HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

MEDICAL AND DENTAL PROFESSIONS BOARD

HANDBOOK ON INTERNSHIP TRAINING

GUIDELINES FOR INTERNS, ACCREDITED FACILITIES AND HEALTH AUTHORITIES

PRETORIA
2024 EDITION

PREFACE

On behalf the Medical and Dental Professions Board (MDB), I have the pleasure of making this Handbook available to all Interns, Intern Curators, and Accredited Facilities for Internship Training and Health Authorities who are involved with internship training and who employ interns.

The Board has come to appreciate the need in practice to obtain clear guidelines for internship training. Thus, based on experiences of Board members, Evaluators of Internship Training and inputs of those who went through Internship Training, this *Handbook for Internship Training* has been revised and we trust that it will be relevant as a guideline that will serve the needs of Interns and those responsible for their training.

The Medical and Dental Professions Board looks forward to ongoing improvement in the nature and quality of internship training as part of its role and mission of "Protecting the Public and Guiding the Professions". Part of this improvement is through the feedback and inputs from all our interns during their internship training. As of January 2020, Internship training model has been modified to incorporate six months of training in the primary health platform in the second year. The training will be for 24 months with specific domains to be completed in the first year before proceeding to the domains of second year. This has resulted in the expansion of existing training platform incorporating the district health system. This we consider as transformational in the area of training and service delivery

The Board expresses its gratitude to all who have contributed to this document, and this include the members of Medical Education, Training and Registration Committee, Panel of Evaluators of Internship Training, Secretariat and all those who have worked tirelessly in the revision of this Handbook.

Please address your comments to Health Professions Council of South Africa, P O Box 205, Pretoria, 0001.

Email: servicedelivery@hpcsa.co.za
Office number: 012 338 9000

PROF JLA RANTLOANE
CHAIRPERSON: MEDICAL AND DENTAL PROFESSIONS BOARD

DECEMBER 2023

TABLE OF CONTENTS

INTRODUCTION

It is accepted and practised world-wide that there should be a period of supervised training for newly qualified doctors before they can register as medical practitioners. This training is usually for one year, but in many countries further training is required before registration is possible for independent practice as a general practitioner, as is the requirement also for independent practice in any specialty.

Internship training refers to the period of training in an accredited facility, i.e. a hospital, clinic, health centre or Complex of facilities. The period of internship training is two years after qualifying as a medical graduate.

This document provides guidelines for the training of graduates in a two-year internship training programme. The principles underlying internship remain the same especially if offered in the same complex of facilities.

This *Handbook on Internship Training* consists of the following sections:

Part I which provides broad guidelines applicable to all facilities and domains (disciplines).

Part II which provides the specific criteria and objectives of internship training in each domain.

Part III which deals with ethical and medico-legal aspects of internship training.

It should be appreciated that these guidelines are based on the comments of many individuals and therefore, reflect a consensus of views. It should also be borne in mind that accredited facilities differ widely in their structure and the scope of the patient care services that they offer.

Apart from the above, this document contains a series of **Annexures** which should provide interns and the bodies/persons involved in their training, with some valuable information on the requirements for, as well as the nature and content of internship training, and the facilities which offer such training.

PART I
GUIDELINES PERTAINING TO THE NATURE, STRUCTURE AND DOMAINS OF INTERNSHIP TRAINING

1 AIMS AND PURPOSE OF INTERNSHIP TRAINING

The purpose of internship training is that interns will complete their medical training under supervision and guidance in accredited facilities. They should effect the transition from undergraduate students, with responsibility primarily to themselves, to professional persons with responsibilities to patients, the health team and communities. Internship training should provide opportunities to further develop interns' knowledge, skills, appropriate behaviour patterns and professional thinking, as well as to gain insight, understanding and experience in patient care to equip themselves to function as competent and safe medical practitioners.

Training should be comprehensive and complementary to the health care system being developed for South Africa which places emphasis on the primary health care approach. The training should provide exposure to a spectrum of clinical conditions to provide a wide base of experience as a first step towards further training and study with a view to private practice, specialisation or continued hospital practice. Skills in the management of common emergencies should also be developed.

The importance of cost consciousness, professional behaviour patterns and ethics in professional practice form additional components in this training, both at the informal and semi-formal levels, and by example. Interns should be aware of the *Charter on Patient Rights* (see the document compiled by the Department of Health as contained in Annexure F) as well as the Batho Pele principles (Annexure G). The investigation and management of patients should be in line with those recommendations.

2 FUNCTIONS OF THE MEDICAL AND DENTAL PROFESSIONS BOARD

Internship training should be a constructive, organised and progressive period of training. It therefore forms part of the responsibility of the Medical and Dental Professions Board (hereafter referred to as "the Board"), in co-operation with educational institutions and employing Health Authorities, to ensure that newly qualified practitioners are adequately trained and sufficiently competent when applying to the Board for registration as medical practitioners. As such, it falls within the Board's statutory obligation to act on behalf of the profession by guidance and in the interest of the public. Training will only take place at facilities accredited by the Board, and such status shall be subject to regular accreditation visits (evaluations) and adherence to the prescribed criteria and requirements. It shall be provided by trainers who are medical practitioners with adequate experience (i.e. at least three years post-internship) in that specific domain, and who are accredited by the Board.

3. CRITERIA FOR THE TRAINING OF INTERNS

The following are basic requirements which shall be complied with:

Internship Training shall only be recognised if the intern was registered in terms of the *Health Professions Act, 1974 (Act No. 56 of 1974 as amended by Act No. 29 of 2007),* for the full period of training (see Annexures A, D and E) and if training took place in one or more of the facilities which were accredited by the Board for this purpose (see Annexure K).

CONDITIONS OF INTERNSHIP TRAINING -

Internship training commencing after **1 July 2004** shall be of not less **than twenty-four (24)** months' duration and, where it is broken or interrupted, it shall be completed within a continuous period of **thirty-six (36) months.** Extension beyond 36 months may be considered under the following circumstances

3.1 Late commencement of training after graduation/registration: The Registrar may register the intern administratively so that the intern can complete the internship programme;

However, if the delay in commencement is more than 5 years post-graduation/registration, the Board shall require the intern to pass a competency assessment before commencing internship:

3.2 Interruption of training due to physical or mental illness: The Registrar may grant permission to resume internship on presentation of a valid fitness certificate either from the treating practitioner or the Health Committee on condition that the period of absence from training is less than five years. If the interruption exceeds five years, the Board shall require the intern to pass a competency assessment before resuming internship

3.3 In any other scenario, the matter must be referred to the Board for consideration.

4. CRITERIA PERTAINING TO THE INTERNSHIP TRAINING PROGRAMME

Internship Training shall take place during a **two-year** training period, as follows:

Year 1

Domain	**Duration**
General Medicine	3 months
General surgery	3 months
Paediatrics	3 months
Obstetrics and Gynaecology	3 months

Year 2

Anaesthesiology	2 months
Orthopaedics	2 months
Psychiatry	2 months
Family Medicine/Primary care	6 months

The two years of internship training should preferably be completed in the same facility/complex/cluster/geographical area and **year one domains must be completed before proceeding to year two domains.**

In the case of interns who would be required to complete additional time in the first year domains due to training/skills needs or absence from duty , or any other reason that a facility may determine , such time should be completed before proceeding to training in the second year domains If such extensions are of short duration, arrangements can be made with the hospital management to complete those extensions within the first 12 months during free periods available in the ensuing domains. This will allow the intern to proceed to second year along with the rest of the group.
Extensions in the second year, if feasible can similarly be planned so that the total training can be within the prescribed period of 24 months.

This will not be possible when there are longer extensions. Unfortunately training of such interns will be asynchronous with the rest of the interns as domains with extensions in first year will have to be completed successfully before proceeding to domains for second year.

All domains should be completed in a single, continuous rotation in the event of late starters, such interns may have to wait till the start date of the domain. For example, if an intern is allocated to an institution in March and the start date of the domain is April, then the intern can commence internship only in April. This is to ensure uninterrupted training in that domain and to be synchronous with the rest of the interns. Interns whose continuation of training has been delayed will have to complete all the domains of first year before proceeding to the second-year domains. This will make them asynchronous. The hospital in such instances must plan appropriately to manage the situation.

SPECIALTY TRAINING

The domains of training will remain the same and all logbook requirements of these domains must be met within the stipulated period.

In the case where an intern is given an opportunity for exposure to related specialities and sub specialities by the domain supervisor, the total duration of such exposure must not be more than two weeks in 3 months rotation.

These supervisors must still take overall responsibility for the domain Examples of specialities/sub specialities include ENT, Ophthalmology, Paediatric Surgery, Urology, Neurosurgery, Neurology, Cardiology, Pulmonology, Dermatology, paediatric sub specialities except Neonatology etc. Please ensure that interns are not used purely for administrative work but would benefit from the clinical experience offered by these divisions.

5. LEAVE DURING THE TWO-YEAR INTERNSHIP TRAINING PROGRAMME

The provision for leave benefits forms part of the conditions of service of the Department of Health and is in accordance with the Labour Relations Act, 1995 (Act No 66 of 1995)

NB: Interns should be sensitized that more than 2 months of leave in the 2-year period may result in extension of training in specific domains were additional leave has been availed. Such extension will be implemented in the following circumstances

- **Competencies not achieved and;**
- **The period of absence exceeds 20% of the total training time of the domain.**

The following arrangements regarding leave during the two-year internship training program shall apply as per the Department of Public Service Association guidelines:

5.1 Annual leave of 22 working days/year thus 44 days over a period of 2 years;
5.2 Sick leave of 24 days over the period of 2 years;
5.3 Family responsibility leave of 10 days/year thus 20 days over the period of 2 years;
   a. A maximum of 5 days for death of a direct family member or spouse (per year);
   b. A maximum of 10 days of paternity leave (per year);
   c. A maximum of 5 days for illness of direct family (per year).

Maternity leave may be granted for a period of four (4) months resulting in the intern having to extend the internship training by an additional four months.
Special leave up to **Seven (7) days per year** may be approved for core skills training related to internship planned leave may be granted in the domains as follows:

i. A maximum of Five working days in a two-month domain
ii. A maximum of Seven working days in a Three-month domain

iii. A maximum of Twelve working days in a Six-month domain

However, the planned leave in each year must not exceed Twenty-Two (22) working days.

6. INTERNSHIP REQUIREMENTS FOR PERSONS GOING ABROAD

Applications received from South African citizens, who qualified in South Africa, but completed their internship training abroad, would be dealt with in the following manner:

Applications would be dealt with on an individual, ad hoc basis.

Recognition could be granted for domains of an equivalent, acceptable standard in accordance with the guidelines for internship training in South Africa.

The domains not covered during training abroad, should preferably be completed within a single complex accredited for internship training.

Such practitioners would have to apply to the Department of Health for positions to complete the remainder of the internship training.

Practitioners would be encouraged to complete the requirements for training and registration with specific reference to internship training in South Africa rather than completing internship training overseas which might not be approved.
Practitioners would be expected to submit a satisfactory and current (not older than three (6) months) Certificate of Good Standing prior to registration.

7. OVERTIME REQUIREMENTS DURING INTERNSHIP TRAINING

It is confirmed that interns in medicine should perform overtime duties. It is expected of interns to be on duty for an average of 56 hours per week to a maximum of 60 hours per week and that overtime was part of service delivery and training. Interns are not permitted to refuse to work overtime. However continuous working hours is limited to a maximum of 26 hours. Shorter shifts are preferred.

8. REQUESTS FOR TRANSFERS

The Board, in September 2007, resolved that the recommendation pertaining to the transfer (swopping) of interns be maintained, namely that it was preferable that interns completed their internship training programme within the same facility/complex and that, should exceptional circumstances arise, management of the facility and provincial authorities concerned be mandated to solve the matter.

The following should be noted regarding a request for a transfer from one facility to another

Once the results of the allocation of interns are released, the respective Provincial Co-ordinators could decide whether to allow a transfer or not.

Should an intern request a transfer, the intern should make a written request to the applicable Provincial Co-ordinator. That Province should then release the intern (in writing) with details of domains completed Logbook must also be up to date.
The Province where the intern would want a transfer to, must then accept the intern in writing.
All correspondence should then be forwarded to the National Department of Health for endorsement as well as copies thereof to the Board. The Board is not responsible for facilitating transfer of interns between facilities.

Should the province in question refuse to release an intern in medicine, the National Department of Health may not be able to permit such a transfer.

9. ACCREDITED FACILITIES

9.1 APPLICATION FOR ACCREDITATION OF FACILITIES

Facilities, on the recommendation of Provincial Authorities or the South African Military Health Services, may apply to the Board for accreditation as internship training facilities, whether district, regional, tertiary, central or specialised. This may be done singly or as a complex, which could include specialised facilities such as psychiatric or maternity hospitals. A group of accredited facilities may thus share interns to provide wider clinical experience and training. Similarly, community health centres may also participate in training; provided that they are complexed with a base hospital and meet the criteria for accreditation (see Annexure I).

9.2 FACILITIES RELATING TO CLINICAL DOMAINS

An accredited facility shall provide adequate opportunities for the intern to obtain a wide range of clinical experience relating to in-patients, out-patients and emergency services. There shall be sufficient facilities to ensure a proper diagnosis and correct treatment under satisfactory conditions. The Board considers it desirable that the intern be responsible for; not more than twenty-five and not less than fifteen short-term in-patients (which may be reduced to ten patients, should the intern rotate through critical care units in appropriate domains) and that he or she be allocated to not more than two out-patient sessions per week as fixed duty.

9.3 SUPPORT SERVICES

Support services such as diagnostic radiological services, main laboratories (Haematology, Biochemistry, Microbiology, and in the other Pathology disciplines), the pharmacy, the services of other health care professionals, a library and other specialised services should be available. Interns should be encouraged to do their own ECG's and routine side-room tests.

9.4 ALLOCATION OF INTERNS

The appointment of interns and the number appointed at any accredited facility are the prerogative of the employing Health Authority. Although primarily training posts, it should be obvious that a smaller than recommended number of interns allocated to an accredited facility, will place a greater clinical burden on other categories of personnel.

It is recommended that at least 80 % of the accredited internship training posts be filled at all accredited facilities.

9.5 ACCREDITATION VISITS TO (EVALUATION OF) ACCREDITED FACILITIES

Regular visits/evaluations by the Board to accredited facilities will be arranged to ensure that the accredited facility is adequately fulfilling its training function and, if not, such status may be withdrawn.

Visits/evaluations at accredited facilities are carried out by Evaluators of Internship Training appointed by the Board for this purpose. Criteria for the appointment of Evaluators for Internship Training are contained in Annexure M. Liaison between the Evaluators and Provincial Co-ordinators of Internship Training, appointed by Provincial Health Authorities, will aid the planning, conducting, as well as an appreciation of the importance of such visits/evaluations.

For the purpose of these visits/evaluations, Medical Superintendents/CEO's/Hospital Managers are required to provide the Board with detailed information on the prescribed forms prior to a

visit/evaluation taking place. This information must be the result of a self-analysis in terms of the *Criteria of Accreditation of Facilities* (see Annexure I and shall, amongst others, include the views of interns. This information is essential and forms the basis for the assessment of a facility/complex by the Evaluators of Internship Training for accreditation purposes.

10. SUPERVISION OF AND RESPONSIBILITY FOR TRAINING

The primary responsibility for interns firstly rests with the Chief Executive Officer/ /Medical Manager as representative of the Health Authority under which the facility functions. Thus, the CEO/ /Medical Manager plays an important role in ensuring that the requirements of the Board are being met.

The secondary responsibility for the training of interns rests with the senior medical staff. The CEO/Medical Manager is aided by Heads of Domains and other senior personnel who will supervise the training of interns on a daily basis to ensure that the aims and objectives of proper internship training are being met. Apart from their clinical obligation towards patients, it is essential that time be devoted to the training of interns. Furthermore, each relevant clinical department should have a named supervisor to co-ordinate training in that domain.

10.1 DOMAIN SUPERVISORS

Clinical Domains should have a specific supervisor who is responsible for the training of interns in that domain.

The Supervisor is to assist the Intern Curator who is appointed for a whole facility. In large hospitals it is not possible for the Intern Curator to keep in touch with the many interns in the various departments.

Most of the minor complaints of interns relate to “in-house” issues that the Domain Supervisor can resolve. Obviously more serious problems (operational or personal) should be reported to the Intern Curator.

10.2 RESPONSIBILITIES

- Welcome and orientation of interns into the Domain.
- Provide job descriptions.
- Allocation of interns within the Domain.
- Act as liaison between the interns and staff whether nursing or medical.
- Drawing up of the duty roster.
- Supervising leave arrangements including sick leave.
- Co-ordinate the evaluation of interns.
- Ensuring the completion and signing of Logbooks.

Interns should be supervised by a registered medical practitioner with at least three (3) years (post internship training) of clinical experience in that specific domain of training.

The ratio of interns, versus supervisors for the supervision of interns in medicine, be based on a ratio of 4:1.

Specialists, Medical Officers and other practitioners are, by their continual contact with interns, important components in their training and all of them are morally obliged to participate in such training. This applies also to part-time appointees.

Access to supervisors should be available 24 hours per day. Interns should be supported by at least one medical officer or registrar on the hospital premises.

After-hours call rosters should be drafted with an intern on duty, a medical officer on first call and a consultant on second call.
An intern should not work alone in any critical areas such as casualty, labour ward, ICU or theatre. The person supporting him or her must therefore remain on the premises of the health facility (suitable call rooms are imperative). In practice this may be a relatively junior person that can support the intern. Note that the responsibility of supervision and patient care rests with a more senior person whether a medical officer or consultant. He or she should be available at all times and personally assist the intern as required. The senior person on call carries the medico-legal responsibility, since supervision means the acceptance of liability for the acts of another practitioner.

In smaller hospitals, the CEO/Medical Manager may personally perform these supervisory functions. In larger hospitals, the CEO/Medical Manager should, however, appoint an Intern Curator to assist him or her. The functions of the Intern Curator are fully described in 11 hereunder.

11. THE INTERN CURATOR

This person, preferably an experienced member of the medical staff, fulfils a very important role in the training of interns. This is particularly so in large hospitals where the complexity of the structure may not always work to the advantage of the intern who is the most junior member of the medical team.

The responsibilities of the Intern Curator include the following:

Ensuring that the training of interns takes place according to the prescribed guidelines.
Serving as an easy channel of communication between management and interns.
Acting as a spokesperson on behalf of interns.

Especially assisting the CEO/Medical Manager in the following:

a. Organising the orientation programme for new interns at the commencement of the internship training year.
b. Establishing a representative intern committee to meet monthly with the Intern Curator and keeping records of discussions.
c. Ensuring that the different departments provide interns with written job descriptions, specifying duties, as well as the training that will be offered.
d. Ensuring that on-going evaluations of interns per domain are recorded and the evaluation forms, as per the Logbook for Interns, are returned to the CEO/ for his or her assessment and signature.
e. Dealing with any personality problems, impairment or disciplinary issues pertaining to interns.

To be available as a confidant to advise individual interns with serious personal or health problems.

The CEO/Medical Manager and Intern Curators are to involve nursing staff in the orientation of interns at the commencement of the internship training year.

Intern Curators to liaise closely with the various Matrons of accredited facilities regarding internship training.

To recognise the advantages of having internal liaison committees between the various levels of health personnel which could include the CEO/ Medical Manager, Intern Curator, Matron and any other relevant role players where issues pertaining to, for example, scopes of practice, competencies, relationships and clinical skills could be addressed.

The following practical suggestions have been useful in several accredited facilities:

a. Arranging for one or two interns from the previous year to address the new interns.
b. Compiling a small handbook for interns pertaining to local services which effect or relate to the work, community or social environment of interns. The interns know from experience what constitutes key information and such handbook saves valuable time, especially for interns from other medical schools.

NOTE:

Where different facilities form a training complex, one person should be the Senior Intern Curator to whom the other curators/trainers are responsible. This is necessary to achieve a co-ordinated overall training programme, an equitable rotation of interns and comparable duty hours.

c. Intern Curators at accredited facilities could, on submission of appropriate motivation, request at any time that a re-visit/re-evaluation be conducted.
d. It should not be expected of interns to draw up their own on-call rosters.

11.1 GUIDELINES FOR INTERN CURATORS

11.1.1 Introduction

Internship is an important period in the on-going development of junior doctors. Accredited facilities are charged with the responsibility of providing suitable facilities, supervision, guidance and evaluation of interns in medicine. The Board has laid down criteria and requirements for such training. The responsibility for interns' rests with the Chief Executive Officer/Chief Medical Superintendent/Hospital Manager as the representative of the Health Authority under which the training facility operates.

In smaller hospitals, the CEO/ Medical Manager may personally supervise the training of the interns. In larger hospitals this is obviously not possible and he or she will be aided by the hospital staff who have daily contact with interns. The portfolio of an Intern Curator had been established to assist the CEO/Medical Manager in ensuring that internship training fulfils the necessary requirements as specified by the Board.

The Intern Curator should play an important role in the lives of the interns. He or she should look after their interests. The term "Curator" is derived from Latin: *curare* - to care for. Interns are the most junior of the medical staff, are appointed on a temporary basis, and have minimal say in their training and service conditions, hence the need for somebody to act as spokesperson on their behalf.

11.1.2 Appointment of the Intern Curator

This responsibility rests with the Chief Executive Officer/medical Manager.

The Curator should be an experienced member of the medical staff. Where possible, the Curator should not be a Head of Department or part of the administration.
Clinical departments should have a specific supervisor who is responsible for the training of interns in that department. This would involve allocations, duty rosters, job descriptions, leave, etc. This is not the same person as the Intern Curator who is appointed for a whole facility.

There should be provision for the appointment of an Intern Curator for the overall Complex (where two or more facilities had formed a Complex for purposes of internship training).

There should be provision for the appointment of a deputy intern curator per facility (where two or more facilities had formed a Complex for purposes of internship training).

There should be provision for the appointment of deputies per domain of training which would report specific areas of concern to the intern curator.

11.2 SPECIFIC RESPONSIBILITIES

The Intern Curator is to assist the CEO/Medical Manager with the following:

i. Selection of interns (this has not been necessary in view of the appointment of interns at Provincial and/or National level).

ii. Organising the welcome and orientation programme for new interns. The following example can be used for the orientation programme

iii. The following persons from the Hospital Management Team to be invited for the orientation programme:

Hospital CEO
Medical Manager
Nurse Manager
Administration Manager/HR
Intern Curator
Domain Supervisors/Clinical Head
Head of Support Services

Suggested programme to be followed:

Welcome - Intern Curator (Programme Director)
Introduction
Presentation on Hospital Services - Hospital CEO/Medical Manager
Hospital policies and protocols including needle stick policy – Medical Manager/Nurse Manager/Admin Manager/CEO
Duty Roster and Intern rotation plan – Intern curator
Meet the domain supervisors – short presentation by Clinical Heads/domain supervisors and distribution of departmental protocols and clinical guidelines
Meet Heads of support services
Election of the intern representative
Refreshments
Hospital Tour

Providing a “starter pack” giving details of conditions of service, communication channels, key personnel members in the facility, allocations, etc.

Establishing a representative Intern Committee to meet monthly with Management and the Intern Curator. Minutes of discussions should be kept and circulated to relevant individuals.

The Human Resources Representative/Clinical Manager of facility to attend meetings as required. Meetings with Domain Supervisors regularly including the end of each rotation. Domain supervisors are to ensure appropriate supervision and guidance in the specific domain, and importantly to review and sign completed logbooks before the end of each rotation.

Ensuring that the different departments provide interns with written job descriptions, specifying duties, as well as the training that will be offered.

Ensuring that on-going evaluations of interns per domain are carried out, and that the Logbooks are completed and signed by the domain supervisors and Heads of Departments.

Investigating the failure of an intern to meet the requirements of a domain. The early detection of such an intern is most important to help the intern.

Dealing with personality problems or disciplinary issues pertaining to interns. The Intern Curator should recruit suitable counsellors to help him or her.

Resolving conflict between interns and management, or between interns and trainers.

Facilitating the accreditation visit or inspection of internship training by the evaluators appointed by the Board.

12. PRACTICAL DETAILS

12.1 TRAINING OF INTERNS

During internship training, the intern will develop and improve his or her skills in the evaluation of patients and decision-making at the levels of diagnosis, further investigations and management. It is also a training period in which new practical skills will be acquired.

The intern should have the opportunity to gain a wide spectrum of experience in the management of medical and surgical emergencies and, where feasible, to perform those procedures himself or herself under supervision. Thus, attendance of ward rounds and service under constant supervision in casualty departments and in critical or high-care units, are of crucial importance in gaining insight into the management of seriously ill patients.

In principle, the intern should assist with major surgical interventions and perform lesser procedures under supervision. He or she should also become familiar with certain common procedures, such as opening and closing of the abdomen, and appropriate parts of operations performed by senior doctors. Special emphasis should be placed on training in pre- and post-operative evaluation and care.

