDI, schools, otology; and MLWs: SLT and AT.
- The Board consulted with the profession (via surveys from its task teams) regarding EHDI, school screening, MLWs.
- The Board liaised with the South African Language Hearing Association. This work is ongoing.
- The Board was part of the Roadshow organised by the Public Relations Department of the HPCSA in 2013 to bring awareness to the public and practitioners about Health Professions Council.
- The Board Deputy Chair person engaged with issues of hearing amplifiers and represented the Board in the media regarding this matter.

10. Committee of preliminary inquiry
- The Committee of Preliminary Inquiry dealt with 61 cases over the period under review as follows:
  (a) Finalised/Closed matters: 19; and
  (b) Matters referred before preliminary inquiry: 6;
  (c) Cases pending: 29.
- Of these, 1206 matters were finalised by Committees of Preliminary Inquiry, an increase from 564 matters in 2010/11.

11. Investigation and prosecution of complaints concerning practitioners
- The Department of Labour is in the process of being developed for (i) audiology technician (AT), and (ii) speech language therapy technician (SLTT)
- The Board liaised with the South African Language Hearing Association regarding the proposed Memorandum of Understanding pertaining to a mutual recognition agreement which would facilitate recognition of credentials among speech language therapy professional associations in six countries.
**Stats and Facts**

**As a Snapshot Review**

**Contact Details**

**Call Centre**
012 338 9300/1
www.hpcsa.co.za

**General Queries**
info@hpcsa.co.za

**Fees and Payments**
finance@hpcsa.co.za

**CPD**
cpd@hpcsa.co.za

**Change of Details**
records@hpcsa.co.za

**Requests for Certificate of Status**
hpcscacs@hpcsa.co.za

**Complaints Against Practitioners**
legalmed@hpcsa.co.za

**Service Delivery Complaints or Compliments**
servicedelivery@hpcsa.co.za

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**Number of Active Registered Categories Registered as at 1 September 2015**

- Dental Therapy and Oral Hygiene: 4,840
- Dietetics and Nutrition: 3,187
- Environmental Health: 3,158
- Emergency Care: 71,251
- Medical and Dental: 49,672
- Medical Technology: 9,352
- Occupational Therapy, Medical Orthotics/Prosthetics and Arts Therapy: 5,827
- Optometry and Dispensing Opticians: 3,804
- Physiotherapy, Podiatry and Biokinetics: 8,913
- Psychology: 11,075
- Radiography and Clinical Technology: 8,481
- Speech/Language and Hearing: 2,919

**Number of Active Intern Categories Registered as of 1 September 2015**

- Medical and Dental: 3,154
- Medical Technology: 664
- Occupational Therapy, Medical Orthotics/Prosthetics and Arts Therapy: 1,144
- Physiotherapy, Podiatry and Biokinetics: 454
- Psychology: 863

**Number of Active Student Categories Registered as at 1 September 2015**

- Dental Therapy and Oral Hygiene: 2,364
- Dietetics and Nutrition: 1,811
- Environmental Health: 1,714
- Medical and Dental: 16,370
- Medical Technology: 7,406
- Occupational Therapy, Medical Orthotics/Prosthetics and Arts Therapy: 2,347
- Optometry and Dispensing Opticians: 1,247
- Physiotherapy, Podiatry and Biokinetics: 3,141
- Psychology: 3,275
- Radiography and Clinical Technology: 2,782
- Speech/Language and Hearing: 1,523

**Number of Active Qualified Practitioners as at 1 September 2015**

- Age
  - <20: 179
  - 20–29: 45,858
  - 30–39: 64,491
  - 40–49: 36,951
  - 50–59: 19,792
  - 60–69: 8,969
  - 70–79: 3,109
  - 80+: 2,842
  - No DOB: 1,548

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**Legal Matters**

**As at 31 March 2015**

**Complaints Received**

- 2013/14: 3,026
- 2014/15: 2,597

**Matters Finalised by Committees of Preliminary Inquiry, Explanations Not-Ed and Cases Withdrawn**

- 2013/14: 1,115
- 2014/15: 1,206

**Matters Finalised by Committees of Preliminary Inquiry**

- 2013/14: 309
- 2014/15: 364

**Most Prominent Finalized Matters per Offence**

- Incompetence: 55
- Insufficient care/treatment and mismanagement of patients: 33
- Overcharging/charging for services not rendered: 25
- Issues relating to consent: 61
- Fraud and theft: 21
- Bringing the professions into disrepute: 21
SUMMARY