Emphasis should be placed on the importance of daily or, where needed, more frequent evaluation and management of patients.

All supervisors should train interns to assess the spiritual and psycho-social needs of patients and to act accordingly. Furthermore, specific attention should be given to the care and counselling of the dying patient and the support of relatives. Supervisors should consistently assist interns with this function.

12.1.1 Domain supervisors

Clinical Departments should have a specific supervisor who was responsible for the training of interns in that domain. The supervisor was to assist the Intern Curator who was appointed for a whole facility. In large hospitals it was not possible for the Intern Curator to keep in touch with the many interns in the various departments.

The responsibilities of a domain supervisor:

a. Welcome and orientate interns into the domain.
b. Provide job descriptions.
c. Allocate interns within the domain.
d. Act as liaison between the interns and staff whether nursing or medical.
e. Draw up the duty roster.
f. Supervise leave arrangements including sickness.
g. Co-ordinate the evaluation of interns.
h. Ensure completion and signing of logbooks.

The majority of the minor complaints of interns related to “in-house” issues should be resolved by the domain supervisor. More serious problems (operational and/or personal) should be reported to the Intern Curator.

Referral of patients to other disciplines for consultation or for taking over the patient, should preferably not be left to interns, except in the event of an emergency where the registrar or another senior practitioner is not available.

The above guidelines have specific implications for academic hospitals where interns are often far removed from the mainstream of activities. The extensive hierarchical personnel structure militates against opportunities for the practical experience of interns. Steps should, therefore, be taken to correct this tendency.

12.2 APPLIED THEORETICAL AND ACADEMIC TEACHING

The intern shall receive teaching during ward rounds and informal discussions which are directed at patient care. It is important that the intern be given opportunities to test and apply his or her knowledge and experience during ward rounds.

Weekly departmental or inter-departmental discussions should be held. It is important that specific problems, such as cardiac arrest, respiratory failure and their management should be discussed with a special view to internship training. Alternatively, interns may be asked to do case presentations.

Interns should be encouraged to express opinions and make proposals during ward rounds.

The intern should be taught by precept and example to care for the patient and his or her family with empathy and to realise that the patient is not simply another case.

Where hospitals conduct statistical, mortality and medical audit meetings, they should be arranged at suitable times to ensure compulsory attendance by interns.

12.3 HISTORY-TAKING, SPECIAL INVESTIGATIONS AND RECORD-KEEPING

The importance of proper recording of a comprehensive history, a full clinical examination and follow-up examinations should be emphasised. The supervisor must satisfy himself or herself that these records are of an acceptable standard.

Because doctors may sometimes find themselves in situations where minimal facilities are available, interns should be taught how to evaluate and treat patients on the basis of a thorough history and physical examination without the benefit of special examinations.

It follows that interns should be taught not to subject patients to needless special and X-ray investigations.

The importance of ethical practices and medico-legal risks in practice must be brought home to interns.

12.4 COST AWARENESS

Cost is a major determinant of individual patient care and hospital budgets. It is, therefore, important to foster cost awareness, paying special attention to the following:

The cost and choice of pharmaceutical agents, as well as their safety. Regular consultations with and participation in relevant training, where applicable, by the hospital pharmacist(s), is therefore essential.

The desirability of requesting selected laboratory tests only, as well as the costs involved.

The importance and cost of relevant X-ray examinations. The dangers of radiation should be emphasised and guarded against.

Costs of other investigations and treatment modalities.

12.5 PATIENT ALLOCATION AND WORKLOAD

The Board has as a guideline recommending that 25 beds per intern should not be exceeded.

Unnecessary administrative duties and red tape are discouraged. Elimination of unnecessary procedures, the use of alternative personnel and modern technology, should be pursued. For example, an intern should not be expected to search for vacant beds for patients.

Each department should, in conjunction with the Medical Manager, draw up a job description for interns, specifying duties, as well as the structured training programme which will be offered.

Departments should also decide how to prevent and deal with stress and unreasonable demands on the intern.

12.6 HOURS OF DUTY

The intern is part of the health team and must learn to fulfil his or her responsibilities to patients. The following are, therefore, guidelines and not fixed rules. The interns' duties should be organised as follows:

Interns should work forty (40) hours per work week during normal hours

Interns should not exceed twenty (20) hours of commuted overtime per week, resulting in a maximum of 60 hours per week and an average of 16 hours/week.

Eighty (80) hours overtime per month should not be exceeded in a four-week cycle.

Interns are not permitted to sign any additional contracts regarding specified overtime requirements.

12.6.1 Guidelines for after hour duty

The continuous working hours of 30 hrs may be excessive and can lead to fatigue, compromising the intern's ability to provide appropriate patient care. The workload in different hospitals and different clinical domains may vary across the country. Periods of rest within this continuous 30 hrs may also vary from hospital to hospital and domain to domain. It was further. noted that the interns should be part of the post intake rounds for training and teaching purposes. Hence the it was. recommended that the number of continuous working hours an intern may work be reduced from thirty (30) hours to a maximum of twenty-six (26) hours. This is to accommodate training requirements and to avoid fatigue related negative outcomes. However individual hospitals and clinical domains are requested to modify the roster with shorter shifts depending on the workload and taking into consideration the possibility of periods of rest within a call. The National Department of Health to engage with provincial departments to implement this approach.

Interns should not work full weekends, unless there is a 12-hour break during the weekend.

The frequency of night duties should allow for sufficient recuperation. Being on duty every second night would be unacceptable.

Interns should be off at least one weekend per month from 17:00 on a Friday to 07:00 on a Monday.

Night duty is a valid and essential learning experience where competencies and skills development take place and allows for exposure to very specific aspects of medicine which differ from the normal day-time exposure.

A medical practitioner (including any intern in medicine) remained personally responsible for the care and treatment of his or her patients for as long as the patients required such care and treatment.

It was within the professional responsibility and discretion of a medical practitioner (including any intern in medicine) to decide when to leave a patient for whom he or she was personally responsible, bearing in mind, however, that should such patient suffer unduly or die as a consequence, the practitioner concerned would be held professionally accountable for his or her actions.

In the case where an intern had met the training requirements, both elective and emergency training requirements for a specific domain of training, interns could be utilized to cover other Departments' after-hour calls, as long as the guideline of 80 hours overtime per four-week cycle was not exceeded, and that no further contracts pertaining to overtime were agreed to or signed.

12.7 ACCOMMODATION AND FACILITIES – INFRASTRUCTURE INCLUDING ACCOMMODATION (HOUSING), ON-CALL ROOMS AND TRANSPORT

The Board. has for some time deliberated on the infrastructural and support issues needed for internship training. These include accommodation, on-call facilities and transport especially where there are hospitals and clinics grouped into a complex. A need has arisen for the Board. to deliberate on guidelines for the aforementioned infrastructure.

Overnight accommodation (call rooms) should be provided on site for Interns that are on call.

Housing for interns is a competency of the employing authority. If accommodation is provided for interns the guidelines as set out in the internship guidelines document must be applied to ensure minimum standards. Employers must let the interns know of available accommodation in each accredited facility so that an informed decision can be taken by the interns before applying for a post.

12.7.1 Accommodation

As far as possible, single rooms to be provided (15 $m^{2)}$ with a locker, a safe, a telephone, wash basin, cupboard, desk, chair and single bed. Ideally, en suite bath and ablution facilities should be provided with all amenities including hot water. In the event of communal bath and ablution facilities being provided, then a maximum of two persons should share these communal facilities.

For married couples, a 25 m^2 room should be provided with a double bed and additional furniture plus en-suite bath and ablution facilities.

Security of the accommodation is important.

Additional support facilities of kitchen, lounge, laundry and garaging for motor vehicles to be provided.

The rooms to be cleaned at least three times per week.

The intern should ensure that he/she has adequate insurance cover for personal and household goods and vehicles.

12.7.2 On-call facilities

Satisfactory sleeping and recreational facilities for interns, especially when on duty, should exist in each accredited facility. Sleeping accommodation should be such that the intern may rest and sleep while awaiting the next patient or operation.

Meals and snacks should be available for persons on emergency duty, especially at night.

A room/area with recreational facilities and refreshments would enhance social interaction between interns. This would greatly improve job satisfaction and acceptance of the work environment.

On-call facilities must be provided as close as possible to the ward or health unit to be covered in the event of there not being accommodation on site.

As far as possible, single rooms to be provided (15 m^2) with a locker, a safe, a telephone, wash basin, cupboard, desk, chair and single bed. Ideally, en-suite facilities should be provided.

The on-call facility must be dedicated for the use of the on-call doctor.

Given the multiuser nature of on-call rooms by doctors, they need to be cleaned and inspected daily.

The facility must have adequate security.

12.7.3 Transport

In general, transport need not be provided for interns except where the intern has to travel to different facilities.

The intern should use a Health Department vehicle (if he/she has a valid driver's license) or be driven to the facility using the Health Department transport pool.

In the event of the intern using his/her own transport, then this should be agreed upon with the management in writing and the applicable tariffs will apply with due documentation/logbooks on a monthly basis being submitted to management. The intern to ensure that he/she has appropriate vehicle insurance cover for business and private use.
The facilities offering internship training should have a budget line for the above.

12.8 TERMINATION OF PREGNANCY

In September 2005 the Board confirmed that although an intern, who was required to perform an abortion, could refer the patient to another practitioner on conscientious grounds, even though "The Choice on Termination of Pregnancy Act", (Act 92 of 1996), did not provide a conscientious objection clause. It was however again re-iterated that interns could not refuse to provide emergency treatment in respect of bleeding or an emergency evacuation of the uterus since such procedures formed part of the essential skills of medical practitioners in South Africa and interns were required to attain those skills during their internship training.

12.9 INTERNS WORKING ON EMERGENCY HELICOPTERS/AMBULANCES

Interns are allocated to facilities with a specific accreditation which requires them to work in a specific facility under direct supervision. They are specifically excluded from working outside of this and may also not work in private practice, irrespective of whether they are paid or not.

Under **NO** circumstances could an intern fly on a helicopter or work outside of the accredited facility. A medical practitioner registered in the category community service could do so, if he or she had permission form their Chief Executive Officer/ Medical Manager and was allowed to fly "as on duty".

Any intern that did work outside of their accredited facility, either on an aircraft or road ambulance and was not registered to do so would be held liable by HPCSA. Should an intern be registered as an emergency care practitioner, their scope of practice was regarded as such until they were fully registered as medical practitioners, they were not allowed to prescribe medication, or exceed their scope of practice.

Any service which “employs” an unregistered medical practitioner, e.g. and intern, is guilty of a criminal offence, and can be prosecuted. This applies whether the individual is paid or not. The blanket comment, “in the interest of saving a human life” as a claimed exemption, does not apply, as anything covered by the above would be regarded as prospectively planned or rostered, and therefore not an emergency.

The same policy would apply for the transportation of patients by ambulance i.e. that the supervisor be physically present with the intern.

13. INTERN RESPONSIBILITIES

Although interns, under supervision, are primarily responsible for patient care, they form an important part of the health team and should learn to work together with colleagues in the wider spectrum of medical and other health care services. The professional responsibilities of the intern should include the following important aspects:

Interns are required to keep carefully documented notes. Notes should be made immediately (on the spot; date and time) after assessing each patient. They are responsible for following-up all investigations ordered, and to ensure that all results are available and charted in the bed letter. They should co-operate with medical, nursing and the relevant other health care professionals, e.g. physiotherapy, social work, occupational therapy - especially in relation to their personal cases. Case summaries must be completed on patient discharge. A concise summary should be given to the patient on discharge to be available at follow-up clinics.

The intern should play an active role in Out-Patient Departments, particularly regarding the follow-up of their own patients. A balance should be struck between exposure to hospitalised and ambulatory patients.

Interns should be aware of the Charter on Patient Rights (see Annexure F) and the investigation and management of patients should be in line with those guidelines.

The intern's care of the patient should be holistic. As the primary medical care giver, the intern is a very appropriate person to deal with emotional, spiritual and family problems that are often present in addition to the physical illness. Confidentiality is imperative.

Interns must be aware of their limitations, both in knowledge and skills, and not hesitate to seek advice from senior colleagues. Such referral is not a sign of weakness, but of maturity and is to the benefit of the patient.

Continuity of care is vital in a hospital situation. Appropriate hand-over of patients is essential.

Interns should avail themselves for formal teaching, as well as of the use of a library or reference books. Reading around patient problems will foster the habit of on-going medical education.

NOTE

The responsibility of registration with the Board as an intern, as a medical practitioner to perform community service and finally, as medical practitioner (independent practitioner) in terms of the *Health Professions Act,* 1974, rests with the individual. However, it should be noted that no person may undergo internship training or perform community service in South Africa without having been so registered (see Annexures A, D and E).

14. EVALUATION AND REGISTRATION

Interns should have monthly. assessments during their training. They should be praised when deserving and receive constructive criticism when necessary.

During each rotation, an evaluation of the Intern's performance should be conducted monthly/bimonthly as well as end of block, using the prescribed form for evaluation of intern rotations and experience, as per the Logbook for Interns. This form has two components: A

section to be completed by the intern, and one by the Domain Supervisor and be validated by the Clinical Manager. The latter should do so in conjunction with his or her colleagues. The assessment must be discussed with and signed by the intern. The form must also be signed by

the Head of Domain. This will facilitate the early recognition and correction of problems. A confidential counselling service, separate from the appraisal system, should be available.

At the end of the year, the CEO/ Medical Manager, together with the Heads of Domains, will certify whether an intern has satisfactorily completed his or her training by issuing the Intern Duty Certificate (see Annexure B), thus enabling the Board to register him or her as a medical practitioner to perform community service.

Should an intern have failed to satisfactorily complete part or the whole of his or her training, the Board may demand additional training or re-do the internship before granting such registration (see Annexure C).

Interns are reminded that it is illegal for them to work in any form of practice outside accredited facilities and performance of such activities can lead to disciplinary procedure initiated by the Board against the intern and also against the practitioner who employs the intern.

Accredited facilities should be aware that the Board could withdraw accreditation for internship training should it find that the facility was aware of interns performing locums.

15. LOGBOOK

Submission of the completed Logbook forms part of the prerequisites for registration as a medical practitioner to perform community service. The Intern Duty Certificate as well as the prescribed registration form is included in the Logbook. Every intern must ensure that he or she has a copy of the Logbook which is provided by the Board upon registration as an intern in medicine.

16. RESOLUTION OF CONFLICT

It does happen that conflicts arise as to the training and employment of interns. This may be due to the physical unsuitability of the facility, the terms of service, the trainers or the intern(s).

Most minor issues usually can be resolved through negotiation between the various parties. In this regard the Intern Curator plays a crucial role. The Evaluator(s) of Internship Training appointed by the Board may also help by drawing attention to deficiencies or by acting as independent facilitator(s).

Should serious problems regarding professional conduct arise; the Board will deal with such matters. This will consist of an investigation of the issues by means of a round-table discussion. The purpose of such inquiry is to verify alleged facts and to resolve the problems in a constructive manner. However, it should also be noted that the “ethical rules” (see Annexure E), and the professional conduct procedures of the Board, equally apply to interns as to medical practitioners.

Apart from the above, it needs to be remembered that interns are in the employ of the relevant Health Authority. As such, their conduct falls under the provisions of the *Public Service Code*. Disciplinary matters in terms of those provisions should be dealt with in accordance with the said *Code* or the *Labour Relations Act*. A copy of any warning letter addressed to an intern should, however, be sent to the Board for its notification.

17. PROCEDURE FOR DEALING WITH IMPAIRED / UNDERPERFORMING INTERNS

17.1 Impaired Intern Due to Health Reasons

The expression “impaired” in terms of the Act “means a mental or physical condition, or the abuse of or dependence on chemical substances, which affects the competence attitude, judgement or performance of a student or another person registered in terms of this Act”.

In principle, the procedures of the Health Committee in relation to individual impaired persons are confidential as in the case of a doctor/patient relationship. This principle has positive results in creating a relationship of trust between the Committee and the different stakeholders concerned.

It needs to be emphasized that management of stress in the study and practicing of medicine and dentistry requires special attention at all levels, but especially in students, interns and young practitioners. Factors creating stress need to be identified urgently and addressed, where possible.

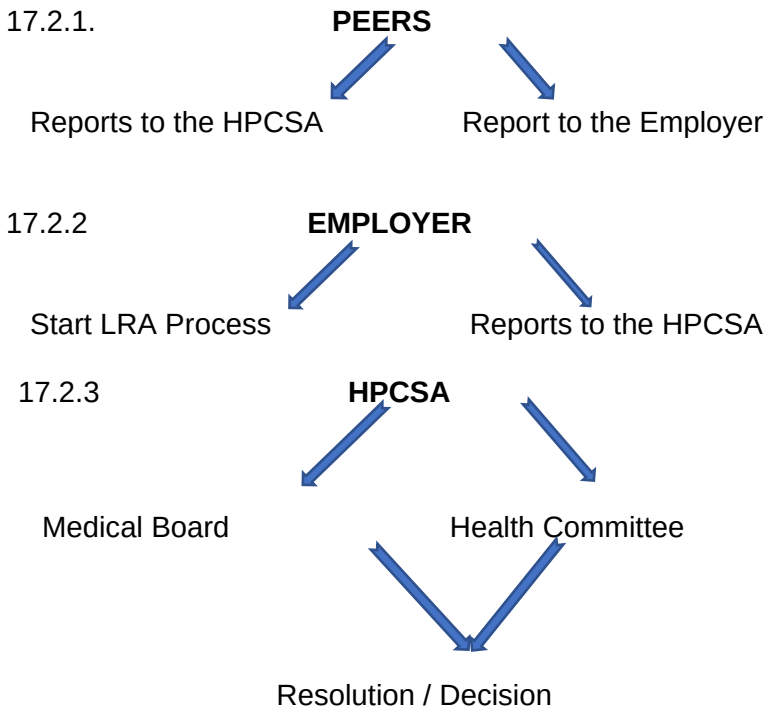
In view of the above, the importance of early identification of impairment in students must be stressed once again, as well as the important role and responsibility of Deans of Faculties or Heads of Schools of Medicine in this respect.
There is a responsibility and duty for colleagues and supervisors to report impaired practitioners to the Health Committee. Please also note that specific reference is made to Interns in this document.

Reporting of an Impaired Intern

17.2 VOLUNTARY DISCLOSURE:

Voluntary disclosure can be reported to: Peers, Employer or HPCSA by the intern.

Please see the following chart for further steps:

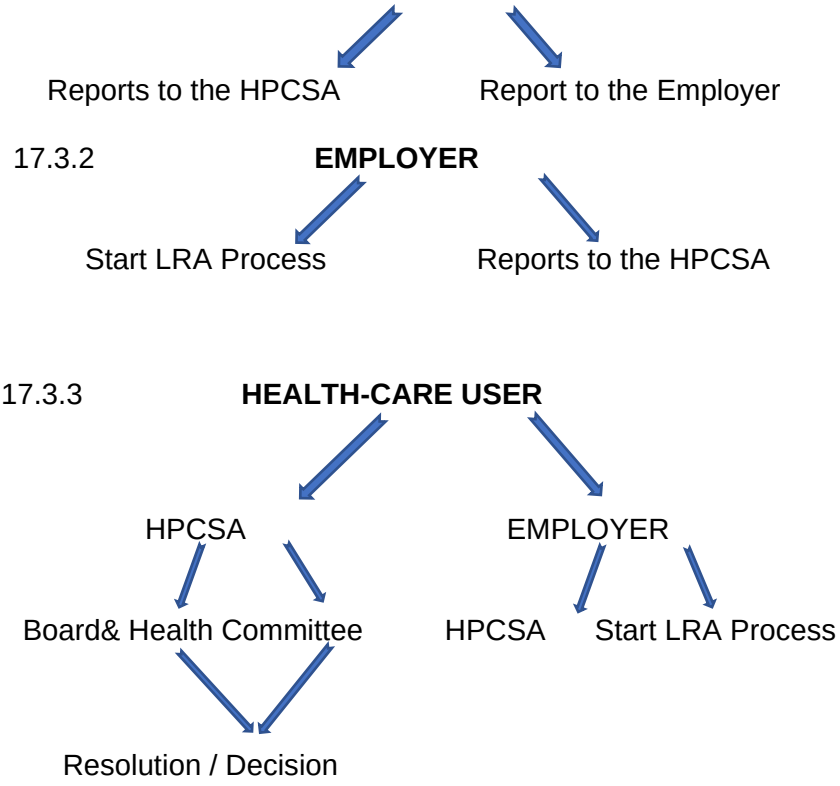


17.3 PERCEIVED/SUSPICION

Perceived/Suspicion can be reported to: Peers, Employer and Health-Care User

- There must be an evidence collection
- There should be a formal complaint with evidence where possible

17.3.1 **PEERS**



Refer to the Health Profession Act Regulation 2 of Suspension Regulation
LRA: Labour relations act

17. 4 UNDERPERFORMING INTERNS

This section deals with an intern who is underperforming due to:–

- Lack of adequate knowledge
- Lack of commitment to work

Continuous assessment, mentorship and corrective measures by supervisors are the best way to address the situation. However, the formal process to assess performance is the midblock evaluation and end of block evaluation.
In instances where misconduct cannot be corrected by mentorship and counselling, disciplinary processes must be initiated as required by the public service regulations and labour relations act. If impairment is suspected as a cause of underperformance all the steps in 17.2.2 should be followed

Extension of training is the formal corrective step if continuous corrective supervision did not yield positive results. Indication of possible extension should be conveyed to the intern at midblock evaluation if the performance is not satisfactory in the first half of the rotation. Extension of training is recommended by the Clinical Head of the Domain at the end of the block. This should be supported by the Clinical Management team of the Hospital.
The period of extension can be decided by the Clinical Management team in consultation with the clinical head of the domain for a period not exceeding the total duration of training in the specific domain.

Such a decision should be notified to the Board of the HPCSA for ratification. If at the end of the maximum allowed period of extension in that domain the intern is still found to be underperforming, then the matter should be referred to the Board for an appropriate decision.

The Board then would send appropriate independent evaluators to the site to determine the causes of incompetence/underperformance. Interviews are done with the intern and all the relevant stakeholders. Logbooks are reviewed in full and the training site inspected. The matter may also be referred to the health committee if not already done by the institution, if impairment

is suspected. In such instances, remedial measures as recommended by the health committee needs to be put in place. The Committee on receiving all the information shall determine whether further additional training is required to achieve competence. In such an instance extension of training is recommended in an alternate accredited site for the full duration of the domain/domains.

If successful, the intern shall be registered as a medical practitioner. If unsuccessful the intern shall be deemed unfit for registration as medical practitioner. The Board shall refer the matter to the board with recommendation as to whether any other future can be charted for the intern.

If an intern is unable to perform any clinical work either due to impairment or incompetence for 10 years or more, a competency reassessment (board examination) has to be successfully undergone before reinstating internship training.

18. PROVINCIAL INTERN CO-ORDINATOR

18.1 INTRODUCTION

The need for a clearly identified co-ordinator of intern matters has been highlighted by the various problems experienced with internship training and related matters in some provinces.

The function of the Provincial Intern Co-ordinator is currently not clearly defined in terms of role and responsibilities. This results in problems being experienced at all levels and especially by interns. The need for a uniform consistent and readily identifiable Provincial Intern Co-ordinator is essential.

The primary role of a Provincial Intern Co-ordinator (PIC) would be to ensure that all matters relating to internship training, emanating both from the National Department of Health and the Board are transmitted accurately and timeously to all parties involved in internship training with special emphasis being placed on all training facilities, especially Hospital Managers, Intern Curators and Clinicians.

In addition to providing information, the PIC should on an on-going and programmed basis ensure that matters relating to internship training are complied with. This would include orientation and induction programmes, completion of evaluation forms, information to facilities on completion of Forms 10-A and 11-A so that there is both uniformity and adherence to a programme.

The mandate of the PIC extends to ensuring that support is provided to interns at training facilities. This includes having an updated list of Intern Curators as the visits of Evaluators of Internship Training are not necessary on an annual basis.

The PIC provides a valuable identifiable link between the National Department of Health, the Board, Evaluators of Internship Training, training facilities and academic institutions, where applicable.

The above is read in conjunction with the functions of the PIC which could be included in his or her job description.

The position of a Provincial Intern Co-ordinator (PIC) in each province should be clearly defined to ensure uniformity in the role and responsibilities of PIC's.

18.2 JOB PURPOSE

To provide an identified person in each province for liaison on internship matters between the National Department of Health, the Provincial Authorities, the Board, Schools of Medicine, and all facilities accredited for internship training.

18.3 JOB DIMENSIONS

The PIC should preferably be based in the Provincial Head Office to facilitate communication between the respective role players. The main functions will be advisory, supervisory, co-ordinating and facilitating of internship programmes at all levels. The position should be at a Medical Advisor level.

18.4 KEY RESPONSIBILITIES

18.4.1 Communication with the Board

The Board is to liaise directly with the PIC in respect of all information that requires to be disseminated to the Provincial Authorities and facilities. The PIC provides a clear channel of communication to ensure that all information from the Board, National Department, and the Provincial Head Office regarding internship matters reaches institutional managers. The PIC ensures that reports from training facilities to the Board are processed within a specified time frame.

18.4.2 Communication with the National Department of Health

The PIC is available to liaise directly with the National Co-ordinator. He or she represents the Provincial Authorities at the Board meetings and gives the necessary feedback. He or she relays information pertaining to internship matters, e.g. yearly schedule, allocations, etc. to the facility on a programmed basis.

18.4.3 Communication with the Provincial Authorities

The PIC acts as a liaison person between the National Department of Health and the Board.
He or she provides communication pertaining to policy from the Provincial Authorities to facilities and follow-up on responses. There needs to be a dynamic two-way process. The PIC informs facilities of intern allocation changes.

18.4.4 Communication with accredited facilities

The PIC is to be available to provide information to training facilities on all matters relating to internship training and supervision. He or she informs the management of facilities and Intern Curators of visits by Evaluators of Internship Training and ensures that all relevant documentation is submitted in time. He or she is to be informed about problems relating to interns. The PIC ensures that facilities are updated on intern matters on a regular basis.

18.5 CO-ORDINATION

The PIC is the co-ordinator of accreditation visits/evaluations and must: Be informed by the Board of visits/evaluations. Inform facilities of proposed visits/evaluations. **Be present at visits/evaluations** and provide the Evaluators of Internship Training with information on provincial policy. Relay urgent problems and concerns of Evaluators of Internship Training to the Provincial Authorities. Liaise with facilities to ensure compliance with recommendations made by the Evaluators of Internship Training. Conduct *ad hoc* evaluations at training facilities where problems have been identified and discuss remedial measures/actions with Evaluators of Internship Training.

18.6 INFORMATION

To facilitate a provincial workshop of key role players on an annual basis to provide an update on internship training matters and to discuss concerns in respect of intern training and supervision. To provide information on allocation of interns to accredited facilities.

To provide information in appropriate time to expedite the annual registration of interns. This alleviates the problem of individual facilities requesting information from the Board, e.g. on registration fees, dates for submission, etc.

18.7 PROVINCIAL REPRESENTATIVE

To represent the Provincial Authorities at the National Department of Health and Board meetings so that there is continuity. The PIC should have the necessary delegated authority to make decisions.

18.8 CONTACT PERSON AT TRAINING FACILITIES

The PIC must be known to all facilities accredited for internship training in the province. He or she must be well informed to assist in all internship training matters as there may be a lack of or discrepancy in the information which the facility managers have. This situation is aggravated by the somewhat rapid turnover of managers and intern curators, some of whom take on the position by default.

PART II
GUIDELINES PERTAINING TO THE CONTENTS OF TRAINING PER DOMAIN

1. INTRODUCTION

1.1 GENERAL REMARKS

Part I of the Handbook described the aims and purposes of internship training, and the general guidelines as to how and where the training should take place.

Part II provides more specific guidelines about the objectives and criteria for each domain through which the intern may rotate. It is meant to be a guide and aid for both the trainers and trainees, recognising that patient profiles and health services may differ widely in different hospitals and clinics.

The overriding goal of the intern year(s) is to expose the trainee to a wide range of patients and common conditions to further develop his or her clinical skills. Internship training is a step in the process of professional development and should not be seen as the completion of training as a medical practitioner.

1.2 EMPHASIS IN TRAINING

The emphasis in training should be on the core values and skills of:

a. History taking.
b. Examination.
c. Clinical diagnosis.
d. Appropriate and cost-effective investigations.
e. Patient management.
f. Need for referral and/or follow-up.

The importance of keeping case records and completing official documents cannot be over-emphasised, both for patient care and for medico-legal purposes.

1.3 ROTATION THROUGH SPECIFIC DOMAINS

The purpose of interns rotating through specific domains is to ensure adequate exposure to and training in that domain. It allows trainers to impart to trainees the knowledge, skills and attitudes of that particular aspect of medical practice. Continuity of training is essential, and blocks should not be broken up. It is recognised that night duties may entail cross-over, but during the day the intern should remain in his or her domain.

1.4 SUPERVISION

Because of the importance of supervision and adequate training, the Board will expect for interns to be trained by practitioners with the following qualifications and experience, namely:

a. A full-time specialist; or
b. A part-time specialist consultant providing at least ten (10) hours of on-site service per week; or –
c. full-time medical officer with a diploma in that domain; or
d. full-time medical officer with at least THREE (3) years' post internship training experience in that domain.

Access to a trainer should be available twenty-four (24) hours per day. Interns must be supported by at least one medical officer or registrar on the hospital premises.

1.5 JOB DESCRIPTIONS

Each hospital and domain must specify what is expected of the intern in terms of –

a. in-patient responsibilities
b. out-patient duties
c. casualty department cover
d. night and weekend duties
e. administrative duties

1.6 EDUCATIONAL OBJECTIVES

Each facility and domain must specify what educational aids and opportunities are available to interns. These would include all or some of the following:

a. Standard management protocols for common conditions.
b. The Standard Treatment Guidelines and Essential Drugs List (provided by the National Department of Health).
c. A checklist of conditions which interns are expected to encounter and/or learn about.
d. A checklist of skills to be acquired and procedures to be observed. (Such a list will depend on the diseases seen at the specific site, and the investigation and management will depend on the facilities available.)
e. Departmental meetings.
f. Presentations by interns.
g. Journal clubs.
h. Medical audit meetings.
i. Courses towards acquiring diplomas.

NOTE

Hospitals should make it possible for all trainees to do an ATLS course.

1.7 EVALUATION

The evaluation of both the training programme and the progress of the intern should be taken extremely seriously. Evaluation should be on-going. There should be an interim assessment monthly through a rotation to institute any correctional steps that may be required. A formal evaluation, using Form 139 (included in the Logbook), should be completed by each individual intern during his/her rotation (midblock) as well as at the end of the rotation. Domains may also decide to include the following in their formal evaluation of trainees, namely: –

a. A completed checklist;
b. A more specific evaluation form.

NOTE

Interns who have failed to satisfactorily complete part or the whole of their training, will be required to undergo additional training.

2. GUIDELINES: DOMAIN OF GENERAL MEDICINE

The following guidelines **should be read in conjunction with the introduction to Part II**

Trainees in this domain should be exposed to the diagnosis and management of common internal medicine conditions and medical emergencies under appropriate supervision. As there will be some overlap with certain topics / skills in the trainee's Family Medicine rotation, emphasis in the General Medicine domain should be on developing robust interpretative diagnostic skills as well as strengthening clinical management in the more complex patient.

2.1 COMMON GENERAL MEDICAL CONDITIONS AND MEDICAL EMERGENCIES FROM THE FOLLOWING SUBSPECIALTIES SHOULD BE COVERED

1.1 Cardiology

1.2 Pulmonology

1.3 Endocrinology including diabetes mellitus

1.4 Haematology

1.5 Gastroenterology and Hepatology

1.6 Rheumatology

1.7 Neurology

1.8 Geriatrics

1.9 Nephrology

1.10 Infectious diseases including HIV and Tuberculosis

1.11 Dermatology

2.2 CORE SKILLS

All procedures should be performed under supervision. The trainee should participate in all stages of the procedure namely:

a. Counselling the patient and obtaining informed consent
b. Performing the procedure with assistance, as needed
c. Documenting the procedure performed
d. Monitor the patient for post procedural com

Please refer to logbook for more details.

3. GUIDELINES: DOMAIN OF GENERAL SURGERY (INCLUDING SURGICAL TRAUMA)

The following guidelines **should be read in conjunction with the introduction to Part II**

The emphasis in this domain should be on exposure to and management of common conditions under appropriate supervision.

3.1. SPECIFIC OBJECTIVES

3.1.1 To understand the importance of the pre-hospital phase and the communication with paramedical personnel.

3.1.2 To understand the “Chain of Survival”.
3.1.3 To observe the correct immobilization of an injured patient.
3.1.4 To learn how to prepare for receiving a medical emergency.
3.1.5 To understand the concept of triage during mass casualties.
3.1.6 To understand the importance of the mechanism of injury and to search for injuries based on the mechanism of injury.

3.1.7 To witness and assist with resuscitation:

- To understand the concepts of the primary and secondary surveys.
- To learn the essential special investigations required for trauma patients.
- To learn how to move and transport trauma patients.
- To learn the importance of continued monitoring of an injured patient, also when referred to X-ray Department, etc.
- To learn how to accurately document findings and to consider medico-legal issues.

3.1.8 To understand the concept of organ protection and the prevention of secondary injuries.

3.2 GENERAL SURGICAL CONDITIONS

a. Soft tissue infections, tumours.
b. Gatroenterology and hepatobilliary conditions.
c. Vascular conditions.
d. Breast conditions.
e. Surgical endocrine conditions.
f. Pre and post-operative assessment and care.

3.3. ADULT SURGICAL EMERGENCIES

Assessment, resuscitation and management of the following including preparing for theatre:

g. Neurogenic, septic and hypovolaemic shock
h. Upper and lower GIT bleeding
i. Acute surgical abdomen.
j. Peripheral vascular emergencies,
k. Penetrating neck, chest and abdominal injuries
l. Blunt abdominal trauma

3.4 ESSENTIAL SKILLS

a. Rectal examination, including protoscopy and rectal biopsy.
b. Assistance at upper and lower GI endoscopy.
c. Excision of minor skin and subcutaneous lesions.
d. Fine needle aspiration – cytology and needle core biopsy of soft tissue lesions.
e. Venepuncture and venous cannulation for intravenous infusions.
f. Technique of endotracheal intubation, insertion of central venous lines, intercostal drains, bladder catheterisation.
g. The technique of cardiopulmonary resuscitation.
h. Minor surgical procedures like suturing of wounds, drainage of abscesses, peri-anal fistulectomy, debridement of wounds etc.
i. Diagnostic skills for trauma abdomen including ultrasound examination. and/or diagnostic peritoneal lavage.
j. *Exposure to debridement.*

NOTE

ATLS (Advanced Trauma Life Support) should be used as a guideline for training.

4 GUIDELINES: DOMAIN OF PAEDIATRICS AND CHILD HEALTH

The following guidelines **should be read in conjunction with the introduction to Part II.**

The emphasis should be on exposure to, and management of common conditions under appropriate supervision.

4.1 EDUCATIONAL OBJECTIVES

a) Three hours teaching per week (formal and/or bedside)
b) Exposure to the range of conditions in the paediatric and neonatal wards.
c) Exposure to the range of conditions presenting in the out-patient department.
d) Exposure to paediatric emergencies (medical and surgical)
e) Knowledge of the requirements regarding notification of a disease, and responsibility for competently notifying cases which are being managed by the Intern.
f) Attendance at mortality and morbidity meetings and an understanding of health statistics, particularly as they relate to the hospital/facility.
g) Knowledge of the requirements for a forensic post-mortem as well as the completion of natural death certificates.
h) One presentation to a departmental meeting per rotation
i) Insight into the interconnected roles and responsibilities of various facilities in the region including CHC's.
j) Knowledge of the Child Health Act and the legal obligations of a health care worker when face with cases of child abuse or neglect.
k) Exposure to issues surrounding consent /assent.

4.2 SPECIFIC TOPICS TO BE COVERED DURING TEACHING AND/OR PRESENTATIONS*

a) The management of preterm and low birthweight infants
b) Congenital infections with emphasis on HIV and syphilis.
c) Prevention and management of birth asphyxia.
d) The management of common conditions responsible for childhood mortality in South (including but not limited to acute gastroenteritis, pneumonia, malnutrition, neonatal sepsis, meningitis, TB, sepsis and shock).
e) The management of common chronic conditions of childhood (including but not limited to asthma, jaundice, congestive cardiac failure, epilepsy, eczema etc.).
f) The expanded programme of immunisation.
g) Use of the Road to Health Card.
h) Optimal infant feeding practices particularly nutritional rehabilitation for malnutrition and PMTCT.

4.3 SPECIFIC CORE PAEDIATRIC SKILLS TO BE ACQUIRED

You will be expected to be competent in the following skills by the end of your paediatric rotation. Please assess your ability to perform the following core skills on a scale of 1 – 3 where 1 is unable to manage this condition, 2 is competent but not able to teach others, and 3 is where you feel competent to teach others how to manage this condition.

This self- evaluation must be discussed with your supervisor in order to guide your learning during the block, to address specific skills deficits and to structure remediation plans.

4.4 CLINICAL PROTOCOLS

Clinical areas should have standard operating procedure protocols for condition regularly admitted to the hospital/facility at both in and out-patient levels.

4.4.1 In-patients

Examples include –

- treatment of severe malnutrition;
- community acquired pneumonia;
- treatment of HIV - infected infants and children;
- cardiac failure;
- gastroenteritis with dehydration;
- diabetic ketoacidosis;
- nephritis and nephrosis;
- bacterial meningitis;
- asthma.

4.4.2 Out-patients

Examples include –

- failure to thrive;
- the unimmunised infant;
- developmental delay;
- tonsillitis;
- otitis media;
- constipation;
- infectious diseases;
- fever;
- anaemia;
- jaundice.

4.4.3 Casualty

Examples include –

- drowning;
- near-miss SIDS;
- convulsions and coma;
- epilepsy;
- hypoglycaemia.

4.5 LOGBOOKS AND CLINICAL RECORDS

The following must be recorder into a logbook at monthly intervals and verified by the supervisor:

a. The five most common conditions (with number of admissions for each of the five).
b. The total number of children attending the general out-patient area per week.
c. The five most common conditions/problems encountered in the out-patients area for the time (with number of encounters for each of the five).
d. Conditions listed in paragraphs 2.1, 2.2 and 2.3 for which no clinical/ protocols were available.
e. Listed procedures which were not performed during the period under review.
f. Number of days on which no teaching took place.
g. Topics formally presented to the department.
h. Autopsies witnessed (diagnosis and causes of death) and number of death certificates completed.
i. Notifiable conditions seen, and number of cases notified to the health authority

5 GUIDELINES: DOMAIN OF OBSTETRICS AND GYNAECOLOGY

The following guidelines **should be read in conjunction with the introduction to Part II**.

The emphasis should be on exposure to and management of common conditions under appropriate supervision.

5.1 CORE OBJECTIVES

5.1.1 OBSTETRICS

To become competent in the management of:

antenatal patients,
labour and delivery,
obstetric emergencies,
postnatal care including the early identification of potential risk factors that contribute to maternal morbidity and mortality
adverse neonatal outcomes such as fetal hypoxia.

5.1.1.1 To become competent in neonatal care (including emergency resuscitation and routine care),

5.1.1.2 To become competent in counselling on breastfeeding practices and contraception;

5.1.1.3 To gain an understanding of the role of community-based obstetric units and postnatal clinics, including criteria for appropriate referral;

5.1.1.4 To develop competency in the counseling and management of antenatal, intrapartum and postnatal care of HIV-positive mothers and their infants;

5.1.1.5 To perform basic ultrasound (both in Obstetrics and Gynaecology) and develop competency in the performance and interpretation of cardiotocographs and partograms;

5.1.1.6 To attend scheduled departmental meetings including maternal and perinatal mortality and morbidity meetings in order to appreciate strategies for future prevention of these catastrophes, including their early diagnosis and effective management;

5.1.1.7 To gain competence in ESMOE (Essential Steps in the Management of Obstetrics Emergencies).

5.1.2 **GYNAECOLOGY**

5.1.2.1 To gain proficiency in the performance of vaginal examinations. (Gynaecological and Obstetric), speculum and rectal examinations;

5.1.2.2 To gain competence in the prevention, diagnosis and management of common gynaecological conditions;

5.1.2.3 To gain competence in basic gynaecological procedures and operations, including post-operative care, and to gain exposure to major gynaecological operations;

5.1.2.4 To perform counselling, conduct testing and offer treatment to HIV-positive patients and their partner/families;

5.1.2.5 To gain a knowledge of contraception including counselling, different methods and side effects, and to promote its usage.

5.1.2.6 To develop an understanding of the prevention, early diagnosis and treatment of gynaecological malignancy including screening for cervical cancer.

5.1.2.7 To develop an empathetic understanding of human sexuality, marital life, fertility and infertility, and offer relevant counselling and referral.

5.2 PROCEDURES IN OBSTETRICS: PERFORMED UNDER SUPERVISION OR OBSERVED

5.2.1 External cephalic version and amniocentesis.
5.2.2 Induction of labour (medical and surgical).
5.2.3 Normal vaginal delivery, episiotomy and its repair.
5.2.4 Abnormal vaginal delivery (twins, breech, forceps, vacuum extraction, prolapsed cord, impacted shoulders, postpartum haemorrhage, repair of a third-degree tear, manual removal of the placenta).
5.2.5 Caesarean section, B-lynch sutures, stepwise devascularisation and the management of inversion of the uterus.
5.2.6 Emergency management of eclampsia and foetal distress.
5.2.7 Tubal ligations (open or laparoscopic) including postpartum sterilisation (mini laparotomy).
5.2.8 Examination of the neonate, Apgar rating, clearing of airways and endotracheal intubation.

5.3 PROCEDURES IN GYNAECOLOGY: PERFORMED UNDER SUPERVISION OR OBSERVED

5.3.1 Ectocervical, endocervical and endometrial sampling procedures.
5.3.2 Colposcopy, VIA, cone biopsy and Lletz procedure.
5.3.3 Laser coagulation of the cervix, vagina and vulva.
5.3.4 Open or laparoscopic sterilisation and other laparoscopic procedures.
5.3.5 Insertion of an intra-uterine contraceptive device (IUCD).
5.3.6 Hysteroscopy.
5.3.7 Marsupialisation/ drainage of a Bartholin's / labial abscess.
5.3.8 Evacuation and/or manual vacuum aspiration of the uterus.
5.3.9 Laparotomy for an ectopic pregnancy.
5.3.10 Hysterectomy (abdominal and vaginal).
5.3.11 Pap smear and liquid based cytology for cancer of cervix screening.
5.3.12 Wet smear microscopy of urine and vaginal discharge.

6 GUIDELINES: DOMAIN OF ANAESTHESIOLOGY

The following guidelines **should be read in conjunction with the introduction to Part II**

6.1 GENERAL

Trainees who undergo the two-month Anaesthesiology domain will have to accept that the aim is to learn the basic skills of anaesthesia. At the completion, the trainees would, however, have gained significant benefits from the introductory course by acquiring the skills and competencies outlined below. They will be able to utilise these in many other fields of medicine, including Emergency Medicine and Critical Care.

6.2 OBJECTIVES

During the two-month anaesthesia training period, intern training will focus on the following interlinked aspects (objectives) of perioperative management:

- Knowledge and understanding of basic anaesthesia.
- Knowledge and understanding of basic resuscitation.
- Recognition of factors playing a role in perioperative risk.
- In addition to the above, there are three critical skills that the intern needs to attain during the anaesthesia training period:

Skills in obstetric anaesthesia. The causes of anaesthesia related maternal death emanating from the Confidential Enquiry into Maternal Deaths include failed intubation, aspiration of gastric contents, high spinal anaesthesia, and hypotension during spinal anaesthesia, with 90% of these deaths considered to be preventable. These causes of death emphasize the need for the intern to develop a safe, competent approach to the obstetric patient requiring anaesthesia care.

Management of the trauma patient or patient suffering hemorrhage. Developing good basic skills, as outlined in the guidelines below, will facilitate management of these patients.

Cardiopulmonary resuscitation. The intern needs to develop knowledge and skills of CPR. It is a prerequisite for completion of the form that the intern demonstrate competence in CPR during the anaesthesia training period.

Completion of the two-month rotation enables the intern to provide an anaesthetic service under supervision. It does not constitute adequate training for the provision of independent anaesthetic practice.

6.3 PREREQUISITES FOR TRAINING

6.3.1 **Adequate equipment:** Theatres and recovery rooms to be equipped according to the standards recommended by the latest SASA Guidelines to Anaesthetic Practice.

6.3.2 **Adequate supervision:** Constant supervision of the intern is of critical importance.

6.3.3 The most acceptable form of “adequate” supervision is the presence of a specialist anaesthesiologist or a registrar in anaesthesiology. In the absence of a specialist, the supervisor should preferably possess the Diploma in Anaesthesia from the College of Medicine of South Africa, or at a minimum, have three (3) years full-time experience of administering anaesthesia as a medical officer. Irrespective of the qualification, the constant presence of the senior physician on a one-to- one basis, is strongly recommended.

6.4 CORE SKILLS AND KNOWLEDGE

6.4.1 **Pre-operative evaluation of the patient:**

6.4.1.1 Emphasis should be placed on eliciting airway, respiratory and cardiovascular symptoms and signs.

6.4.1.2 Other medical or surgical problems that may complicate anaesthesia must be identified pre-operatively.

6.4.1.3 Evaluation of the airway.

6.4.1.4 Previous anaesthesia related problems.

6.4.1.5 Drugs currently and previously being taken.

6.4.1.6 Family history, especially of malignant hyperthermia or porphyria.

6.4.1.7 Appropriate use of pre-operative side-room and special investigations. The pre-operative evaluation should result in the following:

a) The ASA pre-operative classification of the patient. After two months interns should be able to electively manage ASA 1 (normal healthy patients) and ASA 2 patients (patients having mild systemic disease under good control) only.
b) A written summary of the main problems.
c) Evaluation of whether the patient in optimal condition pre-operatively. The anaesthetist must consider whether (further) pre-operative resuscitation or optimization is in the best interests of the patient.
d) An anaesthesia plan needs to be formulated.
e) Pre-medication should be prescribed if indicated.

6.4.2 **Preparation for anaesthesia**

6.4.2.1 Theatre preparation should include:
Machine and breathing circuit check. This includes:

a. Presence of self- inflating resuscitation device (Ambu bag or equivalent device);

b. Suction apparatus.

6.4.2.2 Checking for the presence of emergency drugs.

Availability of a functional defibrillator. The practitioner must be comfortable with the use and checking of a defibrillator.

6.4.2.2.1 Equipment for airway management.
6.4.2.2.2 Anaesthesia drugs.
6.4.2.2.3 Patient preparation should include placement of intravenous cannulae.
6.4.2.2.4 Monitoring needs to be instituted before induction of anaesthesia.

6.4.2.3 The most essential monitor is the vigilant presence of an anaesthesiologist at all times during surgery.

6.4.2.4 Minimum monitoring: the use of oximetry and availability of capnography, non-invasive blood pressure, ECG are considered mandatory, while the facility for temperature monitoring should be available.

6.4.2.5 Minimum monitoring includes continuous monitoring of the inspired oxygen partial pressure.

6.4.3 **Maintenance of physiological homeostasis**

6.4.3.1 The intern needs to understand the deleterious effects of anaesthesia on the airway, respiratory and cardiovascular systems.

6.4.3.2 The intern needs to understand both the need for, and how to, maintain physiological homeostasis while anaesthesia is being administered.

6.4.4 **Airway management**

6.4.4.1 Airway maintenance basic:

a. Application of basic airway maneuvers (jaw thrust, chin lift)
b. Simple airway devices (oropharyngeal airways)
c. The use of supraglottic devices (Laryngeal mask airway).

6.4.4.2 Endotracheal intubation

a. Equipment and drugs needed.
b. Attainment of the sniffing position.
c. Correct use of the rigid laryngoscope.
d. Use of introducer.

6.4.4.3 Confirmation of endotracheal tube position use and value of the capnograph.

6.4.4.4 Management of failed intubation and ventilation. A simple approach such as the "DAMIT" airway algorithm (reference) is strongly encouraged. (This algorithm incorporates three steps:

Step 1 – basic airway maneuvers and devices followed by a single laryngoscopy attempt if ventilation is still difficult.
Step 2 – use of a supraglottic airway (e.g. LMA or iLMA) to facilitate ventilation (and possibly intubation).
Step 3 – infraglottic airway access.)
Safe extubation of patients.

6.4.4.5 Airway protection from aspiration of gastric contents.

a. "Nil per os" guidelines.
b. Pre-operative recognition of the (potentially) full stomach.
c. Actions to prevent aspiration before anaesthesia commences.
d. Correct management of rapid sequence intubation. Attention must be specifically paid to the following:
   - Prior airway evaluation.
   - Correct pre-oxygenation technique. Correct application of cricoid pressure.
   - Correct sequence and dosage of induction agent and succinylcholine. Confirmation of endotracheal intubation.
   - Management of failed intubation.
   - Basic management should aspiration occur.

6.4.4.6 Maintenance of respiration (ventilation)

a. Spontaneous respiration with mask supplemented with an oropharyngeal airway if needed, or with the use of a supraglottic airway.

b. Take over ventilation manually if spontaneous respiration has been abolished or becomes inadequate.
c. Use of a basic anaesthesia ventilator.
d. Availability of and use of a self-inflating resuscitation device (Ambu bag or equivalent), especially in case anaesthesia machine failure.