**BUDGETED INCOME AND EXPENDITURE CONTRIBUTION STATEMENT FOR 2014/15**

**INCOME**

- Annual fees – current year: R152 039 420
- Unidentified receipts recognised: R1 335 013
- Registration fees: R16 897 385
- Annual fees – prior year: R2 847 092
- Fees from penalties imposed: R2 605 350
- Other income: R30 458 741

**TOTAL INCOME**: R206 183 001

**EXPENSES**

- Air-conditioning expenses: R168 035
- Auditors remuneration: R1 723 230
- Increase/(decrease) in provision for bad debts: R377 697
- Bank charges: R118 805
- Cleaning: R915 022
- Consulting and professional fees: R915 022
- Council, professional board and committee meetings: R41 874 610
- Depreciation, amortisation and impairments: R2 806 759
- Employee costs: R104 509 982
- Equipment and furniture less than R1 000: R407 490
- IT expenses: R2 252 105
- Insurance: R458 300
- Internal audit fees: R172 300
- International conference: R590 596
- Lease rentals on operating lease: R1 678 323
- Legal expenses: R2 806 759
- Loss on sale of assets: R7 027
- Municipal expenses: R1 819 714
- Postage: R3 079 699
- Printing and stationery: R3 191 525
- Public relations and promotions: R3 132 262
- RAF expenses: R3 868 381
- Repairs and maintenance: R1 139 968
- Security: R780 989
- Settlement labour cases – employees: R494 776
- Strategic projects: R2 521 835
- Subscriptions: R1 819 714
- Telephone and fax: R883 735
- Tender administrative costs: R71 893

**TOTAL EXPENSES**: R200 642 916

**SURPLUS**: RS 540 085

**179**

**<20 YRS**

**45 858**

**20–29 YRS**

**64 491**

**30–39 YRS**

**36 951**

**40–49 YRS**

**19 792**

**50–59 YRS**

**45 858**

**60–69 YRS**

**45 858**

**70–79 YRS**

**2 842**

**80+ YRS**

**1 548**

**TOTAL INCOME**: R206 183 001

**SURPLUS**: RS 540 085

**179**

**<20 YRS**

**45 858**

**20–29 YRS**

**64 491**

**30–39 YRS**

**36 951**

**40–49 YRS**

**19 792**

**50–59 YRS**

**45 858**

**60–69 YRS**

**45 858**

**70–79 YRS**

**2 842**

**80+ YRS**

**1 548**

**TOTAL INCOME**: R206 183 001

**SURPLUS**: RS 540 085

**AGE DISTRIBUTION OF QUALIFIED REGISTERED PRACTITIONERS AS AT 1 SEPTEMBER 2015:**

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**GUIDANCE**

We have kept to our mandate of providing meaningful guidance to the practitioners. In 2015, we held two successful practitioner roadshows and symposiums. The first roadshow was held in Cape Town on 26 March 2015 and the other one in Gauteng on 15 September 2015. To ensure that HPCSA upholds its mandate of Guiding the Professions across the board, symposiums were held in various regions.

The aim was to engage with practitioners on a face-to-face basis, educate and update on pertinent issues that affect their professional lives. Over 450 community representatives attended the first ever HPCSA public roadshow which was held in Soshanguve, Pretoria on 16 September 2015. This was the first in a series of roadshows scheduled that was aimed at addressing the following:

- The mandate of the HPCSA
- Educating the public on healthcare matters
- How to identify legitimate healthcare practitioners and processes thereafter
- Apprising patients on the scope of practice of healthcare practitioners registered with the HPCSA.
- Apprising the public on the do’s and don’ts when consulting with healthcare practitioners.

As part of the roadshow, the panel, the Registrar and Chief Executive Officer, Dr Mjamba, the Chief Operations Office, Advocate Tshepo Bokanyo, the Head of the Legal Department, Advocate Khumalo the manager for the Inspectorate Office, Mr Eric Mphaipuli had the opportunity to interact with members of the community through and it was evident that more roadshows were needed. By the end of the roadshow, there was a clear indication that the HPCSA has to keep upholding its mandate of protecting the public through these roadshows.

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**ROADSHOWS HIGHLIGHTED KEY ISSUES**

Valuable insights were gained during this year’s roadshows, benefiting both professional boards and practitioners.
The Professional Boards form the backbone to the operations of the HPCSA. As joint co-coordinating bodies for health-care practitioners registered with the HPCSA, the Boards deal with matters relating to specific professions. Following an extensive consultation and nomination process, the HPCSA is proud to announce the appointment of new members to the Professional Boards for a five year term of office. Membership came into effect on 1 July 2015 and ends on 30 June 2020.