6.4.4.7 **Hypoxia**

6.4.4.7.1 Basic understanding of the causes and management of hypoxia.

6.4.4.7.2 Basic understanding of oxygen therapy.

6.4.5 **Equipment for support of airway and respiration**

6.4.5.1 Airway equipment (facemasks, oropharyngeal airways, laryngoscopes, supraglottic devices, endotracheal tubes, introducers).

6.4.5.2 Understanding and check of anaesthesia machine.

6.4.5.3 Understanding of assembly, limitations, advantages and fresh gas flow required in the following anaesthesia breathing circuits:

a. Circle system.

b. Ayres T piece.

c. Magill system – dangers and appropriate use only in spontaneously breathing patients.

6.4.6 **Cardiovascular system**

6.4.6.1 Pre-load

a. Pre-operative recognition of the four degrees of hypovolaemia.

b. Fluid resuscitation – volumes needed, different types of fluid including the use of colloids.

c. Placement of intravenous cannulae.

d. Oxygen delivery

6.4.6.2 Importance of adequate hemoglobin concentration.

6.4.6.3 Blood transfusion – indications and complications.

6.4.6.4 Importance of an adequate cardiac output.

6.4.6.5 Determinants of cardiac output.

6.4.6.6 Hypotension

a. An approach to the etiology of hypotension.

b. A balanced approach to the treatment of hypotension using fluids, vasopressor and inotropes.

c. Availability of vasopressors – knowledge of how to dilute these drugs and use in severe hypotension.

d. Anaphylaxis – diagnosis and management.

6.4.6.7 Cardiopulmonary resuscitation (CPR)

a. It is a pre-requisite for certifying competence in anaesthesia that the intern demonstrates both knowledge of and practical competence in basic and advanced CPR. Three alternate routes to certification of competence in CPR are available:

b. Ideally, this should take place in a laboratory type setting where mannequins are available.

c. Alternatively, a question and answer session by the anaesthesia supervisor can be held with the intern.

d. A current valid ACLS certification is also an acceptable way to fulfill this requirement.

6.4.7 **Anaesthesia drug pharmacology**

6.4.7.1 Induction agents.

6.4.7.2 Inhalation anaesthesia agents and nitrous oxide.

6.4.7.3 Muscle relaxants.

a. Depolarizers – Succinylcholine

b. Non-depolarizers
c. Reversal of non-depolarizers
d. Opioids – intra-operative and post-operative use
e. Non-opioid analgesics – paracetamol – non-steroidal anti-inflammatory drugs.
f. The concepts of balanced anaesthesia including the synergistic and addictive interactions between various drugs.

6.5 SPECIFIC INTRA-OPERATIVE PROBLEMS

6.5.1 The obstetric patient

6.5.1.1 The physiological changes of pregnancy that affect anaesthesia management, especially airway, respiratory system, cardiovascular system, aorta-caval compression.

6.5.1.2 The safe performance of a subarachnoid (spinal) anaesthetic for the obstetric patient (drugs, dose, spinal needles, safe levels of injection, prevention and management of hypotension) is considered a core competency for interns rotating through anaesthesia. In this regard, it is essential that the interns possess a detailed knowledge of the following article on management of spinal anaesthesia for caesarean section: Prevention and treatment of cardiovascular instability during spinal anaesthesia for caesarean section. R A Dyer, C C Rout, A M Kruger, et al. SAMJ March 2004, Vol 94, No. 3 (available free on "Pubmed").

6.5.1.3 The causes of anaesthesia related maternal death emanating from the Confidential Enquiry into Maternal Deaths.

6.5.1.4 Pre-eclampsia and anaesthesia.

6.5.2 Regional anaesthesia

6.5.2.1 Spinal (subarachnoid) anaesthesia – see above.

6.5.2.2 Pharmacology of local anaesthesia agents. Safe dosages, complications, how to avoid accidental intravascular injection, correct use and abuse of added vasoconstrictors with local anaesthetics.

6.5.2.3 Peripheral nerve Domains – knowledge of the following is useful – infiltration techniques, digital nerve Domains, Bier's block.

6.5.3 The trauma patient, hypovolaemic shock and emergency anaesthesia

6.5.3.1 Recognition and management of problems with the airway, respiration, hypovolaemia, hypotension, anemia, head injury and the injured cervical spine.

6.5.3.2 Choice of anaesthesia agents in hypovolaemic shock.

6.5.4 Paediatric anaesthesia

6.5.4.1 Airway management of the child.

6.5.4.2 Paediatric fluid management.

6.5.4.3 Basics of paediatric anaesthesia.

6.5.5 Essential administrative functions of anaesthetics

6.5.5.1 Consent.

6.5.5.2 Maintenance of a contemporaneous anaesthesia record.

6.5.5.3 Post-operative instructions.

6.5.6 Post-operative management

6.5.6.1 An approach to delayed awakening from anaesthesia.

6.5.6.2 Written post-operative instructions.

6.5.6.3 When can the patient be left in the care of a nurse?

6.5.6.4 Post-operative complications (airway, breathing, circulation) that need to be watched for –

6.5.6.5 Opioids – uses, advantages, dangers, correct dosing and intervals, endpoints of therapy.

6.5.6.6 Non-opioid analgesia – uses, limitations, complications, contra-indications.

6.5.6.7 Use of simple regional techniques and infiltration of local anaesthetics for post-operative analgesia.

6.5.7 **Assessment/evaluation**

6.5.7.1 A detailed logbook of all anaesthetics administered, including the name, age and hospital number of the patient, nature and date of surgical procedure and drugs used, is to be kept by each intern. All entries are to be signed by the supervisor on an on-going basis. The Logbook will assist in ensuring that interns are adequately exposed to all aspects of anaesthesia. The Logbook in addition to a general section, will contain specified sections to ensure exposure to areas of anaesthesia which are considered essential to the training process (e.g. caesarean sections, D & C procedures, emergency surgery and paediatric anaesthesia).

6.5.7.2 CPR competence must be assessed.

7 GUIDELINES: DOMAIN OF ORTHOPAEDICS/ORTHOPAEDIC TRAUMA

The following guidelines **should be read in conjunction with the introduction to Part II.**

The emphasis should be on exposure to and management of common conditions under appropriate supervision (included at the end of this section for ease of reference).

7.1 OBJECTIVES

7.1.1 The objective of this training period is to expose the intern to the diagnosis and management of musculoskeletal diseases and trauma. He or she must be able to obtain and record the relevant information in a systematic manner, identify the problem(s) of trauma management and make decisions on the level of management. He or she should have the knowledge and ability to foresee and diagnose possible complications and should know the steps to be taken to prevent and/or treat these complications.

7.1.2 The trainee should develop the skills to treat less complex fractures, dislocations and soft tissue injuries, and should be able to resuscitate, splint, manipulate and reduce fractures and dislocations, apply Plaster of Paris (POP) casts to the limbs and apply both skeletal and skin traction, where applicable. He or she should be able to perform minor operations, where indicated, on trauma patients.

7.2 SPECIFIC OBJECTIVES

7.2.1 Primary management of dislocations of the shoulder, elbow, hip and knee, wrist, hand, ankle, foot and toes.

7.2.2 Recognition of joint injuries, including intra-articular fractures and ligament disruptions. Closed methods of treatment, where applicable.

7.2.3 Recognition of and closed methods of treatment for the common metaphysical and diaphysial fractures in adults and children.

7.2.4 Diagnosis of tendon injury and nerve injury to the upper and lower limbs.

7.2.5 Diagnosis and emergency treatment of spinal injuries and pelvic injuries.

7.2.6 Recognition and management of open fractures (Gustilo plus Anderson classification), with

primary debridement of open wounds.

7.2.7 Management of fingertip injuries and traumatic amputation of digits.

8 GUIDELINES: DOMAIN OF PSYCHIATRY

The following guidelines **should be read in conjunction with the introduction to Part II.**

The domain of Psychiatry will facilitate the experience of the integration of the management of psychiatric disorders at primary care level within a health team.

The specific rotation through Psychiatry should be decided on by each accredited facility based on its resources, but in accordance with the Guidelines.

8.1 FACILITIES REQUIRED

The placement and exposure to psychiatric practice must be such that a full range of disorders is managed at the various levels of severity, under supervision. The facilities utilised should have referral to specific psychiatric services within the complex or cluster of services. There should be exposure to services in facilities for inpatient and out-patient care, treatment, and rehabilitation, as well as consultation-liaison and emergency services and outpatient management as part of community-based psychiatric services by multidisciplinary teams (MDTs) in districts. Services at inpatient specialist facilities should include a MDT program and supervising specialist psychiatrist, in an psychiatric inpatient unit either in a general specialist or specialized psychiatric hospital. There should be the same standard of clinical care as in other disciplines and the full range of special investigations must be available.

8.2 SUPERVISION / HUMAN RESOURCES REQUIRED

8.2.1 There must be adequate number of supervisors allocated for supervising the interns.

8.2.2 The grade of experience of the supervisor must be that of a specialist psychiatrist (consultant), psychiatric registrar or a medical officer with at least three (3) years post registration experience in the field of psychiatry.

8.3 SUPPORT

There should be consistent and immediate access to support in the form of a registrar, medical officer and/or consultant.

8.4 JOB DESCRIPTION

8.4.1.1 This should be completed and provided by each complex in view of local differences and services available. The duties to be included are to be specified in relation to the site and lines of authority.

8.4.1.2 The responsibilities of the intern should be designated to include emergency care and assessment, as well as acute and/or longer-term in-patient and out-patient care of the spectrum of psychiatric disorders, medical disorders presenting with psychiatric symptoms (including delirium), as well as substance-related disorders/conditions and intellectual impairment.

8.4.1.3 The intern should also be competent with regard to responsibilities in terms of the Mental Health Care Act, No 17 of 2002 and the appropriate referral of patients between levels of care. Attendance at specialist psychiatric community-based clinics in districts, where available should be included if based at a psychiatric facility. Emergency duties in general hospitals and after hour duties under supervision must form part of the experience.

8.4.1.4 Duties in relation to report writing and record keeping must be monitored and evaluated.

8.5 OBJECTIVES

8.5.1 The aim of the postgraduate experience is to provide the intern with the capability to effectively manage common clinical problems of Psychiatry as a general medical practitioner.

8.5.2 There must be allocation of teaching time in the form of case presentations/ward rounds, tutorials and attendance at departmental meetings.

8.5.3 There must also be exposure to common conditions and the range of adult and child/adolescent disorders in clinical and emergency settings, as well as the rehabilitative role of community clinic duties.

8.5.4 Familiarity with the workings of the Mental Health Care Act, no 17 of 2002, other relevant legislation, national and provincial policy, as well as the ethical principles relevant to Psychiatry must be achieved.

8.5.5 There could be some exposure to subspecialties such as child, forensic, substance abuse and addiction psychiatry and old age psychiatry, where applicable, in the clinical setting.

8.5.6 During the placement, there should be experience and exposure to emergency and crisis situations, as well as the psychosocial rehabilitation processes in the context of a multi-disciplinary professional team functioning wherever possible.

8.6 SPECIFIC SKILLS AND COMPETENCE TO BE ACQUIRED

8.6.1 Skills in psychiatric evaluation, management and counselling should be achieved, with a bio-psychosocial approach, seeing the patient as a person in a holistic fashion within the various contexts.

8.6.2 Exposure to cognitive-behavioural therapy, anxiety/stress management pro- grammes or substance rehabilitation programmes is recommended.

8.6.3 Specific skills and confidence in the management and evaluation of violent/ dangerous patients and suicidal risk assessment should be achieved.

8.7 CLINICAL PROTOCOLS

There should be standard treatment protocols available in all areas which reflect the standard to be followed. These could have been formulated by the provincial or national Mental Health Directorate of a Department of Health. Familiarity with such to include the following:

8.7.1 Admission criteria and procedures in terms of the Mental Health Care Act, No17 of 2002.

8.7.2 Management of the violent or dangerous patient.

8.7.3 Diagnosis and management of delirium

8.7.4 Management of schizophrenia and other psychotic disorders.

8.7.5 Management of alcohol and other substance dependence and withdrawal.

8.7.6 Investigations at first presentation/admission of a patients with psychiatric symptoms, to exclude/confirm underlying or co-morbid medical conditions.

8.7.7 Management of Mood Disorders.

8.7.8 Management of Anxiety Disorders.

8.7.9 Management of Cognitive Disorders

8.7.10 Management of Personality Disorders

8.7.11 Management of acute and long-term side-effects of psychiatric medications

8.8 ASSESSMENT AND EVALUATION

8.8.1 A record should be kept of the experiences of the intern using log- books of clinical cases managed. This should aim to record the numbers of, and categories of admissions clerked, presented, out-patients seen, reviews of cases, certification process, journal club, lectures, ward rounds attended, etc.

8.8.2 Objective evaluation forms to be completed during and again after the placement with the opportunity of feedback on progress to the intern at set intervals.

8.9 KNOWLEDGE

A basic knowledge of general psychiatry, as expected at MBChB level, must be supplemented during the placement to include:

8.9.1 Diagnostic criteria (DSM), adult and common childhood disorders.

8.9.2 Therapeutic management and investigations.

8.9.3 Preventative and rehabilitative interventions.

8.9.4 Psychopharmacology.

8.9.5 Aetiology.

8.9.6 Human development.

8.9.7 Assessment and interviewing skills.

8.9.8 Cultural context and issues.

8.9.9 Interpersonal dynamic and therapeutic relations with patient, family and staff

8.10 PROFESSIONAL THINKING, ATTITUDE AND ETHICAL STANDARDS

An awareness of transference/counter-transference reaction should be aroused.

8.11 STANDARDS

An awareness of transference/counter-transference reaction should be aroused. There should be an opportunity in supervision for feedback by the intern on progress and feelings and to develop a sensitivity to ethical standards and appropriate attitudes to psychiatric patients and their management.

9 GUIDELINES: DOMAIN OF FAMILY MEDICINE/PRIMARY CARE

The following guidelines **should be read in conjunction with the introduction to Part II.**

The emphasis should be exposure to and management of undifferentiated conditions under appropriate supervision.

9.1 GENERAL

The domain of Family Medicine/Primary Care gives the intern the opportunity to manage the spectrum of patients who present in the context of primary care. This includes the management of undifferentiated conditions, chronic diseases, palliative care and clinical forensic medicine. Interns must learn to integrate the experience, knowledge and skills gained in all other domains and learn to work in health care teams. Opportunities for collaboration with other primary care workers such as nurses, allied health professionals must be created. Colleagues working in other specialties at secondary and tertiary levels of care must provide continued support and assist towards capacity-building when performing structured outreach at facilities where interns are based. In instances where certain core competencies were not achieved in the other domains arrangements will be made to obtain those competencies from those domains while in Family Medicine.

The specific rotation through the domain of Family Medicine/Primary Care should be decided on by each accredited facility based on its resources, but in accordance with the Guidelines.

The six (6) month rotation in the domain of Family Medicine/Primary Care should be completed during a single period.

9.2 AIMS AND OBJECTIVES

To produce a generalist doctor who at the end of the 2-years of internship training will:

- 9.2.1 Have the knowledge and skills to be able to be function at a District Hospital with appropriate access to supervision, support and referral systems.
- 9.2.2 Be able to function independently in **ambulatory care** in the context of the district health system
- 9.2.3 Be able to contribute to the management of the spectrum of patients who present at any primary care facility
- 9.2.4 Be able to apply appropriate knowledge, skills and attitudes in the management of all patients presenting in primary care settings in collaboration with other primary care practitioners and to be able to identify patients that warrant referral

9.3 EXPOSURE AND RESPONSIBILITIES

9.3.1 The domain of Family Medicine/Primary Care should be the entry point into the health care system where interns should be exposed to first contact patientcare of both routine ambulatory care and emergencies, combined with responsibilities for patients in wards under their care.

9.3.2 The programme should show evidence of a continuum of training from ambulatory care in the community clinics, community health centres and district hospitals.

9.3.3 Interns will have the opportunity to perform relevant side-room tests and investigations with respect to their level of care and service ("Norms and Standards for District hospitals" Department of Health, Pretoria, 2002.). They should also be able to perform (minor) surgical procedures under supervision until they are competent to do so independently.

9.3.4 Every effort must be made to ensure personal follow-up of patients previously seen by the intern to provide continuity of care to patients, and for the intern to learn to form professional relationships with patients that last over an extended period.

9.3.5 Interns must work together with other health care providers such as nurses, physiotherapists, social workers, dietitians, etc., in the care of their patients, in order to learn the team approach to health problems in primary care practice.

9.3.6 Interns must have the opportunity to refer patients to health care providers in medical specialties, as well as receive patients back after consultations with specialists.

9.4 KNOWLEDGE AND SKILLS

9.4.1 Having completed all year one domains prior to starting FM, interns will have a set of knowledge and skills signed off in these domains. As Family Medicine is an integrated rotation, interns will be expected to proficient in these skills.

9.4.2 There is a list of skills which interns should self-assess their knowledge and competencies as these will not be signed off again in the Family Medicine rotation.

9.4.3 During the Family Medicine/Primary Care domain, the intern should acquire the following knowledge and skills:

9.4.3.1 Diagnosis and appropriate management of undifferentiated conditions in an out-patient / ambulatory care facility. The range of the conditions will be dictated by the morbidity profile of the community where the health care facility is situated.

9.4.3.2 Diagnosis and appropriate management of undifferentiated diseases related to lifestyle, such as tuberculosis, AIDS and HIV-infection, hypertension, diabetes, stress disorders, headaches, backache and depression.

9.4.3.3 Diagnosis and appropriate management of undifferentiated diseases related to stress of day to day living such as anxiety, depression, drug and alcohol abuse.

9.4.3.4 Diagnosis and management of undifferentiated conditions that are amenable to short duration surgery under local anaesthesia such as the following: Suturing of lacerations; finger/hand injuries; excision of subcutaneous lumps; removal of foreign bodies (ear, nose, cornea); aspiration and injection of joints (knee, wrist, ankle, shoulder); reduction of paraphimosis /dorsal slit; excision cautery / cryotherapy of skin lesions, removal of toenails; etc.

9.4.3.5 The appropriate generalist management of all emergencies; resuscitation of patients in shock; the stabilisation and transport of the severely ill patient.

9.4.3.6 The appropriate intervention in family crises e.g. domestic violence; disability; death; substance abuse; infertility; abortion; divorce.

9.4.3.7 The appropriate clinical forensic medicine skills for managing e.g. Rape; inter-personal violence; drunken driving.

9.4.3.8 Appropriate skills in palliative care.

9.4.3.9 Rational prescribing habits: A thorough knowledge of the drugs on the Primary care Essential Drug List used by the facility, their indications, contra- indications important drug interactions and cost implications.

9.4.3.10 A sensitivity to cultural differences with respect to illness experience and its influence on the causation of disease, healing and compliance with medical interventions.

9.4.3.11 An awareness and understanding of the total spectrum of health care resources in the community, and an approach to the optimal use of these resources for the health of the community and individual patient care.
9.4.3.12 The knowledge and skills to render appropriate inpatient care at generalist level.
9.4.3.13 The knowledge and skills to render appropriate mental health care at generalist level.
9.4.3.14 An approach to the management of common conditions presenting in primary care.
9.4.3.15 An approach to the management of common dermatological conditions.
9.4.3.16 Specific objectives for Public Health Medicine:

- Improve quality of care by facilitating quality improvement cycles (including the audit of clinical care as one step in the cycle)
- Improve cost-effectiveness through reflection on routinely collected data, particularly rational prescribing and use of investigations
- Critically appraise new evidence
- Make a community diagnosis, and interpret and prioritise health indicators
- Promote health in communities
- Report notifiable conditions (measles, TB, malaria etc)
- Use routine data for disease surveillance
- Apply an appropriate Monitoring and Evaluation (M&E) framework (e.g. inputs, process, outputs, outcomes, impact) to monitor and evaluate a health intervention
- Explain a population-level approach to disease prevention and apply the 'levels of prevention' framework to recommend disease prevention interventions
- Describe the main health indicators (e.g. IMR, MMR) and their use in planning

9.5 LIST OF ETHICAL ISSUES TO WHICH INTERNS SHOULD BE EXPOSED

Please refer to the Ethics, Human Rights, Clinical Governance and Medical Administration Section of the Logbook

Training sites

The training sites include accident and emergency department, district hospital, community health centres and primary health care clinics.

The areas of exposure must include:

- Accident and Emergency care (1 month)
- Maternal care
- Child health, IMCI, neonatal care
- Integrated Chronic care management including exposure to the management of HIV and tuberculosis
- Acute care
- In patient care

Please fill in the table below.

Site	From	To	Supervisor's signature
District hospital (minimum of 1 month)			
Accident and emergency (1 month)			
General outpatients			
Antiretroviral Clinic			

Gateway Clinic			
Community Health Centres (CHC)			
Day hospital			
Primary Health Clinic (PHC)			
Family medicine OPD departments			
Other			

After-hours work is compulsory for interns and can be done at the accident and emergency department at the tertiary, regional or district hospital or CHC

In addition, interns should be involved with a Quality improvement project, reporting on patient safety issues, morbidity and mortality meetings and actively participate in CPD programmes at the different sites

9.6 SUPERVISION

9.6.1 Supervision must be provided by a Family Physician or a general medical practitioner with at least three-years post-internship experience in primary care domain, who must be accessible for support.

9.6.2 An MO/FP must be physically present when an intern is allocated to work in the following areas: A & E, labour ward, high care / ICU or theatre.

9.6.3 A Public Health Medicine specialist at the affiliated university or training hospital can be consulted for guidance for all public health-related topics and activities.

9.7 EVALUATION

9.7.1 Ongoing evaluation by the supervisor should take the form of direct observation of consultations, patient record reviews, and case discussions.

9.7.2 A checklist of required skills is provided to the intern for determining what specific skills need to be acquired and documented during the Family Medicine domain.

9.7.3 At the end of each rotation both intern and supervisor must complete, discuss and sign the general assessment form. The Head of Family Medicine will sign the intern off at the end of the 6 months rotation.

PART III
GUIDELINES PERTAINING TO MEDICO-LEGAL AND ETHICAL ASPECTS OF INTERNSHIP TRAINING

1. DUTIES OF A MEDICAL PRACTITIONER REGISTERED WITH THE MEDICAL AND DENTAL PROFESSIONS BOARD

Patients must be able to trust doctors (medical practitioners) with their lives and wellbeing. To justify that trust, we as a profession have a duty to maintain high standards of good medical practice and care and to show respect for human life. Medical practitioners need to ensure the following:

a. Make the care of their patient their first concern.
b. Treat every patient politely and considerately.
c. Respect patients' dignity and privacy.
d. Listen to patients' and respect their views.
e. Give patients information in a way they can understand.
f. Respect the rights of patients to be fully involved in decisions about their care.
g. Keep their own professional knowledge and skills up to date.
h. Recognise the limits of their professional competence.
i. Be honest and trustworthy.
j. Respect and protect confidential information.
k. Make sure that their personal beliefs do not prejudice their patients' care.
l. Act quickly to protect patients from risk if they have good reason to believe that they themselves or a colleague may not be fit to practice.
m. Avoid abusing their position as a doctor.
n. Work with colleagues in ways that best serve patients' interests.

In all these matters doctors must never discriminate unfairly against their patients or colleagues and must always be prepared to justify their actions.

2. LIST OF ETHICAL ISSUES TO WHICH INTERNS SHOULD BE EXPOSED

Obtaining informed consent from patients, including taking informed consent from the parent of a child, from the guardian of a mentally ill patient, as well as obtaining consent from a patient to participate in a research study.

Respect for confidentiality. It is necessary to have some insight into the limits of confidentiality and how, for example confidentiality would be broken if one wished to inform the partner of a patient with an infectious condition of the risk of contagion.

Respecting the dignity of persons (autonomy).

Informing patients of bad news.

Counselling families.

Dealing with procedures for withholding or withdrawing treatment and communicating with families regarding such procedures and why that is done.

Having knowledge of potential human rights abuses and of the available mechanisms to report such abuses.

3. INTERNS AND LEGAL LIABILITY

3.1 LEGAL STATUS OF AN INTERN IN MEDICINE

The intern in medicine is, of course, not yet a doctor (medical practitioner). He or she has successfully completed at least five years of university study as a registered medical student and must now undergo training for a further period of time. For that purpose, he or she must register with the Health Professions Council of South Africa as an intern in medicine. The intern can, therefore, be described as a "trainee doctor" who will receive supervised instruction in medical practice in an accredited facility.

An experienced medical practitioner who is a staff member of an accredited training facility at which the intern will receive training is appointed as Intern Curator who will oversee the process of internship training under supervision of experienced trainers. The intern will, therefore, perform his or her functions under supervision. It goes without saying that the intern will not only be observing the work done by experienced doctors but will begin to become increasingly involved in performing – under supervision – medical procedures himself or herself. That is the only way in which practical skills can be acquired. In so doing, the intern from the outset assumes legal and ethical responsibilities and in this section the implications thereof will be briefly addressed.

It is important to emphasise that it is not the function of the intern to undertake independent functions off his or her own bat, as it were, without proper supervision and guidance. Should the intern do so, he or she will expose himself or herself to legal liability and such action may also result in liability being incurred by his or her employer.

3.2 EMPLOYER – EMPLOYEE RELATIONSHIP

Interns are trained in public sector facilities (i.e. hospitals or clinics) and receive their salaries as part of the public sector. Legally speaking, therefore, the intern is an employee of government or the State. This has important implications as far as potential legal liability is concerned. It may lead to what is known as "vicarious liability", on which more information will be given below.

3.3 STANDARD OF CARE REQUIRED FROM INTERNS

It is a principle of South African law that, in performing medical procedures or in treating patients medically, a qualified medical practitioner's conduct must conform with certain standards. Should the doctor's performance fall short of those standards, his or her conduct will be judged to be negligent, which may result in legal liability for damage should the patient have sustained harm and loss.

South African courts have on numerous occasions held that the standard of care required of a doctor who undertakes the treatment of a patient is not the highest possible degree of professional skill, but reasonable skill and care. But the courts will, in assessing culpability, take into consideration the branch of the profession to which the practitioner belongs. Thus, a general practitioner will be judged in the light of the knowledge, skill and proficiency expected from the reasonable general practitioner. In the case of a specialist, the practitioner's conduct will be assessed by having regard to the standards reasonably required in his or her specialty.

If a general practitioner were to embark upon procedures usually performed by specialists, the general practitioner must expect to be judged in accordance with the standards pertaining to that specialty. The same principle applies to specialists venturing into fields of specialty for which they

have neither been qualified, nor registered. This, in effect, means that the doctor venturing beyond his or her own field and must expect to be judged much sterner than would otherwise be the case.

What does this imply for the intern? It means, simply, that the intern's conduct will in the event of an allegation of negligence on his or her part, be measured not against the standard of competence required from a fully qualified, experienced doctor, but against the standard of competence that may be expected from the reasonable intern. It may be assumed that an intern

who has already gained a lot of knowledge and practical experience and is nearing the end of his or her period of internship training, may expect to be adjudged against a somewhat sterner measure than that of the intern who has just started.

What had been stated thus far, applies to the usual, routine situation. In cases of dire emergency, different considerations apply. This aspect shall be returned to below.

At this point it must be emphasised that the Intern Curator and qualified doctors under whose guidance and supervision interns work, bear a heavy responsibility towards interns. If they were to observe an intern performing an assigned task wrongly, dangerously or clumsily – with potential harm to a patient – they should give clear and proper instructions and even an admonition, forthwith. Otherwise these supervisors may run the risk themselves of being charged with negligence.

3.4 LEGAL CONSEQUENCES OF MEDICAL NEGLIGENCE

It is not necessary to say much about this subject. During the academic education and training of medical students, they are constantly being made aware by their teachers of the dire legal consequences that negligent treatment of a patient may have. These may include the following:

Firstly, there is the possibility of an action (lawsuit) for damages by the patient or his or her dependents being brought against the offending doctor or his or her employer. Today there is world-wide a greater awareness of patients' rights than ever before. A lawsuit is invariably unpleasant, time-consuming and usually very costly, and there is also the possibility of negative publicity in the media.

Secondly, in the unhappy event of a patient dying in consequence of medical negligence, there is the possibility of a criminal charge of culpable homicide being brought against the practitioner(s) involved. This is invariably a highly unpleasant and embarrassing experience. A successful prosecution may result in a very severe fine being imposed or even a sentence of imprisonment.

Thirdly, there is the possible sequel of a complaint of unprofessional conduct being lodged with the Medical and Dental Professions Board. Should an inquiry follow, it will take place in public and in the full glare of media attention.

3.5 HOW TO AVOID ALLEGATIONS OF NEGLIGENCE

The staff situation in public sector facilities may on occasion not be ideal and it is possible that interns may be called upon to perform tasks of which they have not yet had adequate experience or gained sufficient proficiency. Save in the absence of a dire emergency, however, the intern should never undertake such a task unless guidance and advice has been sought from an experienced supervisor. There is no reason why the intern should be expected to stick out his or her neck, as it were, and thereby risk exposure to legal action – not to mention the possibility of causing harm to the patient.

In this regard an interesting 1965 South African case should be mentioned: An intern who was on duty over an Easter weekend administered a massive overdose of medicine intravenously to a patient in a case of suspected epilepsy. She died within 15 minutes. The intern was charged with and convicted of culpable homicide. The court refused to uphold his defense of inexperience. It

ruled that he should first have telephoned a senior or consulted a textbook or sent for a nurse for assistance.

3.6 VICARIOUS LIABILITY (EMPLOYERS' LIABILITY)

In terms of this legal doctrine, the employer may incur liability for the wrongful act of his or its employee. First, a person may be held legally liable for damages if he or she has ordered or authorised another to perform a wrongful act. Thus, a doctor who has instructed his or her

professional assistant or an intern to perform an unlawful procedure cannot later seek refuge in the excuse that he or she did not perform the procedure with his or her own hands.

Ordinarily, however, the question of vicarious liability will arise where a person or an organisation (such as the State) employs another to perform a lawful activity and the employee then does not proceed with the required or expected measure of skill and care and causes harm to others. There have been numerous cases in South Africa in which a hospital authority incurred liability for damages on account of the negligence of personnel employed by it.

A requirement of employers' liability is that the act of the employee complained about, must have taken place within his or her scope of employment. It goes without saying that a body employing people cannot be held liable for acts performed by an employee in his or her own time which is unrelated to the job for which the employee was engaged.

It should be emphasised that "scope of employment" does not mean that, at the time when the harmful act was perpetrated, the employee must have worked under the actual, direct or physical control of the employer. In modern times the emphasis has shifted from actual control by the employer to the **right** of control. For a court to hold the employer liable, all that is required is that the relationship was such that the employee could lawfully receive directions from his supervisors in the manner of performing the act in consequence.

This, in practical terms, means that the State can be held liable for a negligent procedure performed by an intern even if his or her superiors were not looking over his or her shoulder at the time when the procedure was performed. This truth again underlines two important aspects: Firstly, senior staff members should ensure that sound instructions are constantly issued to interns and they should be allowed to watch procedures done by experienced staff who should keep them informed on what is being done and why. Secondly, if an intern is uncertain on the correctness of a procedure, he or she should not hesitate for a moment to seek advice and assistance from experienced staff.

There is yet another point to be made in regard to vicarious liability: The intern who has acted negligently does not only incur liability on the part of the State, but he or she himself or herself can be held liable in his or her personal capacity. In practice aggrieved parties who sue for damages will usually target the party with the "deepest pocket" - which will be the State – but there is nothing to prevent them from suing also the intern. The intern may be a penniless young man or woman, but once a court judgment has been obtained, it may lead to attempts in future to enforce it against the intern who has in the meantime become a doctor with something to his or her name. There is one consolation, however: If the intern has acted in good faith when performing the act complained of, the State's lawyers will normally defend also the intern.

3.7 **EMERGENCIES**

Emergencies arising have already been alluded to. In a case of a dire emergency, where a patient is at death's door and remedial action is required immediately in a hope to save his or her life, desperate measures by someone who is not medically qualified may be legally justified. If no doctor, experienced nurse or paramedic is readily available and the time factor is crucial, an intern can take such steps as he or she regards necessary.

It goes without saying that an intern who has had at least five years' university education and training and some clinical experience, would be in a far better position to come to the rescue of a person than a complete layperson as far as medicine is concerned. Even if the rescue attempt is unsuccessful, the intern should expect praise from the law rather than condemnation.

In this regard a rather sensitive situation that arises occasionally in hospitals should be addressed briefly. In the course of the medical treatment of a patient in hospital or an operation being performed in theatre, a nurse or an intern may notice that the doctor commits a serious error or is physically or mentally unfit at the time, for example because he happens to be intoxicated. What may, or should the nurse or intern do? This, of course, is a kind of emergency and may require immediate action. Particularly if the patient is in serious danger of being harmed, the

nurse or intern should be bold enough to point out in polite terms to the doctor what is going wrong and should further take immediate steps to summon another doctor to intervene to the extent that it is necessary. A full report in writing should be made to the intern's curator at the earliest opportunity.

3.8 INFORMED CONSENT AND PATIENT PRIVACY

A patient's right to personal autonomy and privacy is fully recognised and protected by the common law, as well as the South African Constitution and should be respected by medical personnel at all times. An unjustifiable invasion of his or her privacy can result in serious legal consequences.

The taking of an informed consent is primarily the responsibility of the doctor who is in charge of the case and certainly not that of interns who are still in the process of being trained. Doctors frequently delegate the function of taking a written consent to the administrative or nursing staff of a hospital. The cautious doctor should check that a proper consent has been taken. Interns are ordinarily not involved at all in the consent formalities. It is only where it comes to the attention of an intern that the patient is apparently unwilling to undergo the proposed procedure or is dissatisfied because of a lack of information that the intern should tactfully take it up with the doctor in charge of the case or a senior nursing sister.

It should always be borne in mind that the normal adult patient who is *compos mentis* is entitled to refuse medical treatment or an operation unless the procedure has already commenced. The patient may in other words, freely revoke a consent previously given.

As far as the patient's right to privacy is concerned, unauthorised outsiders should never be allowed to be present at a medical examination, medical treatment of or an operation performed on a patient, unless the patient has given consent thereto.

Confidentiality of patient information should at all times be kept in mind. Any unwarranted disclosure of details to outsiders may have serious consequences for the intern, both legally and ethically. Patient particulars may, however, be recorded in the prescribed manner and made available to the hospital's administrative staff and the patient's medical aid scheme (if any) to the extent necessary.

3.9 PATIENT RECORDS

The importance of accurate and complete patient records cannot be over-emphasized. Several members of the hospital staff, as well as treating doctors are charged with the responsibility of making entries in the patient's file, charts or the bed record. To the extent that an intern is required to make any entries, he or she should ensure that it is done reliably, accurately and legibly. It is a trite saying amongst lawyers that the first line of defence of a hospital, doctor, nurse or staff member in the event of a lawsuit, disciplinary inquiry or inquest, is invariably accurate patient records.

3.9 MISCELLANEOUS ASPECTS

3.9.1 An intern seeks assistance from senior personnel, but receives no response

It was pointed out in paragraph 3.1 that save in a situation of dire emergency, the intern should not perform a task, which is beyond his or her competence unless guidance has been sought from an experienced supervisor. If telephone assistance is sought from senior personnel, but the senior(s) fail to respond, the intern should not perform the task but forthwith make a written report, sign it and hand it to the superintendent of the hospital, keeping a copy for himself or herself. (If a dire emergency arises, the situation is as described in paragraph 3.7).

3.9.2 Protection of interns in matters of professional liability

As was observed previously, an intern may incur personal legal liability for acts of negligence and other forms of medical malpractice such as violation of the right of privacy of a patient. Many medical practitioners hold malpractice insurance which offers protection in the form of legal representation being provided in lawsuits for damages brought against doctors and cover against eventual liability, as well as in professional conduct inquiries conducted by the Medical and Dental Professions Board. Because of the ever-present danger of aggrieved patients suing medical personnel who attended to them for damages – sometimes huge amounts are claimed – it is advisable for doctors to take out professional indemnity insurance such as that provided by Glenrand MIB or membership of the Medical Protection Society. Membership is available also to interns and student interns. Information may be obtained from the following contact addresses:

Medical Protection Society
P O Box 74789
LYNNWOOD RIDGE
0040

Glenrand MIB
Medical Malpractice Division
P O Box 2544
RANDBURG
2125

3.9.3 Certificates signed by interns

During the performance of their duties, doctors may be called upon to sign a variety of documents, such as sick certificates, death certificates and certificates relating to accidents and injuries sustained or illnesses contracted by employees in the course of their employment. In terms of the Health Professions Act, 1974, (Act No. 56 of 1974), section 36(2), interns may issue any certificate or document, which in terms of any law, other than this Act, may be issued by a medical practitioner. In so doing the intern may describe himself or herself as a medical practitioner. In practice it is wise for interns who are called upon to sign important documents, particularly death certificates, to seek guidance from those doctors under whose supervision they work. (Note that student interns may also issue documents pertaining to the service they perform under the supervision of a medical practitioner in respect of the performance of their duties (see section 36(2) (aA) of Act No. 56 of 1974.))

Please note that official documents to be signed such as reports, certificates or prescriptions, need to be signed next to the name of the practitioner in printed letters (see Ethical Rule 15).

4. INTERNS PERFORMING LOCUMS

Interns are reminded that it is illegal for them to work in any form of practice outside accredited facilities.

During recent evaluations and inquiries pertaining to internship training, the various delegations, including the intern delegations, confirmed their awareness of the fact that interns were legally restricted to practicing under supervision in facilities accredited by the Board for the purpose of internship training.

Despite the above paragraphs, it had become necessary to recommend to the Board that urgent steps be taken to advise all interns and medical practitioners that the employment of interns in any clinical practice outside accredited facilities was illegal and could lead to disciplinary action on the part of the Board against any intern who might engage in such practices, as well as against any medical practitioner who might be found to employ an intern as a *locum* or in any other fashion outside accredited facilities.

Accredited facilities should be aware that the Board could withdraw accreditation for internship training should it find that the facility was aware of interns performing locums.

5. DEATH CERTIFICATES

Interns are registered and can therefore sign death certificates. But it is much safer and kinder to the intern that a more senior person does so. It places undue medico-legal responsibility on the intern, which can be avoided in a big hospital.

6. TERMINATION OF PREGNANCIES

In September 2005 the Medical Education, Training and Registration Committee confirmed that although an intern in medicine, who was required to perform an abortion, could refer the patient to another practitioner on conscientious grounds, despite the fact that "The Choice on Termination of Pregnancy Act", (Act 92 of 1996), did not provide a conscientious objection clause. It was however again re-iterated that interns could not refuse to provide emergency treatment in respect of bleeding or an emergency evacuation of the uterus since such procedures formed part of the essential skills of medical practitioners in South Africa and interns in medicine were required to attain those skills during their internship training.

7. RENDERING AFTER HOURS SERVICES

A medical practitioner or casualty officer who receives a patient, remains responsible for the safety and well-being of that patient until such time as the patient has been handed over into the care of another medical practitioner who accepts responsibility for that patient.

A medical practitioner remains personally responsible for the care and treatment of his or her patients for as long as they require such care and treatment.

It is, nevertheless, within the professional discretion of a medical practitioner to decide when to leave a patient for whom he or she was personally responsible, bearing in mind, however, that, should such patient suffer unduly or die as a consequence, the practitioner concerned will be held professionally accountable for his or her actions.

Should a critically ill patient, therefore, be referred to a medical practitioner or dentist for treatment, the welfare of such a patient outweighs any policy decision regarding the treatment of patients by the State or any other health care employer agency and, thus, any critically ill patients shall appropriately be treated by the medical practitioner or dentist concerned.

8. OVERTIME REQUIREMENTS DURING INTERNSHIP TRAINING

The Medical Education, Training and Registration Committee holds the view that overtime has to be performed by interns; that it is expected of interns to be on duty for a maximum of 80 hours per week; that overtime is part of service delivery; and that interns are not permitted to refuse to work overtime. Furthermore, the Committee agrees that night duty is a valid and essential learning experience where development of competencies and skills takes place and exposure to very specific aspects of medicine is possible which differs from the normal daytime exposure.

It be confirmed that interns in medicine had to perform overtime duties. It was expected of interns to be on duty for a maximum of 60 hours per week and that overtime was part of service delivery. Interns were not permitted to refuse to work overtime.

In June 2006 it was again confirmed that interns in medicine were required to perform overtime duties. It was, however, indicated that due to exhaustion and the possible risk to patients as a result, interns should not be required to be on duty for more than 60 hours per week which would

include overtime duties as part of service delivery. In terms of the agreement with the Department of Health and because of emergencies, interns could not refuse to perform overtime duties.

The ruling of the Board of December 1999 referred to in paragraphs 6.2 and 6.3 above (Rendering after hours services) needs to be kept in mind and guide responsibilities pertaining to overtime.

9. THE IMPORTANCE OF ADOPTING GOOD, SOUND AND ETHICAL FINANCIAL MANAGEMENT

The acquisition of medical education and training, whether undergraduate or postgraduate, is a very expensive exercise. Furthermore, the purchase of items necessary or essential for practicing the profession such as cars, stethoscopes, diagnostic sets etc. are a heavy drain on any family's financial resources.

When being an independent medical practitioner, the purchase, setting up and furnishing of a practice is another big drain on precious financial resources. Thus, the long road to a successful medical career involves the constant need for money discipline, sacrifice, dedication and the need for hard work.

The medical student is an unproven item and is financially dependent upon his or her family, banks, loans, bursaries or scholarships to exist. As an unproven item it is very difficult for him or her to obtain loans or other financial assistance.

In contrast, the medical graduate has a medical degree to offer as collateral with guaranteed work as an intern or community service doctor with regular pay cheques. Consequently, the doctor is a strong attraction to those who profit or earn a commission by offering a service, soft loans and luxury items on tick.

The medical graduate, whilst skilled in medical knowledge, is often very naïve in financial matters and can sometimes fall prey to unscrupulous sales people.
It is a human desire and very understandable that, upon qualifying, the intern wishes to enjoy the fruits of his or her hard work, sacrifice and dedication. However, upon graduation the graduate enters a new world governed by the Hippocratic Oath, Regulations and Rules enacted via the Medical and Dental Professions Board, which grant him or her license to practice. Any transgression of such Regulations and Rules may result in an injury into unprofessional conduct and its possible consequences. Thus, it is incumbent for every graduate to earn his money ethically and honestly.

A good starting point to learn money management principles and avoid pitfalls is good communication and preparedness to listen to wise counsel from senior colleagues, Intern Curators, hospital superintendents, bank managers and accountants.

The following are examples of "do's" and "don'ts" –

a. Do not spend money that you have yet to earn.
b. Being a medical practitioner is both a dedication and a vocation. It is never a vehicle to amass a big fortune.
c. Never practice medicine outside of the prescribed guidelines, such as performing locums for gain whilst still being a medical student or intern.
d. The internship training period requires so much of your time and attention that it is prudent and wise to delay the purchase of expensive cars, electronic goods, etc., until there exist more opportunities for leisure time.
e. Lastly, the intern needs to remember that he or she has a legal and moral obligation to repay all outstanding student loans.

10. ETHICAL GUIDELINES FOR GOOD PRACTICE IN MEDICINE, DENTISTRY AND MEDICAL SCIENCES

The Medical and Dental Professions Board has embarked on a project to bring together ethical and professional guidelines for doctors (medical practitioners), dentists, and medical scientists. However, a Handbook on Good and Ethical Practice will be provided to all persons registering for the first time as medical practitioners. The following Booklets are separately available:

Booklet 1: Guidelines good practice

Booklet 2: *General ethical guidelines*

Booklet 3: Patients' Rights Charter

Booklet 4: Informed Consent

Booklet 5: Confidentiality Protecting and Providing Information

Booklet 6: Gen Ethical Guidelines for management of Patients with HIV

Booklet 7: Guidelines withholding and withdrawing treatment

Booklet 8: Reproductive Health

Booklet 9: Keeping of Patients Records

Booklet 10: Telemedicine

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

Booklet 12: Guidelines for the management of health care waste

Booklet 13: Gen Ethical Guidelines for Health Researchers

Booklet 14: Biotechnology Research in SA

Booklet 15: Research Development and use of Chemical and Biological Weapons Business Practice

ANNEXURE A

GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R 992

16 September 2008

HEALTH PROFESSIONS ACT, 1974 (ACT NO. 56 OF 1974)

REGULATIONS RELATING TO THE REGISTRATION AND TRAINING OF INTERNS IN MEDICINE

The Minister of Health has, in terms of section 61(5) of the Health Professions Act, 1974 (Act No. 56 of 1974) and after consultation with the Health Professions Council of South Africa, to amend the regulations published as Government Notice No. R 57 of 23 January 2004 as it appears in the Schedule.

SCHEDULE

1. DEFINITIONS

In these regulations **"the Act"** means the Health Professions Act, 1974 (Act No. 56 of 1974) and any expression to which a meaning has been assigned in the Act, shall bear such meaning and unless the context otherwise indicates -

"approved facility" means a hospital, clinic or a health care centre which has been accredited by the board for the purpose of internship training;

"board" means the Medical and Dental Professions Board established, in terms of section 15 of the Act.

2. Registration as an intern in medicine

(1) Any person who holds a qualification prescribed in the regulations made in terms of section 24 of the Act shall, after or in connection with obtaining such a qualification and before he or she is entitled to registration as a medical practitioner in any category of such registration, undertake training to the satisfaction of the board as an intern in medicine for a period and in the manner described in regulation 3, unless the board exempted him or her partially or in full from this requirement on submission of documentary evidence to the satisfaction of the board of internship or equivalent training undergone or experience obtained outside South Africa.

(2) The register kept in terms of section 18 of the Act shall reflect all such information as the board may require.

(3) A person referred to in subregulation (1) shall -
  (a) submit his or her application to the board in terms of section 17 of the Act for registration as an intern in medicine on an application form supplied by the board and duly completed;
  (b) submit proof that he or she holds a qualification –
    (i) prescribed in the Regulations relating to the Registration of Persons as
    (ii) General Practitioners and Family Physicians in Medicine made in terms of section 24 of the Act; or
    (iii) accepted by the board in terms of section 25 of the Act and has passed an

(iv) examination or other evaluation determined by the board;

(c) submit the name of the accredited facility to which he or she was allocated by the relevant health authority to undergo training as an intern and shall notify the board in writing in advance if he or she intends to change from that facility to another facility; and

(d) pay the prescribed fee.

3. Conditions of internship training

Regulation 3 of the regulations is hereby amended by the substitution for sub-regulation (1) of the following sub-regulation – (1) internship training shall commence not later than one year from date of fulfillment of the requirements of the degree in medicine. Provided that should this requirement not be complied with, a detailed submission shall be made to the board on the reasons for the delay to commence the internship training and the board may condone such delay.

(1) Internship training commencing **before 1 July 2004** shall be of not less than twelve months' duration and, where it is broken or interrupted, it shall consist of periods which, when added together, are not less than twelve months in total, including vacation leave not exceeding one month's duration per annum, and sick leave not exceeding one month's duration and shall comply with criteria laid down by the board from time to time.

(2) For a person who is enrolled for a five year curriculum, internship training commencing **after 30 June 2004** shall be of not less than twenty four months' duration and, where it is broken or interrupted, it shall consist of periods which, when added together, are not less than twenty four months in total, including vacation leave not exceeding one month's duration per annum and sick leave not exceeding two months' duration and shall comply with criteria laid down by the board from time to time.

(3) For a person who is enrolled for a six year curriculum, internship training commencing **during the period 1 July 2004 to 30 June 2006** shall be of not less than twelve months' duration and, where it is broken or interrupted, it shall consist of periods which, when added together, are not less than twelve months in total, including vacation leave not exceeding one month's duration per annum and sick leave not exceeding one month's duration and shall comply with criteria laid down by the board from time to time.

(4) Internship training commencing **after 30 June 2006** shall be of not less than twenty four months' duration and, where it is broken or interrupted, it shall consist of periods which, when added together, are not less than twenty four months in total, including vacation leave not exceeding one month's duration per annum and sick leave not exceeding two months' duration and shall comply with criteria laid down by the board from time to time.

(5) If a break or interruption in internship training, excluding leave referred to in subregulation (1), (2) or (3) as the case may be, exceeds a period of one year, the internship training prior to such break or interruption shall not be recognised as part of completed internship training.

(6) The period of twelve months of internship training referred to in subregulation (1) shall be completed within a period of two years from the date of having been registered in terms of section 17 of the Act as an intern in medicine.

(7) The period of twenty-four months of internship training referred to in subregulations (2) or 3) shall be completed within a period of three years from the date of having been registered in terms of section 17 of the Act as an intern in medicine.

(8) If an intern does not complete his or her internship training within a period of two or three years, as the case may be, his or her registration in terms of section 18 of the Act shall be cancelled unless he or she provides the board with satisfactory reasons as to why his or her registration should not be cancelled.

(9) (a) The training shall be undertaken by an intern in a facility accredited by the board.
(b) If a facility referred to in paragraph (a) is not available, the board may, at its discretion, accept alternative training which in the board's opinion is equivalent to training at a facility accredited by the board.
(c) When accrediting a facility or alternative training, the board may stipulate that only a portion of an intern's training shall be undertaken thereat, and the remainder shall be undertaken at another approved facility.
(d) If internship training at an accredited facility is regarded by the board for any reason to be inadequate or unsatisfactory, the board may withdraw its approval thereof, in which case the board shall inform any interns at the facility accordingly in writing and request such interns to undertake internship training at another approved facility for the remaining period.

(10) Interns in medicine shall be subject to all the rules of professional conduct prescribed by the board for medical practitioners.