**NEW PROFESSIONAL BOARDS**

**DIETETICS AND NUTRITION**

Back row: Ms A Nkosi; Ms S Makhathini; Ms H Koornhof; Mr T Mazinyo; Ms M Maifadi; Prof P Kuzwayo.

Front row: Ms P von Poser; Ms F Segooa; Ms S Singh; Mr J Nair; Mr M Pradzi; Ms Y Naidoo; Ms A Pinto-Prins.

**OPTOMETRY & DISPENSING OPTICIANS**

Back row: Ms T Vundule (Board Manager); Ms M Mphidi (Committee Co-ordinator); Ms C Botha; Mr N Naidoo; Ms Modern Ramare (Secretary); Mr M Kobee (Chairperson); Mr M Dookza; Dr M Ndlela; Prof O Maguvhe.

Front row: Ms H Mbhatsani; Ms L Spies; Prof S Hanekom (sitting, Chairperson); Dr R Ladzani; Ms M Mabusela (Committee Coordinator).

**EMERGENCY CARE**

Back row: Ms A Mayekiso; Ms C Monica Maponyane; Mr W van der Net; Mr N Silhoti; Dr C Silwanda; Mr V Vcoorendyk; Mr B van Nueten; Mr J Ramalivhana; Mr K Naidoo; Mr F Steyn; Mr D Francis; Mrs A Pieters (Board Manager).

Front row: Mr J Mokoena; Ms M Malatetsa; Mrs D Mhlaube; Mr L Makotana (Chairperson); Dr B Mjamba-Matshoba (Registrar/CEO); Mr S Sibuwa (Vice Chairperson); Ms M Modise; Mrs S Shrimidi; Prof S Paruk.

**MEDICAL AND DENTAL (AND MEDICAL SCIENCE)**

Back row: Ms A Mayekiso; Ms C Monica Maponyane; Mr W van der Net; Mr N Silhoti; Dr C Silwanda; Mr V Vcoorendyk; Mr B van Nueten; Mr J Ramalivhana; Mr K Naidoo; Mr F Steyn; Mr D Francis; Mrs A Pieters (Board Manager).

Front row: Mr J Mokoena; Ms R Mafetsa; Mrs D Muhlbauer; Mr L Malatotsa (Chairperson); Dr B Mjamba-Matshoba (Registrar/CEO); Mr S Sibuwa (Vice Chairperson); Ms M Modise; Mrs S Shrimidi; Prof S Paruk.
What is your idea of perfect happiness?
World peace. And week on an idyllic island with no cell phone reception.

What is your greatest fear?
Failing to recognise opportunities on my path of life on earth.

What is the trait you most deplore in yourself?
Impatience.

What is the trait you most deplore in others?
Dishonesty and insincerity.

Which living person do you most admire?
My parents.

What is your greatest extravagance?
I like to think that I am of humble cloth. Not being materialistic, I believe almost everything is extravagant!

What is your current state of mind?
Depends on who wants to know.

On what occasion do you lie?
I would be lying if I say I occasionally lie; I prefer to deal with the consequences of being truthful.

What do you most dislike about your appearance?
Nothing. Being around disability and hardship daily, I am just so grateful to be healthy.

What is the quality you most like in a man?
Gentle, honest, faithful, self-confident, mature, strong convictions. The most important qualities are unpretentiousness and sincerity.

What is the quality you most like in a woman?
Is it different for women?

Which words or phrases do you most overuse?
"You always have a choice."

What or who is the greatest love of your life?
My family.

When and where were you happiest?
With family and/or friends.

Which talent would you most like to have?
Professional golfer – it teaches you patience.

If you could change one thing about yourself, what would it be?
My tendency to be impatient.

What do you consider your greatest achievement?
To my parent’s relief, finishing school!

If you were to die and come back as a person or a thing, what would it be?
My Jack Russel, Zettie.

Where would you most like to live?
Home is where your heart is. However, the Southern Cape has beautiful landscapes and people.

What is your most treasured possession?
My mind - not that it really belongs to me.

What do you consider the most overrated virtue?
Loyalty.

What do you regard as the lowest depth of misery?
Skinny women complaining about their weight.

What do you most value in your friends?
Their brutal honesty and unconditional love and support.

Who are your heroes in real life?
All of those who despite adversities, continue to live a life of gratitude, encouraging and inspiring others with their positive attitude, accepting that life is not fair.

What are your favorite names?
Joshua and Louise.

What is it that you most dislike?
Turkish Delight.

What is your greatest regret?
I am afraid, I have none. All our experiences shape and mould us and that in itself is a privilege, not something to regret.

How would you like to die?
Quickly….

What is your motto?
Be kind always.

Do not be scared to fail in search of achieving your goal or dream.
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