(11) (a) Upon completion of internship training, an intern shall submit a duty certificate to the satisfaction of the board to certify that he or she has satisfactorily undertaken internship training as required by the board and such submission shall be a precondition for his or her registration as a medical practitioner to perform community service as prescribed in terms of section 24A of the Act.
(b) The duty certificate referred to in paragraph (a) shall be issued by such officials of an accredited facility where an intern successfully undertook internship training, as the board may require.

4. Repeal

The regulations published under Government Notice Nos. R. 2271 of 3 December 1976, R. 2272 of 3 December 1976, and R57 of 23 January 2004 are hereby repealed.

DR M E TSHABALALA-MSIMANG
MINISTER OF HEALTH

Form 10-A1

MEDICAL AND DENTAL PROFESSIONS BOARD

INTERN DUTY CERTIFICATE FOR COMPLETION OF A TWO-YEAR INTERNSHIP TRAINING PROGRAMME

NAME OF INTERN (Full names): REG NO: IN PLEASE COMPLETE IN BLACK BALLPOINT PEN.

NAME OF ACCREDITED TRAINING COMPLEX:

I, the undersigned, Head of the Training Complex/Designate, hereby certify that the said intern has completed year one of internship training in the specified domains of this facility for the periods specified, that he or she has fulfilled the prescribed requirements, and that all information furnished herein is correct.

Notes:

A. If the training of an intern had been unsatisfactory, a detailed statement should be submitted to the Internship Committee by the Head of the Clinical Domain and the CEO/Medical Director of the accredited facility as to the reasons why the training was considered to be unsatisfactory. If the domain was not completed satisfactorily, the domain should not be signed off.

B. Although this certificate may be signed by the CEO/Medical Director and Head of the Clinical Domain one month prior to completion of internship training, each intern is required to perform his or her duties in a satisfactory manner during the last month of his or her training, failing which the signed Intern Duty Certificate may be withdrawn. In such a case, the intern would be required to complete the additional period of internship training specified by the CEO/Medical Director and Head of the Clinical Domain.

DOMAIN	PERIOD		Months	Was Internship training completed satisfactorily		Signature of Head of Clinical Domain		
	From	To		Yes (Tick)	No (Tick)	Name (Print)	Signature	Date
1. CLINICAL DOMAINS								
1.1 General Medicine (3 months)								
If training Extended /Interrupted								
1.2 General Surgery (3 months)								
If training Extended /Interrupted								
1.3 Paediatrics (3 months)								
If training Extended /Interrupted								
1.4 Obstetrics & Gynaecology (3 months)								
If training Extended /Interrupted								
2 LEAVE TAKEN								
2.1 Annual leave	Total no. of days taken							
2.2 Maternity leave (if applicable)	Total no. of days taken							
2.3 Sick-leave	Total no. of days taken							
2.4.1 Other leave (specify type)	Total no. of days taken							
2.4.2 Other leave (specify type)	Total no. of days taken							

HPCSA
Health Professions Council of South Africa

Form 10-A2

MEDICAL AND DENTAL PROFESSIONS BOARD

INTERN DUTY CERTIFICATE FOR COMPLETION OF A TWO-YEAR INTERNSHIP TRAINING PROGRAMME

NAME OF INTERN (Full names): REG NO: IN **PLEASE COMPLETE IN BLACK BALLPOINT PEN.**

NAME OF ACCREDITED TRAINING COMPLEX:

I, the undersigned, Head of the Training Complex/Designate, hereby certify that the said intern has completed year one of internship training in the specified domains of this facility for the periods specified, that he or she has fulfilled the prescribed requirements, and that all information furnished herein is correct.

Notes:

C. If the training of an intern had been unsatisfactory, a detailed statement should be submitted to the Internship Committee by the Head of the Clinical Domain and the CEO/Medical Director of the accredited facility as to the reasons why the training was considered to be unsatisfactory. If the domain was not completed satisfactorily, the domain should not be signed off.

D. Although this certificate may be signed by the CEO/Medical Director and Head of the Clinical Domain one month prior to completion of internship training, each intern is required to perform his or her duties in a satisfactory manner during the last month of his or her training, failing which the signed Intern Duty Certificate may be withdrawn. In such a case, the intern would be required to complete the additional period of internship training specified by the CEO/Medical Director and Head of the Clinical Domain.

DOMAIN	**PERIOD**		**Months**	**Was Internship training completed**		**Signature of Head of Clinical Domain**		
	From	**To**		**Yes (Tick**	**No (Tick**	**Name (Print)**	**Signature**	**Date**
1. CLINICAL DOMAINS								
1.5 Anaesthesiology (2 months)								
If training Extended /Interrupted								
1.6 Orthopaedics (2 months)								
If training Extended /Interrupted								
1.7 Psychiatry (2 months)								
If training Extended /Interrupted								
1.8 Family Medicine/Primary care								
If training Extended /Interrupted								
2 LEAVE TAKEN								
2.1 Annual leave	Total no. of days taken							
2.2 Maternity leave (if applicable)	Total no. of days taken							
2.3 Sick-leave	Total no. of days taken							
2.4.1 Other leave (specify type)	Total no. of days taken							
2.4.2 Other leave (specify type)	Total no. of days taken							

SIGNATURE OF HEAD OF TRAINING COMPLEX/DESIGNATE | SIGNATURE OF INTERN CURATOR | STAMP | DATE

No alterations to this document will be accepted.

ANNEXURE C

MEDICAL AND DENTAL PROFESSIONS BOARD

DELAYED REGISTRATION OF AN INTERN AS A MEDICAL PRACTITIONER

1. BACKGROUND

All interns must produce a formally signed Intern Duty Certificate (see Annexure B), which shows satisfactory performance during the intern year before the Medical and Dental Professions Board will register them as medical practitioners. The Intern Duty Certificate is to be signed by the CEO/Chief Medical Superintendent of the Hospital and the Heads of the various domains in which the intern worked. Should a Head or the Superintendent refuse to sign, the intern may be required to spend more time training in that domain.

2. CRITERIA FOR DELAYED REGISTRATION

Undue absence from work, other than for recognised vacation or sick leave.

Repeated failure to perform required duties.

Gross incompetence or negligence in patient care.

Mental or physical unsuitability for registration as a medical practitioner (see definition of "impaired" as contained in section 1 of the *Health Professions Act*, 1974, which reads as follows:

"'impaired' means a mental or physical condition, or the abuse of or dependence on chemical substances, which affects the competence, attitude, judgement or performance of a student or another person registered in terms of this Act".

Interns who would be required to complete additional time due to training/skills needs, or any other reason that a facility would require, such time should be completed at the end of the internship training programme, and not at the end of a specific domain.

3. RECOMMENDED PROCEDURE FOR DELAYED REGISTRATION

The following procedures shall be adopted where an intern's performance was a cause for concern:

The intern should be verbally warned of his or her poor performance and a joint record of the verbal warning to be kept on his or her personal file.

A second warning should be issued in writing to the intern with a copy on his or her file and a copy to the Board.

Should the CEO/Chief Medical Superintendent and/or Head of Department refuse to sign the Intern Duty Certificate, a letter detailing the reasons for delayed registration should be submitted to the Medical Education, Training and Registration Committee and the intern involved. The letter should also include recommendations on the duration of extra training and the domains in which such extra training was to be obtained.
Should it become obvious that an intern is impaired as defined above and that his or her impairment causes a threat to himself or herself or to his or her patients, such an intern needs to be reported to the Health Committee of the Board to be investigated in terms of Regulations made under section 52 of the Health Professions Act, 1974.

If such an investigation were to confirm the alleged impairment, the Health Committee shall be entitled to impose such conditions of registration or practice on that person as the Committee may deem essential to ensure –

a. patient protection and safety;

b. treatment of the impaired individual in order to achieve his or her rehabilitation or the stabilization or control of his or her illness or condition.

4. INTERNS NOT BEING ABLE TO PERFORM OVERTIME DUTIES

In the event of an intern not being able to perform overtime duties as per the Guidelines for Internship Training, due to impairment, an additional twenty-five (25 %) of time would be added to the internship training programme in either the specific rotation or to the entire programme (which ever one is applicable and depending on the nature, course and length of impairment). Relevant and appropriate medical reports should accompany such a request.

ANNEXURE D

HEALTH PROFESSIONS ACT, 1974
(ACT NO. 56 OF 1974)

EXTRACTS

SECTIONS 17, 19 AND 36

Registration a prerequisite for practicing

17(1) No person shall be entitled to practice within the Republic -

(a) the profession of a medical practitioner, dentist, psychologist or as an intern or an intern psychologist or any profession registrable in terms of this Act; or
(b) except in so far as it is authorised by the provisions of the Nursing Act, 1978 (Act No. 50 of 1978), the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act No. 63 of 1982), the Pharmacy Act, 1974 (Act No. 53 of 1974), and sections 33, 34 and 39 of this Act, for gain any other profession the practice of which mainly consists of -

(i) the physical or mental examination of persons;
(ii) the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in man;
(iii) the giving of advice in regard to such defects, illnesses or deficiencies; or
(iv) the prescribing or providing of medicine in connection with such defects, illnesses or deficiencies,

unless he is registered in terms of this Act.

(2) Every person desiring to be registered in terms of this Act shall apply to the registrar and shall submit the qualification which, in his or her submission, entitles him or her to registration, together with such proof of identity and good character and of the authenticity and validity of the qualifications submitted as may be required by the professional board concerned.

(3) If the registrar is satisfied that the qualification and the other documents submitted in support of the application satisfy the requirements of this Act, he shall, upon payment by the applicant of the prescribed registration fee, issue a registration certificate authorizing the applicant, subject to the provisions of this Act or of any other law, to practice the profession in respect whereof he has applied for registration, within the Republic.

(4) If the registrar is not satisfied that the qualification or other documents submitted in support of the application satisfy the requirements of this Act, he or she shall refuse to issue a registration certificate to the applicant, but shall, if so required by the applicant, submit the application to the professional board concerned for decision.

Removal of name from, and restoration to, register

19(1) The professional board concerned may direct the registrar to remove from the register the name of any person -

(a) who has been absent from the Republic during the three years immediately preceding such removal;
(b) who has failed to notify the registrar, within a period of three months as from the date of an enquiry sent by the registrar by certified mail to the address appearing in the register in respect of such person, of his or her present address;

(c) who has requested that his name be removed from the register, in which case such person may be required to lodge with the registrar an affidavit to the effect that no disciplinary or criminal proceedings are being or are likely to be taken against him;
(d) who has failed to pay to the professional board, within three months as from the date on which it became due for payment, any annual fee prescribed by the professional board in terms of section 62;
(e) whose name has been removed from the register, record or roll of any university, hospital, college, society or other body from which that person received the qualification by virtue of the holding whereof he was registered;
(f) who has been registered in error or through fraud.

(2) Notice of the removal, in terms of subsection (1), of his or her name form the register, or of the removal, in terms of section 18(5), of an entry from the register, shall be given by the registrar to the person concerned by way of certified mail addressed to such person at the address appearing in respect of him or her in the register.

(3) As from the date on which notice has been given in terms of subsection (2) -

(a) any registration certificate issued in terms of this Act to the person concerned shall be deemed to be cancelled; and
(b) such person shall cease to practice the profession in respect of which he was registered or to perform any act which he, in his capacity as a registered person, was entitled to perform,

until such time as his name or the entry removed from the register in terms of section 18(5), as the case may be, is restored to the register.

(4) If from the documents submitted to him in terms of section 18(3) of the Mental Health Act, 1973 (Act No. 18 of 1973), it appears to the judge concerned, or it is brought to his notice in any other manner, that the person to whom the documents relate is a person registered under this Act, he shall, if the said person is declared a mentally ill person as contemplated in section 19(1)(b) of the said Mental Health Act, direct that a copy of the order declaring such person a mentally ill person be transmitted to the registrar and the registrar shall, on receipt of the said copy, remove the name of the person concerned from the register.

(5) The name of a person whose name has in terms of this section been removed from the register or an entry removed from the register in terms of section 18(5), shall be restored to the register by the registrar upon the person concerned -

(a) applying on the prescribed form for such restoration;
(b) paying the fee prescribed in respect of such restoration (if any);
(c) in the case where his name has been removed from the register in terms of subsection (4), submitting proof to the satisfaction of the council of his discharge in terms of the provisions of the Mental Health Act, 1973, from the institution at which he had been detained;
(cA) paying any annual fee which was not paid and payment of an additional fee as may be decided upon; and
(d) complying with such other requirements as the council may determine.

(6) ……..

Penalties for practicing as a medical practitioner or as an intern, or for performing certain other acts, while unregistered

36(1) Subject to the provisions of subsections (2) and (3) and section 37 any person, not registered as a medical practitioner or as an intern, who -

(a) for gain practices as a medical practitioner (whether or not purporting to be registered);

(b) for gain -
(i) physically examines any person;

(ii) performs any act of diagnosing, treating or preventing any physical defect, illness or deficiency in respect of any person;
(iii) advises any person on his physical state;
(iv) on the ground of information provided by any person or obtained from him in any manner whatsoever -
(aa) diagnoses such person's physical state;
(bb) advises such person on his physical state;
(cc) supplies or sells to or prescribes for such person any medicine or treatment;
(v) prescribes or provides any medicine, substance or thing; or
(vi) performs any other act specially pertaining to the profession of a medical practitioner;

(c) except in accordance with the provisions of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), the Pharmacy Act, 1974 (Act No. 53 of 1974), the Health Act, 1977 (Act No. 63 of 1977), the Nursing Act, 1978 (Act No. 50 of 1978), the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982 (Act No. 63 of 1982), and sections 33, 34 and 39 of this Act, performs any act whatsoever having as its object -
(i) the diagnosing, treating or preventing of any physical defect, illness or deficiency in any person; and
(ii) by virtue of the performance of such act, the obtaining, either for himself or for any other person, of any benefit by way of any profit from the sale or disposal of any medicine, foodstuff or substance or by way of any donation or gift or by way of the provision of accommodation, or the obtaining of, either for himself or for any other person, any other gain whatsoever;

(d) pretends, or by any means whatsoever holds himself out, to be a medical practitioner or intern (whether or not purporting to be registered) or a healer of whatever description, of physical defects, illness or deficiencies in man;

(e) uses the name of medical practitioner, intern, healer or doctor or any name, title, description or symbol indicating, or calculated to lead persons to infer, that he is the holder of any qualification as a medical practitioner, physician or surgeon, or as an obstetrician or intern or of any other qualification enabling him to diagnose, treat or prevent physical defects, illnesses or deficiencies in man in any manner whatsoever, or that he is registered under this Act as a medical practitioner or an intern;

(f) except in accordance with the provisions of the Medicines and Related Substances Act, 1965, the Pharmacy Act, 1974, the Health Act, 1977, the Nursing Act, 1978, the Chiropractors, Homeopaths and Allied Health Service Professions Act, 1982, and sections 33, 34 and 39 of this Act, by words, conduct or demeanour holds himself or herself out to be able, qualified or competent to diagnose, treat or prevent physical defects, illnesses or deficiencies in man or to prescribe or supply any medicine, substance or thing in respect of such defects, illnesses or deficiencies; or

(g) (i) diagnoses, treats or offers to treat, or prescribes treatment or any cure for cancer;
(ii) holds himself out to be able to treat or cure cancer or to prescribe treatment therefore; or
(iii) holds out that any article, compound, medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer,

shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding twelve months or to both such fine and such imprisonment.

(2) The provisions of subsection (1) shall not prohibit -

(a) an intern working at an institution recognised by the council from -

(i) performing any function or issuing any certificate or other document which in terms of any law, other than this Act, may be or is required to be performed or issued by a medical practitioner, whether described in such law as a medical practitioner or by any other name or designation; or

(ii) describing himself as a medical practitioner in connection with the performance of any such function or the issuing of any such certificate or other document, and any reference in any such law to such a medical practitioner shall be deemed to include a reference to an intern;

(aA) a student intern in the course of his training from -

(i) performing under the supervision of a medical practitioner any act mentioned in paragraph (b) of subsection (1) which has been prescribed;

(ii) issuing in connection with such performance of that act in the institution where he is undergoing his training, any document required in respect of the performance of that act;

(b) a pharmacist registered under the Pharmacy Act, 1974 (Act No. 53 of 1974), from performing any act falling within the scope of his profession as contemplated in that Act; or

(c) a dentist from performing any act falling within the scope of his profession as contemplated in this Act or from using any name, title, description or symbol normally associated with his profession.

(3) The provisions of subsection (1)(g) shall not -

(a) apply in respect of any act performed by any person in the course of *bona fide* research at any institution approved for that purpose by the Minister;

(b) be construed as prohibiting a dentist from -

(i) diagnosing cancer while performing in respect of any person any act pertaining to the practice of dentistry; or

(ii) treating cancer so diagnosed;

(c) apply in respect of -

(i) any act performed by a pharmacist registered under the Pharmacy Act, 1974, or by an employee of such pharmacist acting within the scope of his employment, for the purposes of selling or promoting the sale of any medicine to another pharmacist or to any medical practitioner; or

(ii) the sale of any medicine by any pharmacist to any person in pursuance of a written prescription of a medical practitioner.

(4) For the purposes of subsection (1) “cancer” shall include all neoplasms, irrespective of their origin, including lymphoma and leukaem

ANNEXURE E

HEALTH PROFESSIONS ACT 56 OF 1974

ETHICAL RULES OF CONDUCT FOR PRACTITIONERS REGISTERED UNDER THE HEALTH PROFESSIONS ACT, 1974

Published under Government Notice R717 in *Government Gazette* 29079 of 4 August 2006 and amended by

GN R68	**GG 31825**	**20090202**
GN R654	**GG 33400**	**20100730**

The Health Professions Council of South Africa, in consultation with the professional boards, and with the approval of the Minister of Health, has, in terms of section 49 read with section 61(2) and 61A(2) of the Health Professions Act, 1974 (Act No. 56 of 1974), made the rules in the Schedule.

1. SCHEDULE

ANNEXURE 6

MEDICAL AND DENTAL PROFESSIONS BOARD

1. Performance of professional acts by medical practitioner or medical specialist
2. Performance of professional acts by dentist or dental specialist
3. Partnerships and juristic persons
4. Medical specialist and dental specialist
5. Performance of professional acts by biomedical engineer, clinical biochemist, genetic counsellor, medical biological scientist, medical physicist
6. Performance of professional acts by intern in medicine
7. Performance of professional acts by interns in biomedical engineering, clinical biochemistry, genetic counselling, medical biological science or medical physics
8. Performance of professional acts by student in medicine or dentistry
9. Performance of professional acts by a clinical associate

1. Definitions

In these rules, any word or expression to which a meaning has been assigned in the Act shall bear such meaning and, unless the context indicates otherwise -

"Act" means the Health Professions Act, 1974(Act No. 56 of 1974);
"annexure" means an annexure to these rules;
"association" means a form of practising where two or more practitioners practise for their own account, but share communal assets or facilities;
"board" means a professional board established in terms of section 15 of the Act;
"canvassing" means conduct which draws attention, either verbally or by means of printed or electronic media, to one's personal qualities, superior knowledge, quality of service, professional guarantees or best practice;
"close collaboration" means consultation by a practitioner at one stage or another in the treatment of a patient with another practitioner and the furnishing by the latter practitioner, at the end of such treatment, of a report on the treatment to the practitioner whom he or she consulted;
"dental specialist" means a dentist who has been registered as a specialist in a speciality or subspeciality in dentistry in terms of the Regulations relating to the Specialities and Subspecialities in Medicine and Dentistry, published under Government Notice No. R. 590 of 29 June 2001;
"dispensing optician" means a person registered as such in terms of the Act and the Rules for the registration of Dispensing Opticians, published under Government Notice No. R. 2339 of 3 December 1976;
"impairment" means a mental or physical condition which affects the competence, attitude, judgement or performance of professional acts by a registered practitioner;
"independent practice" means a practice where a registered health profession is conducted by a health practitioner without the supervision of another health practitioner;
"itinerant practice" means a practice which a practitioner conducts on a regular basis at a location other than at his or her resident practice address;
"medical device" means a medical device as defined in section 1 of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965);
[Definition of "medical device" inserted by GN R68/2009]
"medical scientist" means a person registered under the Act as a biomedical engineer, clinical biochemist, genetic counsellor, medical biological scientist or medical physicist;
"medical specialist" means a medical practitioner who has been registered as a specialist in a speciality or subspeciality in medicine in terms of the Regulations relating to the Specialities and Subspecialities in Medicine and Dentistry, published under Government Notice No. R. 590 of 29 June 2001;
"optometrist" means a person registered as such under the Act;

"pharmaceutical concern" means a company registered as such under the Pharmacy Act, 1974 (Act No. 53 of 1974);
"practitioner" means a person registered as such under the Act and, in the application of rules 5, 6 and 9 of these rules, also a juristic person exempted from registration in terms of section 54A of the Act;
"private practice" means the practice of a health practitioner who practises for his or her own account, either in solus practice, or as a partner in a partnership, or as an associate in an association with other practitioners, or as a director of a company established in terms of section 54A of the Act;
"public company" means a company registered as such under the Companies Act, 1973 (Act No. 61 of 1973);
"public service" means a service rendered by the state at the national, provincial or local level of government and includes organizations which function under its auspices or are largely subsidized by the state or recognized by a board for the purposes of these rules;
"resident practice" means a place where a registered health practitioner conducts his or her practice on a daily basis;
"rooms" means a physical structure, with an exclusive entrance and walled all round for the privacy of patients, the preservation of their confidentiality and the safe keeping of records, where a practitioner conducts his or her practice;
[Definition of "rooms" inserted by GN R68/2009]
"section" means a section of the Act;
"specialist" means a practitioner who is registered as a specialist in a speciality or subspeciality (if any) in terms of the Regulations relating to the Specialities and Subspecialties in Medicine and Dentistry, published under Government Notice No. R. 590 of 29 June 2001, and who confines his or her practice to such speciality or subspeciality;
"supervision" means the acceptance of liability by a supervising practitioner for the acts of another practitioner; and
"touting" means conduct which draws attention, either verbally or by means of printed or electronic media, to one's offers, guarantees or material benefits that do not fall in the categories of professional services or items, but are linked to the rendering of a professional service or designed to entice the public to the professional practice.
[Definition of "touting" substituted by GN R68/2009]

2. Interpretation and application

(1) Failure by a practitioner to comply with any conduct determined in these rules or an annexure to these rules shall constitute an act or omission in respect of which the board concerned may take disciplinary steps in terms of Chapter IV of the Act.
(2) Conduct determined in these rules or an annexure to these rules shall not be deemed to constitute a complete list of conduct and the board concerned may therefore inquire into and deal with any complaint of unprofessional conduct which may be brought before such board.
(3) At an inquiry referred to in subrule (2) the board concerned shall be guided by these rules, annexures to these rules, ethical rulings or guidelines and policy statements which the board concerned or council makes from time to time.

3. Advertising and canvassing or touting

(1) A practitioner shall be allowed to advertise his or her services or permit, sanction or acquiesce to such advertisement: Provided that the advertisement is not unprofessional, untruthful, deceptive or misleading or causes consumers unwarranted anxiety that they may be suffering from any health condition.
(2) A practitioner shall not canvass or tout or allow canvassing or touting to be done for patients on his or her behalf.

4. Information on professional stationery

(1) A practitioner shall print or have printed on letterheads, account forms and electronic stationery information pertaining only to such practitioner's -
(a) name;

(b) profession;
(c) registered category;
(d) speciality or subspeciality or field of professional practice (if any);
(e) registered qualifications or other academic qualifications or honorary degrees in abbreviated form;
(f) registration number;
(g) addresses (including email address);
(h) telephone and fax numbers;
(i) practice or consultation hours;
(j) practice code number; and
(k) dispensing licence number (if any).

(2) A group of practitioners practising as a juristic person which is exempted from registration in terms of section 54A of the Act or a group of practitioners practising in partnership, shall print or have printed on letterheads, account forms and electronic stationery information pertaining only to such juristic person or partnership practitioners' -
(a) name;
(b) profession;
(c) registered category;
(d) speciality or subspeciality or field of professional practice (if any);
(e) registered qualifications or other academic qualifications or honorary degrees in abbreviated form;
(f) registration number;
(g) addresses (including email address);
(h) telephone and fax numbers;
(i) business hours;
(j) practice code number;
(k) exemption from registration in terms of section 54A of the Act; and
(l) dispensing licence number (if any).

(3) A practitioner shall not use prescription forms or envelopes on which the name or address of a pharmacist is printed.

5. Naming of a practice

(1) A practitioner shall use his or her own name or the name of a registered practitioner or practitioners with whom he or she is in partnership or with whom he or she practises as a juristic person, as a name for his or her private practice.

(2) A practitioner referred to in subrule (1) may retain the name of such private practice even if another practitioner, partner of such partnership or member of such juristic person is no longer part of such private practice: Provided that the express consent of the past practitioner or, in the case of a deceased practitioner the consent of the executor of his or her estate or his or her next-of-kin, has been obtained.

(3) A practitioner shall not use, in the name of his or her private practice, the expression "hospital", "clinic" or "institute" or any other expression which may give the impression that such private practice forms part of, or is in association with, a hospital, clinic or institute.

6. Itinerant practice

A practitioner may conduct a regularly recurring itinerant practice at a place where another practitioner is established if, in such itinerant practice, such practitioner renders the same level of service to patients, at the same fee as the service which he or she would render in the area in which he or she is conducting a resident practice.

7. Fees and commission

(1) A practitioner shall not accept commission or any material consideration, (monetary or otherwise) from a person or from another practitioner or institution in return for the purchase,

sale or supply of any goods, substances or materials used by him or her in the conduct of his or her professional practice.

(2) A practitioner shall not pay commission or offer any material consideration, (monetary or otherwise) to any person for recommending patients.

(3) A practitioner shall not offer or accept any payment, benefit or material consideration (monetary or otherwise) which is calculated to induce him or her to act or not to act in a particular way not scientifically, professionally or medically indicated or to under- service, over-service or over-charge patients.

(4) A practitioner shall not share fees with any person or with another practitioner who has not taken a commensurate part in the services for which such fees are charged.

(5) A practitioner shall not charge or receive fees for services not personally rendered, except for services rendered by another practitioner in his or her employment or with whom he or she is associated as a partner, shareholder or locum tenens.

8. Partnership and juristic persons

(1) A practitioner may practise in partnership or association with or employ only a practitioner who is registered under the Act and who is not prohibited under any of the annexures to these rules or any ethical rulings from entering into such partnership or association or being so employed: Provided that, in the case of employment, the practitioner so employed either provides a supportive health care service to complete or supplement the employing practitioner's healthcare or treatment intervention or is in the same professional category as the employing practitioner.
[Subrule (1) substituted by GN R68/2009]

(2) A practitioner shall practise in or as a juristic person who is exempted from registration in terms of section 54A of the Act only if such juristic person complies with the conditions of such exemption.

(3) A practitioner shall practise in a partnership, association or as a juristic person only within the scope of the profession in respect of which he or she is registered under the Act.

(4) A practitioner shall not practise in any other form of practice which has inherent requirements or conditions that violate or potentially may violate one or more of these rules or an annexure to these rules.

8A. Sharing of Rooms

A practitioner shall not share his or her rooms with a person or entity not registered in terms of the Act.
[Rule 8A inserted by GN R68/2009]

9. Covering

(1) A practitioner shall employ as professional assistant or locum tenens, or in any other contractual capacity and, in the case of *locum tenens* for a period not exceeding six months, only a person -

(a) who is registered under the Act to practise in independent practice;

(b) whose name currently appears on the register kept by the registrar in terms of section 18 of the Act; and

(c) who is not suspended from practising his or her profession.
[Subrule (1) substituted by GN R68/2009]

(2) A practitioner shall help or support only a person registered under the Act, the Pharmacy Act, 1974 (Act No. 53 of 1974), the Nursing Act, 1978 (Act No. 50 of 1978), the Social Service Professions Act, 1978 (Act No. 110 of 1978), the Dental Technicians Act, 1979 (Act No. 19 of 1979), or the Allied Health Professions Act, 1982 (Act No. 63 of 1982), if the professional practice or conduct of such person is legal and within the scope of his or her profession.

10. Supersession

A practitioner shall not supersede or take over a patient from another practitioner if he or she is aware that such patient is in active treatment of another practitioner, unless he or she -

(a) takes reasonable steps to inform the other practitioner that he or she has taken over the patient at such patient's request; and

(b) establishes from the other practitioner what treatment such patient previously received, especially what medication, if any, was prescribed to such patient and in such case the other practitioner shall be obliged to provide such required information.

11. Impeding a patient

A practitioner shall not impede a patient, or in the case of a minor, the parent or guardian of such minor, from obtaining the opinion of another practitioner or from being treated by another practitioner.

12. Professional reputation of colleagues

A practitioner shall not cast reflections on the probity, professional reputation or skill of another person registered under the Act or any other Health Act.

13. Professional confidentiality

(1) A practitioner shall divulge verbally or in writing information regarding a patient which he or she ought to divulge only -
   (a) in terms of a statutory provision;
   (b) at the instruction of a court of law; or
   (c) where justified in the public interest.

(2) Any information other than the information referred to in subrule (1) shall be divulged by a practitioner only -
   (a) with the express consent of the patient;
   (b) in the case of a minor under the age of 12 years, with the written consent of his or her parent or guardian; or
   [Para. (b) substituted by GN R68/2009]
   (c) in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate.

14. Retention of human organs

(1) A practitioner shall only for research, educational, training or prescribed purposes retain the organs of a deceased person during an autopsy.

(2) The retention of organs referred to in subrule (1) shall be subject -
   (a) to the express written consent given by the patient concerned during his or her lifetime;
   (b) in the case of a minor under the age of 14 years, to the written consent of such minor's parent or guardian; or
   (c) in the case of a deceased patient who had not previously given such written consent, to the written consent of his or her next-of-kin or the executor of his or her estate.

15. Signing of official documents

A student, intern or practitioner who, in the execution of his or her professional duties, signs official documents relating to patient care, such as prescriptions, certificates (excluding death certificates), patient records, hospital or other reports, shall do so by signing such document next to his or her initials and surname printed in block letters.

16. Certificates and reports

(1) A practitioner shall grant a certificate of illness only if such certificate contains the following information -
- (a) the name, address and qualification of such practitioner;
- (b) the name of the patient;
- (c) the employment number of the patient (if applicable);
- (d) the date and time of the examination;
- (e) whether the certificate is being issued as a result of personal observations by such practitioner during an examination, or as a result of information which has been received from the patient and which is based on acceptable medical grounds;
- (f) a description of the illness, disorder or malady in layman's terminology with the informed consent of the patient: Provided that if such patient is not prepared to give such consent, the practitioner shall merely specify that, in his or her opinion based on an examination of such patient, such patient is unfit to work;
- (g) whether the patient is totally indisposed for duty or whether such patient is able to perform less strenuous duties in the work situation;
- (h) the exact period of recommended sick leave;
- (i) the date of issue of the certificate of illness; and
- (j) the initial and surname in block letters and the registration number of the practitioner who issued the certificate.

(2) A certificate of illness referred to in subrule (1) shall be signed by a practitioner next to his or her initials and surname printed in block letters.

(3) If preprinted stationery is used, a practitioner shall delete words which are not applicable.

(4) A practitioner shall issue a brief factual report to a patient where such patient requires information concerning himself or herself.

17. Issuing of prescriptions

(1) A practitioner authorized in terms of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), to prescribe medicines shall issue typewritten, handwritten, computer-generated, pre-typed, pre-printed or standardized prescriptions for medicine scheduled in Schedules 1, 2, 3 and 4 of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), subject thereto that such prescriptions may be issued only under his or her personal and original signature.

(2) A practitioner authorized in terms of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), to prescribe medicines shall issue handwritten prescriptions for medicine scheduled in Schedules 5, 6, 7 and 8 of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), under his or her personal and original signature.

18. Professional appointments

(1) A practitioner shall accept a professional appointment or employment from employers approved by the council only in accordance with a written contract of appointment or employment which is drawn up on a basis which is in the interest of the public and the profession.

(2) A written contract of appointment or employment referred to in subrule (1) shall be made available to the council at its request.

19. Secret remedies

A practitioner shall in the conduct and scope of his or her practice, use only -

(a) a form of treatment, apparatus or health technology which is not secret, and which is not claimed to be secret; and

(b) an apparatus or health technology which proves upon investigation to be capable of fulfilling the claims made in regard to it.

20. Defeating or obstructing the council or board in the performance of its duties

A practitioner shall at all times cooperate and comply with any lawful instruction, directive or process of the council, a board, a committee of such board or an official of council and in particular, shall be required, where so directed to -

(a) respond to correspondence and instructions from the council, such board, a committee of such board or an official of council within the stipulated time frames; and

b) attend consultation at the time and place stipulated by the council, such board, a committee of such board or an official of council.

21. Performance of professional acts

A practitioner shall perform, except in an emergency, only a professional act -

(a) for which he or she is adequately educated, trained and sufficiently experienced; and

(b) under proper conditions and in appropriate surroundings.

22. Exploitation

A practitioner shall not permit himself or herself to be exploited in any manner.

23. Medicine and medical devices

[Heading substituted by GN R68/2009]

(1) A practitioner shall not participate in the manufacture for commercial purposes or in the sale, advertising or promotion of any medicine or medical device or in any other activity that amounts to selling medicine or medical devices to the public or keeping an open shop or pharmacy.
[Subrule (1) substituted by GN R68/2009]

(2) A practitioner shall not engage in or advocate the preferential use or prescription of any medicine or medical device which, save for the valuable consideration he or she may derive from such preferential use or prescription, would not be clinically appropriate or the most cost-effective option.
[Subrule (2) substituted by GN R68/2009]

(3) The provisions of subrules (1) and (2) shall not prohibit a practitioner from -
  (a) owning shares in a listed company;
  (b) manufacturing or marketing medicines whilst employed by a pharmaceutical concern;
  (c) whilst employed by a pharmaceutical concern in any particular capacity, performing such duties as are normally in accordance with such employment; or
  (d) dispensing in terms of a licence issued in terms of the Medicines and Related Substances Act, 1965.

(4) A practitioner referred to in subrule (3) shall display a conspicuous notice in his or her waiting room and also duly inform his or her patient about the fact that he or she-
  (a) owns shares or has a financial interest in a listed public company that manufactures or markets the medicine or medical device prescribed for that patient; or
  (b) is in the employ of or contractually engaged by the pharmaceutical or medical device company that manufactures such medicine or medical device, and shall, subject to subrule (5), obtain the patient's informed written consent prior to prescribing such medicine or medical device for that patient.
  [Subrule (4) substituted by GN R68/2009]

(5) A practitioner may prescribe or supply medicine or a medical device to a patient: Provided that such practitioner has ascertained the diagnosis of the patient concerned through a personal examination of the patient or by virtue of a report by another practitioner under whose treatment the patient is or has been and such medicine or medical device is clinically indicated, taking into account the diagnosis and the individual prognosis of the patient, and affords the best possible care at a cost-effective rate compared to other available medicines or medical devices and the patient is informed of such other available medicines or medical devices.
[Subrule (5) substituted by GN R68/2009]

(6) In the case of a patient with a chronic disease the provision of subrule (5) shall not apply.

23A. Financial interests in hospitals

A practitioner may have a direct or indirect financial interest or shares in a hospital or any other health care institution: Provided that -

(a) such interests or shares are purchased at market-related prices in arm's length transactions;

(b) the purchase transaction or ownership of such interest or shares does not impose conditions or terms upon the practitioner that will detract from the good, ethical and safe practice of his or her profession;

(c) the returns on investment or payment of dividends is not based on patient admissions or meeting particular targets in terms of servicing patients;

(d) such practitioner does not over-service patients and to this end establishes appropriate peer review and clinical governance procedures for the treatment and servicing of his or her patients at such hospital or health care institution;

(e) such practitioner does not participate in the advertising or promotion of the hospital or health care institution, or in any other activity that amounts to such advertising or promotion;

(f) such practitioner does not engage in or advocate the preferential use of such hospital or health care institution;

(g) the purchase agreement is approved by the council based on the criteria listed in paragraphs (a) to (f) above; and

(h) such practitioner annually submits a report to the council indicating the number of patients referred by him or her or his or her associates or partners to such hospital or health care institution and the number of patients referred to other hospitals in which he or she or his or her associates or partners hold no shares.

[Rule 23A inserted by GN R68/2009]

24. Referral of patients to hospitals

[Heading substituted by GN R68/2009]

(1) A practitioner who has a direct or indirect financial interest or shares in a private clinic or hospital shall refer a patient to such clinic or hospital only if a conspicuous notice is displayed in his or her waiting room indicating that he or she has a financial interest or shares in that clinic or hospital and the patient is duly informed about the fact that the practitioner has an interest or shares in the clinic or hospital to which the patient is referred and the patient's informed written consent is obtained prior to such referral.

[Subrule (1) substituted by GN R68/2009]

(2) …….

[Subrule (2) deleted by GN R68/2009]

(3) …….

[Subrule (3) deleted by GN R68/2009]

(4) …….

[Subrule (4) deleted by GN R68/2009]

(5) …….

[Subrule (5) deleted by GN R68/2009]

(6) A practitioner may admit a patient to such private clinic or hospital: Provided that such practitioner -

(a) has ascertained the diagnosis of the patient concerned through a personal examination of such patient or by virtue of a report by another practitioner under whose treatment such patient is or has been;

(b) has informed such patient that such admission in such private clinic or hospital was necessary for his or her treatment; and

(c) has obtained such patient's consent for admission to such private clinic or hospital.

25. Reporting of impairment or of unprofessional, illegal or unethical conduct

(1) A student, intern or practitioner shall -

(a) report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired;

(b) report his or her own impairment or suspected impairment to the board concerned if he or she is aware of his or her own impairment or has been publicly informed, or has been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment, and
(c) report any unprofessional, illegal or unethical conduct on the part of another student, intern or practitioner.

26. Research, development and use of chemical, biological and nuclear capabilities

(1) A practitioner who is or becomes involved in research, development or use of defensive chemical, biological or nuclear capabilities shall obtain prior written approval from the board concerned to conduct such research, development or use.
(2) In applying for written approval referred to in subrule (1), such practitioner shall provide the following information to the board concerned:
(a) Full particulars of the nature and scope of such research, development or use;
(b) whether the clinical trials pertaining to such research have been passed by a professionally recognized research ethics committee;
(c) that such research, development or use is permitted in terms of the provisions of the World Medical Association's Declaration on Chemical and Biological Weapons; and
(d) that such research, development or use is permitted in terms of the provisions of the applicable international treaties or conventions to which South Africa is a signatory.

27. Dual registration

A health practitioner who holds registration with more than one statutory council or professional board shall at all times ensure that -
(a) no conflict of interest arises from such dual registration in the rendering of health services to patients;
(b) patients are clearly informed at the start of the consultation of the profession in which the practitioner is acting;
(c) informed consent regarding the profession referred to in paragraph (b) is obtained from the said patient;
(d) patients are not consulted in a dual capacity or charged fees based on such dual consultation; and
(e) the ethical rules applicable at a given moment to the profession in which the practitioner is acting, are strictly adhered to.

27A. Main responsibilities of health practitioners

A practitioner shall at all times -
(a) act in the best interests of his or her patients;
(b) respect patient confidentiality, privacy, choices and dignity;
(c) maintain the highest standards of personal conduct and integrity;
(d) provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others;
(e) keep his or her professional knowledge and skills up to date;
(f) maintain proper and effective communication with his or her patients and other professionals;
(g) except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment himself or herself, from his or her next of kin; and
(h) keep accurate patient records.
[Rule 27A inserted by GN R68/2009]

28. Repeal

The Rules Specifying the Acts or Omissions in respect of which Disciplinary Steps may be taken by a Professional Board and the Council, published under Government Notice No. R. 2278 of 3 December

1976 and Government Notice No. R. 1379 of 12 August 1994, as amended by Government Notice No. R. 1405 of 22 December 2000 are hereby repealed.

(Signed)
ME TSHABALALA-MSIMANG
MINISTER OF HEALTH

ANNEXURE 6

MEDICAL AND DENTAL PROFESSIONS BOARD

RULES OF CONDUCT PERTAINING SPECIFICALLY TO THE MEDICAL AND DENTAL PROFESSIONS

A medical practitioner, dentist, medical specialist, dental specialist, biomedical engineer, clinical biochemist, genetic counsellor, medical biological scientist, medical physicist, an intern in biomedical engineering, intern in clinical biochemistry, intern in genetic counselling, intern in medical biological science and intern in medical physics shall adhere to the following rules of conduct in addition to the rules of conduct referred to in rules 2 to 27. Failure by such medical practitioner, dentist, medical specialist, dental specialist, biomedical engineer, clinical biochemist, genetic counsellor, medical biological scientist, medical physicist, intern in biomedical engineering, intern in clinical biochemistry, intern in genetic counselling, intern in medical biological science and intern in medical physics to comply with the rules of conduct listed herein shall constitute an act or omission in respect of which the board may take disciplinary steps in terms of Chapter IV of the Act.

1. Performance of professional acts by medical practitioner or medical specialist

A medical practitioner or medical specialist -

(a) shall perform professional acts only in the field of medicine in which he or she was educated and trained and in which he or she has gained experience, regard being had to both the extent and the limits of his or her professional expertise;

(b) shall not fail to communicate and cooperate with medical practitioners, medical specialists and other health practitioners in the diagnosis and treatment of a patient; and

(c) shall not sign official documents such as reports, certificates or prescriptions unless his or her name is printed next to his or her signature.

2. Performance of professional acts by dentist or dental specialist

A dentist or dental specialist -

(a) shall perform professional acts only in the field of dentistry in which he or she was educated and trained and in which he or she has gained experience, regard being had to both the extent and the limits of his or her professional expertise;

(b) shall not fail to communicate and cooperate with dentists, dental specialists and other health practitioners in the diagnosis and treatment of a patient; and

(c) shall not sign official documents such as reports, certificates or prescriptions unless his or her name is printed next to his or her signature.

3. Partnerships and juristic persons

(1) Where a patient is seen -

(a) by both a medical specialist or a dental specialist and a medical practitioner or a dentist practising as specified in rule 8(3), such specialist and medical practitioner or dentist shall charge the fees applicable to either the medical practitioner or the dentist and not those applicable to a medical specialist or a dental specialist; and

(b) by a medical specialist or a dental specialist only, the fees applicable to such specialist may be charged.

(2) The provisions in rule 8 (3) shall be limited in that -

(a) a medical specialist who practises in one of the prescribed related specialities in medical pathology shall be excluded from the concession to form an incorporated practice in terms of section 54A, or to form a partnership or association with a medical practitioner, a medical specialist or another practitioner who does not practise in one of the related specialities in medical pathology;

(b) a medical specialist who practises in diagnostic radiology shall be excluded from the concession to form an incorporated practice in terms of section 54A, or to form a

partnership or association with a medical practitioner, medical specialist or another practitioner who does not practise in the speciality diagnostic radiology;

(c) the only exception to the restriction pertaining to specialities in medical pathology referred to in paragraph (a) hereof shall be that a pathologist shall be permitted to form an incorporated practice, partnership or association with a medical technologist registered in the relevant discipline in view of the fact that the said two professions are related to each other in terms of the nature of the field of professional practice; and

(d) the only exception to the restriction pertaining to radiology referred to in paragraph (b) hereof shall be that a radiologist shall be permitted to form an incorporated practice, partnership or association with a nuclear physician or a radiographer registered in the relevant discipline, in view of the fact that the said professions are related to each other in terms of the nature of their field of professional practice.
[Para. (d) substituted by GN R68/2009]

4. Medical specialist and dental specialist

A medical specialist and a dental specialist shall adhere to the Regulations relating to the Specialities and Subspecialities in Medicine and Dentistry, published under Government Notice No. R. 590 of 29 June 2001.

5. Performance of professional acts by biomedical engineer, clinical biochemist, genetic counsellor, medical biological scientist, medical physicist

A biomedical engineer, a clinical biochemist, a genetic counsellor, a medical biological scientist and a medical physicist -

(a) shall perform professional acts only at the request of and in consultation with a medical practitioner or dentist;

(b) shall perform professional acts directly related to the treatment or diagnosis of a patient, in close cooperation with the medical practitioner or dentist concerned with the diagnosis or treatment of such patient; and

(c) shall not sign official documents such as reports, certificates or prescriptions, unless his or her name is printed next to his or her signature.

6. Performance of professional acts by intern in medicine

An intern in medicine -

(a) shall perform acts as part of a structured internship training programme at an approved facility only under the supervision of a medical practitioner as prescribed for this purpose and in accordance with the guidelines of the board;

(b) shall limit acts referred to in (a) to acts related to his or her education and training as part of a structured internship programme;

(c) shall not conduct a private practice;

(d) shall not act as a locum or perform professional acts in a private practice;

(e) if he or she has completed his or her internship, shall not perform any professional act until he or she has satisfied all the academic requirements for registration as a medical practitioner and has been registered as such; and

(f) shall not sign official documents such as reports, certificates or prescriptions, unless his or her name is printed next to his or her signature.

7. Performance of professional acts by interns in biomedical engineering, clinical biochemistry, genetic counselling, medical biological science or medical physics

An intern in biomedical engineering, clinical biochemistry, genetic counselling, medical biological science or medical physics -

(a) shall perform professional acts as part of a structured internship training programme at an approved facility only under the supervision of a practitioner as prescribed for this purpose and in accordance with the guidelines of the board;

(b) shall limit the acts referred to in paragraph (a) to acts directly related to his or her education and training as part of a structured internship programme in his or her discipline of study;
(c) shall not conduct a private practice;
(d) shall not act as a locum or perform professional acts in a private practice;
(e) if he or she has completed his or her internship, shall not perform any professional act until he or she has satisfied all the academic requirements for registration as a medical scientist and has been registered as such; and
(f) shall not sign official documents such as reports, certificates or prescriptions, unless his or her name is printed next to his or her signature.

8. Performance of professional acts by student in medicine or dentistry

A student in medicine or dentistry -
(a) shall perform professional acts only under the supervision of a practitioner approved for this purpose by the board;
(b) shall limit acts referred to in (a) to acts related to his or her education and training;
(c) shall not conduct a private practice; and
(d) shall not act as a locum or perform professional acts in a private practice.

9. Performance of professional acts by a clinical associate

A clinical associate-
(a) shall perform professional acts only under the supervision of a medical practitioner;
(b) shall limit the acts referred to in paragraph (a) to acts related to his or her education and training;
(c) shall not conduct a private practice; and
(d) shall not act as locum tenens.
[Rule 9 inserted by GN R68/2009]

ANNEXURE F

NATIONAL PATIENTS' RIGHTS CHARTER

PREAMBLE

The Department of Health, in consultation with various other bodies, developed a National Patients' Rights Charter. The Medical and Dental Professions Board also submitted input into the different drafts that were circulated for comments.

The document contained herein was agreed to by the Board and has since been included in the *Handbook for Interns, Accredited facilities and Health Authorities*.

the Board takes this opportunity to make the National Patients' Rights Charter available to all practitioners provided for by the Board as part of its series of Booklets on Guidelines for Good Practice in Medicine, Dentistry and Medical Sciences.

NATIONAL PATIENTS' RIGHTS CHARTER

3 INTRODUCTION

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realisation of the right of access to health care services as guaranteed in the *Constitution of the Republic of South Africa*, 1996 (Act No. 109 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and, therefore, proclaims this PATIENTS' RIGHTS CHARTER as common standard for achieving the realisation of this right.

4 PATIENTS' RIGHTS

Healthy and safe environment: Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal, as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

Participation in decision-making: Every citizen has the right to participate in the development of health policies, whereas everyone has the right to participate in decision-making on matters affecting one's own health.

Access to health care: Everyone has the right to access to health care services that include –

receiving timely emergency care at any health care facility that is open, regardless of one's ability to pay;

treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;

provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV or AIDS patients;

counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;

palliative care that is affordable and effective in cases of incurable or terminal illness;

a **positive disposition** displayed by health care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance;

health information that includes information on the availability of health services and how best to use such services, and such information shall be in the language understood by the patient.

Knowledge of one's health insurance/medical aid scheme: A member of a health insurance or medical aid scheme is entitled to information about that health insurance or medical aid scheme and to challenge, where necessary, the decision of such health insurance or medical aid scheme relating to the member.

Choice of health services: Everyone has a right to choose a particular health care provider for services or a particular health facility for treatment, provided that such choice shall not be contrary to the ethical standards applicable to such health care provider or facility.

Treated by a named health care provider: Everyone has a right to know the person that is providing health care and, therefore, must be attended to by only clearly identified health care providers.

Confidentiality and privacy: Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or any order of court.

Informed consent: Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved.

Refusal of treatment: A person may refuse treatment and such refusal shall be verbal or in writing, provided that such refusal does not endanger the health of others.

A second opinion: Everyone has the right on request to be referred for a second opinion to a health provider of one's choice.

Continuity of care: No one shall be abandoned by a health care professional who or a health facility which initially took responsibility for one's health.

Complaints about health services: Everyone has the right to complain about health care services, to have such complaints investigated and to receive a full response on such investigation.

5 RESPONSIBILITIES OF THE PATIENT

a. Every patient or client has the following responsibilities:
b. To take care of his or her own health.
c. To care for and protect the environment.
d. To respect the rights of other patients and health care providers.
e. To utilise the health care system properly and not abuse it.
f. To know his or her local health services and what they offer.
g. To provide health care providers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.
h. To advise health care providers of his or her wishes with regard to his or her death.
i. To comply with the prescribed treatment or rehabilitation procedures.
j. To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
k. To take care of the health records in his or her possession.

ANNEXURE G

BATHO PELE PRINCIPLES

1. PRINCIPLES

Eight Batho Pele principles were developed to serve as acceptable policy and legislative framework **regarding** service delivery in the public service. These principles are aligned with the Constitutional ideals of:

a. Promoting and maintaining high standards of professional ethics.
b. Providing service impartially, fairly, equitably and without bias.
c. Utilising resources efficiently and effectively.
d. Responding to people's needs, the citizens are encouraged to participate in policy making, and;
e. Rendering an accountable, transparent, and development-oriented public administration.

2. THE BATHO PELE PRINCIPLES ARE AS FOLLOWS

The Batho Pele Principles are as follows:

Consultation

There are many ways to consult users of services including conducting customer surveys, interviews with individual users, consultation with groups, and holding meetings with consumer representative bodies, NGOs and CBOs. Often, more than one method of consultation will be necessary to ensure comprehensiveness and representativeness. Consultation is a powerful tool that enriches and shapes government policies such as the Integrated Development Plans (IDPs) and its implementation in Local Government sphere.

Setting service standards

This principle reinforces the need for benchmarks to constantly measure the extent to which citizens are satisfied with the service or products they receive from departments. It also plays a critical role in the development of service delivery improvement plans to ensure a better life for all South Africans. Citizens should be involved in the development of service standards.

Required are standards that are precise and measurable so that users can judge for themselves whether or not they are receiving what was promised. Some standards will cover processes, such as the length of time taken to authorise a housing claim, to issue a passport or identity document, or even to respond to letters.

To achieve the goal of making South Africa globally competitive, standards should be benchmarked (where applicable) against those used internationally, taking into account South Africa's current level of development.

Increasing access

One of the prime aims of Batho Pele is to provide a framework for making decisions about delivering public services to the many South Africans who do not have access to them. Batho Pele also aims to rectify the inequalities in the distribution of existing services. Examples of initiatives by government to improve access to services include such platforms as the Gateway, Multi-Purpose Community Centres and Call Centres.
Access to information and services empowers citizens and creates value for money, quality services. It reduces unnecessary expenditure for the citizens.

Ensuring courtesy

This goes beyond a polite smile, 'please' and 'thank you'. It requires service providers to empathize with the citizens and treat them with as much consideration and respect, as they would like for themselves.

The public service is committed to continuous, honest and transparent communication with the citizens. This involves communication of services, products, information and problems, which may hamper or delay the efficient delivery of services to promised standards. If applied properly, the principle will help demystify the negative perceptions that the citizens in general have about the attitude of the public servants.

Providing information

As a requirement, available information about services should be at the point of delivery, but for users who are far from the point of delivery, other arrangements will be needed. In line with the definition of customer in this document, managers and employees should regularly seek to make information about the organisation, and all other service delivery related matters available to fellow staff members.

Openness and transparency

A key aspect of openness and transparency is that the public should know more about the way national, provincial and local government institutions operate, how well they utilise the resources they consume, and who is in charge. It is anticipated that the public will take advantage of this principle and make suggestions for improvement of service delivery mechanisms, and to even make government employees accountable and responsible by raising queries with them.

Redress

This principle emphasises a need to identify quickly and accurately when services are falling below the promised standard and to have procedures in place to remedy the situation. This should be done at the individual transactional level with the public, as well as at the organisational level, in relation to the entire service delivery programme.

Public servants are encouraged to welcome complaints as an opportunity to improve service, and to deal with complaints so that weaknesses can be remedied quickly for the good of the citizen.

Value for money

Many improvements that the public would like to see often require no additional resources and can sometimes even reduce costs. Failure to give a member of the public a simple, satisfactory explanation to an enquiry may for example, result in an incorrectly completed application form, which will cost time to rectify.

ANNEXURE H

GUIDELINES FOR THE MANAGEMENT OF PATIENTS WITH HIV INFECTION OR AIDS

1. PREAMBLE

HIV infection and AIDS have emerged as the most challenging health matter of modern times. The pandemic has created not only medical, but also ethical, legal, social, political and fiscal issues. The original version of the policy guidelines pertaining to the management of patients with HIV Infection or Aids has been amended substantially on the basis of inputs received from a wide range of stakeholders in the field of HIV/AIDS, both locally and internationally.

It should, however, be realised that the matter concerning HIV/AIDS is a highly sensitive and quite often a controversial issue to address. It is, therefore, not surprising that the inputs received for the revision of the guidelines were not always wholly uniform. Thus, it was necessary to follow an approach of compromise in selecting the most appropriate and suitable inputs for inclusion in the guidelines at hand. The guidelines are now much in keeping with international best practice and they reflect to a large extent, if not fully, the views of organisations such as the United Nations Joint Programme on HIV/AIDS (UNAIDS) and that of the World Health Organisation (WHO)

2. PREMISES

HIV infection and aids: Although infection with HIV and of AIDS is incurable at present, AIDS is considered a manageable life-threatening disease.

Modes of transmission: HIV is transmitted primarily in three ways, namely -

a. Sexually (usually heterosexual);
b Prenatally; and
c. via Bloodborne infections (e.g. sharing of injection equipment).

It has, therefore, become impossible and unjustifiable to identify and focus on "high risk groups or individuals".

Occupational transmission of HIV

The risk of transmission of HIV infection in the health care area from patient to patient, patient to health care worker and from health care worker to patient through inoculation of infected blood or other body fluids has been shown scientifically to be very small. Fears, which are not always based on reality, have thus tended to exaggerate the risks out of all proportion.

Health care workers and patients are exposed not only to HIV. It should be recognised that at present infection by the hepatitis B virus poses a far greater risk. Universal precautions against bloodborne infections should, therefore, be adhered to in all health care encounters to minimise exposure of health care workers and their patients. Post-exposure treatment of health care workers in whom inoculation or significant contamination might have occurred, may be beneficial and should be considered in consultation with the Infection Control Medical Officer of the institution, or other designated person. When there has been a risk of contamination, PEP should also be strongly recommended, and the health care worker should receive thorough counselling about the possible benefits of PEP in reducing the risk of sero-conversion.

Responsibilities of Health Care Workers

In the management of the HIV positive patient, the health care worker has a primary responsibility towards the individual patient. The health care worker also has certain responsibilities towards other health care workers and other parties that might be in danger of contracting the disease from the patient. No health care worker may ethically refuse to treat any patient solely on the grounds that the patient is, or may be, HIV seropositive. Equally, no doctor may withhold normal standards of treatment from any patient solely on the grounds that the patient is seropositive, unless such variation of treatment is determined to be in the patient's interest. Treatment should not be suboptimal because of a perceived potential risk to health care workers. It is accepted that a health care worker will examine or treat a patient only with the informed consent of the patient.

Health care professionals are being reminded that an HIV diagnosis, without further examination (such as measuring viral load or CD4 cell counts), provides no information about a person's prognosis or actual state of health. Unilateral decisions not to resuscitate people with HIV are a violation of fundamental rights and may lead to disciplinary action being taken against a health care professional who make himself or herself guilty of such action.

Confidentiality

There is no persuasive evidence that knowledge of a patient's HIV status diminishes the incidence of exposure-incidents. In fact, our law has recognised the important public health benefits of maintaining patient confidentiality regarding HIV status, in order to encourage patients with HIV to be tested and treated.

HIV testing

HIV testing should only take place with the voluntary, informed consent of the individual. In accordance with the guidelines set out below. Requirements of routine or universal testing of patients in the health care setting are unjustifiable and undesirable. However, patients may be requested to consider HIV testing when certain well-defined high-risk procedures are to be undertaken. These are set out below.

The attention of patients should be drawn to the potential abuse of HIV test kits that are nowadays available on the market. Any person who wishes to use such kits should ascertain from his or her doctor or another credible source whether such kits are reliable and safe. New forms of HIV testing should only be adopted if they conform to the guidelines set out in this policy document.

Limiting the spread of HIV

The medical fraternity supports all efforts to keep the spread of HIV infection in the community as low as possible. Such measures include appropriate education regarding the infection, alteration of lifestyle, improved management of predisposing and aggravating factors, including other sexually transmitted diseases, mobilising support from the community and disseminating information regarding preventive measures. Since the guidelines were first published there have been very significant advances in the treatment of opportunistic infections and in the use of antiretroviral drugs. The medical fraternity is committed thereto that patients suffering from whatever disease will have improved access to medical care and treatment.

Education

Education and training are essential components of the successful implementation of universal precautions, i.e. those precautions which should be universally applied to prevent transmission of HIV and other diseases in the health care setting. These precautions have proven to be the most effective measures to protect health care workers. These, and all other measures instituted to prevent the transmission of infections in the health care setting will, however, probably fail if they are not supported by an ongoing educational programme.

To be effective, such educational schemes should be -

a. **structured** and preferably assessed by formal examinations;

b. **ongoing** throughout the period of employment; and

c. **continuously evaluated and monitored.**

Employers, compensation and insurance

Health care workers, who are employed, may take irrational and scientifically unjustifiable steps to minimise the perceived risk of acquiring HIV infection from patients, if there is a notion that their employers are unconcerned and not willing to minimise the risk of occupational infection of health care workers.

Obligations of employing authorities

An employer should have a clear-cut *policy statement* that declares the responsibility of the employer towards his employees who become infected whilst performing official duties. This policy should state the procedures the employee should follow after occupational exposure, which should be the guidelines with regard to the reporting of the incident for purposes of compensation, including the HIV testing of the health care worker and, where informed consent can be obtained, of the source patient and on access to post-exposure prophylaxis

Employers should ensure that all employees are insured against the consequences of such infections. This insurance may be under the Compensation for Occupational Injuries and Diseases Act, 1997 (Act No. 61 of 1997), and/or by a private insurance scheme. Although HIV/AIDS is not a listed occupational disease in terms of the said Act, an employee who can show that he or she was infected as a result of an exposure during the course of carrying out his or her occupational duties, may claim compensation. Medical students, who are not legally recognised employees, should also be insured, either by their university or by the hospital where they undergo their training, against such incidents.

There is consensus that adherence to universal precautions is the most important, and possibly the only, action that will significantly protect health care workers against infection by HIV and other bloodborne pathogens. (The exception is immunisation against hepatitis B.)
For the above reason the following must be in place:

a. All employers must make available to health care workers facilities to institute universal precautions.

b. Such facilities should be provided to the full spectrum of health care workers and should include those paramedical personnel who initially come into contact with the patient, as well as auxiliary and unskilled workers who handle the patients, or could be exposed to contaminated materials. Such facilities should also be available to medical students, who, because they are technically inexperienced and not recognised as official employees, are particularly vulnerable.

c. The facilities available should include the additional sophisticated precautionary measures which may have to be instituted to protect the professional personnel performing invasive procedures known to be associated with a high risk of inoculation with patients' blood.

Knowledge of the HIV status of patients

There is persuasive scientific evidence that knowledge of the HIV status of a patient does not provide additional protection to the doctor or other health care workers treating the patient. Nevertheless, there is a perception amongst some doctors that under exceptional circumstances, the knowledge of the HIV status of a patient may be useful in order to ensure the use of 'extended' universal precautionary measures such as special gloves, clothing and face masks, and that inexperienced personnel should not be allowed to perform surgery on such patients. It is argued that selective use of such expensive measures will be cost-effective. Exceptional circumstances are defined as palpation of a needle-tip in a body cavity, or the simultaneous presence of the health care worker's fingers and needle or another sharp object or instrument in a poorly visualised or highly confined anatomic cavity. Orthopaedic and other procedures where there is an aerosol of blood, bone fragments or bloody fluids, also quality.

Where certain well-defined high risk or exposure-prone procedures are contemplated, the patient should be informed of the concerns and asked to consent to HIV testing. It should be emphasised that the condoning of pre-operative or pre-treatment HIV testing when high-risk procedures are contemplated, should not be abused to justify routine HIV testing of all patients, nor should patients be told that pre-HIV testing is mandatory in such circumstances. All patients have a right to refuse testing, and where a patient refuses to test for HIV under such circumstances, the patient may not be refused treatment on this basis. However, should a patient decline to be tested for HIV, such patient should be managed by health care professionals as if he or she was HIV positive.

Health care workers should realise that there are factors which make it unrealistic to rely on HIV testing of patients to protect themselves against occupational exposure. Thus, health care workers must appreciate the significance of the window period of infectivity; the ever-increasing prevalence of HIV infection, especially among hospital patients; the time it takes to obtain a reliable HIV test result; and the need to treat, under less than ideal conditions, patients outside hospitals and in emergency care units.

These factors are not under the control of the health care worker and strengthen the view that, to minimise the risk of infection, health care workers should adopt appropriate universal precautions in all clinical situations rather than rely on knowledge of the HIV status of patients.

Testing patients for HIV antibodies

A patient should be tested for HIV-infection only if he or she gives **informed consent**. Such informed consent is made up of the following important elements:

Information: The patient should be given information regarding the purpose of the laboratory test; what advantages or disadvantages testing may hold for him or her as patient; why the surgeon or physician wants this information; what influence the result of such a test will have on his or her treatment; and how his or her medical protocol will be altered by this information. The psychosocial impact of a positive test result should also be addressed. All such communication should be conducted in a language that is easily understood by the patient.

Understanding: Furthermore, the patient should clearly understand the information provided, so that he or she may agree to the HIV test, based on such understanding. The importance of the patient's ability to understand the information given means that If posters are displayed in an attempt to inform patients that testing for HIV may be undertaken, these must be supplemented by a verbal pre-test counselling of the patient by the doctor in order to appropriately obtain the patient's informed consent.

The principle of informed consent entails that the health care worker accepts that, if the patient were HIV-positive, appropriate counselling will follow. The health care worker must, therefore, ensure that the patient is directed to appropriate facilities that will oversee his or her further care and, if possible, counsel his or her family and/or sexual partners.

Refusal to have blood tested for HIV antibodies

It is justifiable to test for HIV without the patient's consent, but only in the circumstances set out in the National Policy on Testing for HIV as follows:

a. As part of unlinked and anonymous testing for epidemiological purposes undertaken by the national, provincial or local health authority or an agency authorised by any of these bodies, provided that HIV testing for epidemiological purposes is carried out in accordance with national legal and ethical provisions regarding such testing.

b. Where statutory provision or other legal authorisation exists for testing without informed consent.

c. In emergency situations where infection is suspected and it is impossible to obtain consent, subject to the conditions in paragraphs 8.2 and 8.3 below.

d. An emergency situation in terms of a patient, is generally considered to be a situation where a patient's health is in serious danger and immediate treatment is necessary. In terms of HIV testing, it is generally argued that there are few, if any, situations where, in order to provide for the immediate care of a patient who is unable to consent, it would be necessary to determine the patient's HIV status.

e. In terms of a health care worker, where a health care worker has sustained a risk bearing incident such as a needlestick injury, this may be determined to be an emergency situation.

f. In view of the fact that immediate post-exposure measures may be beneficial to the health care worker, information as to the HIV status of the source patient may be obtained in the following ways:

g. Testing any existing blood specimen. This should be done with the source patient's consent, but if consent is withheld, the specimen may nevertheless be tested, but only after informing the source patient that the test will be performed and providing for the protection of privacy. The information regarding the result may be disclosed to the health care worker but must otherwise remain confidential and may only be disclosed to the source patient with his or her informed consent.

If the patient is unable to give informed consent and is likely to remain unable for a significant length of time in relation to the prophylactic needs of the health care worker or other patients, then every reasonable attempt should be made to obtain appropriate vicarious consent. **Vicarious consent** means the consent of the patient's closest relative or, in the case of a minor, the consent of the medical superintendent in the absence of a parent or guardian.

The doctor's duty towards HIV positive patients

No doctor may ethically refuse to treat any patient solely on the grounds that the patient is, or may be, HIV seropositive. No doctor may withhold normal standards of treatment from any patient solely on the grounds that the patient is HIV seropositive, unless such variation of treatment is determined to be in the patient's interest and not by perceived potential risk to the health care worker.

Confidentiality

The test results of HIV positive patients should be treated at the highest possible level of confidentiality. Our courts have recognised that confidentiality regarding HIV status extends to other medical colleagues and health care workers, and other health care workers may not be informed of a patient's HIV status without that patient's consent. The need for transmission of clinical data to those medical colleagues and health care workers directly involved with the care of the patient should be discussed with the patient in order to obtain his or her consent for disclosures considered to be in the patient's best interest in terms of treatment and care.

The principle of confidentiality applies in respect of the patient. The decision whether to divulge the information to other parties involved must, therefore, be in consultation with the patient. If the patient's consent cannot be obtained, ethical guidelines recommend that the health care worker should use his or her discretion whether or not to divulge the information to other parties involved who are at clear risk or danger. To date, we have not had legal clarity regarding whether this situation is an acceptable limitation of the right to confidentiality. Therefore, such a decision must be made with the greatest care, after explanation to the patient and with acceptance of full responsibility at all times.

The following steps are recommended:

a. Counselling the patient on the importance of disclosing to his or her sexual partner and for taking other measures to prevent HIV transmission.

b. Providing support to the patient to make this disclosure.

c. Where the patient still refuses to disclose his or her HIV status or refuse to consider other measures to prevent infection, counselling the patient on the health care worker's ethical obligation to disclose such information and requesting consent to do so.

d. Disclosing such information.

When informing the patient about the importance of disclosure, the attention of the patient should be drawn to the possibility of violence and other adverse consequences that such disclosure may hold in store for the patient concerned.
The report of HIV test results by a laboratory, as is the case with all laboratory test results, should be considered confidential information. Breach of confidentiality is, however, more likely to occur in the ward, hospital or doctor's reception area than in the laboratory. It is, therefore, essential that health care institutions, pathologists and doctors formulate a clear policy as to how such laboratory results will be communicated and how confidentiality of the results will be maintained.

Doctors infected with HIV

No doctor or health care worker is obliged to disclose his or her HIV status to an employer nor may any employee be unfairly discriminated against or dismissed as a result of his or her HIV status. The benefits of voluntary HIV testing should be explained to all health care workers and they should be encouraged to consider HIV testing. Any doctor or health care worker who finds himself or herself to be HIV positive, should be encouraged, to seek counselling from an appropriate professional source, preferably one designated for this purpose by a medical academic institution. Counsellors must of course be familiar with recommendations such as those of the Centres for Disease Control so that unnecessary, onerous, and scientifically unjustifiable restrictions are not placed on the professional activities of an HIV positive doctor.

Infected doctors may continue to practise. However, they must seek and implement the counsellor's advice on the extent to which they should limit or adjust their professional practice in order to protect their patients.

Basic elements of practically applicable and universal precautions

These precautions are designed to prevent -

a. penetration of the skin by contaminated sharp objects;

b. contamination of the skin, especially non-intact skin and mucous membranes, in particular the conjunctivae.

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

Body fluids which should be handled with the same precautions as blood

a. Cerebrospinal fluid

b. Peritoneal fluid

c. Pleural fluid

d. Pericardial fluid

e. Synovial fluid

f. Amniotic fluid

g. Semen

h. Vaginal secretions

i. Breast milk

j. Any other body fluid which blood is stained.

k. Saliva in association with dentistry.

l. Unfixed tissues and organs.

m. Body fluids such as urine, sweat and saliva

These body fluids do not pose any risk, (except in the context of dentistry).

Avoidance of injuries with “sharps”

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

b. Never allow a sharp object, especially a contaminated one, to come near one's fingers. (Do not re-use needles, use instruments to load and unload scalpel blades, etc.)

c. Be personally responsible for the immediate safe disposal of all 'sharps' that one uses into an approved container.

d. Never handle a 'sharp' without looking at it.

e. Never put down a 'sharp' except in an agreed neutral area.

f. Use the safest 'sharp' that will do the job; knives and sharp needles only for skin, scissors and blunt (round-nosed) needles for tissues.

g. Never feel for a needle point (or other sharp object) with fingers.

h. Never put one's fingers in an area or wound where someone else is using a 'sharp'.

i. Avoid use of wire sutures.

j. Use heavy-duty gloves (ring-link or similar) in danger situations (broken bones, sharp foreign bodies).

Avoidance of skin/mucous membrane contamination

Three risks are identified, namely -

a. blood or body fluid on hands;

b. spillage on the health care worker's body;

c. spray-aerosol to eyes and face.

Never have contact with patients, soiled linen, etc. if skin of hands is not intact (cuts, eczema, etc.) unless the lesions can be completely isolated by impermeable adhesive tape.

Use gloves

a. Latex gloves to be used by every health care worker handling blood/body fluid.

b. Torn glove to be removed immediately and contamination washed away.

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

Spillage

a. Where risk of spillage exists, use plastic aprons and impermeable boots.

b. Ensure that all spillage is immediately cleaned.

c. Double seal all containers of blood and body fluid.

Spray/aerosol

a. Where risk exists, use face/eye protection (face shields, eye-goggles).

b. Laser and fulguration smoke should be continuously aspirated by suction.

Routine implementation of these simple, logical measures, which are not time consuming, nor significantly expensive, by all members of the health care team, should reduce the risk of infection of health care workers by patients, and of patients by health care workers to very nearly zero. Disciplined implementation of these precautions in dealing with all patients should make pre-treatment determination of a patient's HIV status irrelevant in terms of the safety of health care workers.

ANNEXURE I

INTERNSHIP TRAINING FOR MEDICINE

CRITERIA FOR ACCREDITATION OF FACILITIES FOR INTERNSHIP TRAINING

1. VISION OF INTERNSHIP TRAINING AND ACCREDITATION FOR SUCH TRAINING

The main objective of internship training is to provide practitioners holding registration as Interns with opportunities to further develop their competence by providing them with knowledge, skills, appropriate behavior patterns and professional thinking, and to gain insight, understanding and experience in patient care to equip them to function as safe and independent general practitioners. Training, therefore, shall be comprehensive, address shortcomings of the current system and provide for and be complementary to the future health care system presently being developed for South Africa. The primary health care approach shall play a significant role during the period of internship training.

The primary health care approach is a developmental approach that emphasises community participation and empowerment, inter-sectoral collaboration and cost-effective care, as well as the integration of preventive, promotive, curative and rehabilitative services. The primary health care approach does not, therefore, define a level of care, but is more appropriately to be viewed as a philosophy of the promotion of health and the provision of health care at all levels of service.

Against this background, internship training shall be a properly planned and an ongoing process; be offered as an integrated system; and be undergone only at facilities and complexes accredited by the Board. Facilities and trainers shall be subject to regular accreditation visits or inspections and adherence to the prescribed criteria. Internship training shall extend over a period of twelve months and from 1 July 2004, 24 months. The structure and requirements of rotations during training shall be as specified by the Board.

Accreditation for internship training, therefore, is the process whereby the Board, on the basis of specified criteria, inspects and assesses facilities and complexes as being appropriate in terms of training teams, ethos, as well as physical structures and resources to provide such training and, if found to comply or provisionally comply, accredits them for internship training.

Accreditation of facilities for the purpose of internship training shall be the sole responsibility of the Board and it shall be the Board's prerogative to grant or not to grant, or provisionally to grant accredited status to any facility or, should circumstances require, to withdraw such status.

2. MAJOR PARTNERS IN IMPLEMENTATION

In order to achieve the above objectives in the best interest of interns, the Medical and Dental Professions Board, the employing Health Authorities and the Faculties/Schools of Medicine/Health Sciences all have an important role to play. The Board, in terms of its statutory function, must protect the interests of the public by establishing and maintaining standards of education, training, practice, conduct and behavior.

The Health Authorities as responsible employers have a duty to ensure that their employees receive appropriate in-service training in order to help to continually improve the standard of service to the public. Faculties/Schools of Medicine/Health Sciences must provide broadly based support to assist the Board and employing Health Authorities to develop and maintain appropriate

and professionally sufficient training programmes, to assist in the training of trainers and to be accessible as sources of professional knowledge, consultation and advice.

3. EMPHASIS OF ACCREDITATION

FOCUS ON TRAINERS

Internship training is intended to train medical graduates to practice as competent and safe general practitioners. Accreditation for such training shall primarily be directed at assessing the existence within facilities of a culture and atmosphere of "training and learning", a caring ethos and competent patient care. The quality of the training team is of prime importance.

TEAM APPROACH IN TRAINING

Internship training for medicine is a professional matter and training, therefore, is the responsibility of adequately qualified, experienced and competent medical practitioners. However, assessment for accreditation requires an acknowledgement of the need for and nature of a multi-disciplinary team approach in the rendering of high-quality patient care. Assessment, therefore, shall evaluate the quality of such team work and the opportunities which it offers for multi-professional interchange in training.

TRAINING COMPLEXES

Many facilities will be accredited by the Board as parts of complexes and not in isolation. Members of the training team may be based at different facilities within each complex. The relevant trainer would, however, retain overall responsibility, whether stationed elsewhere or not.

COMPREHENSIVE NATURE OF ACCREDITATION

Against this background, the assessment leading to accreditation for internship training shall be comprehensive. It will include an ongoing self-analysis by the applying facility, information gathering and the assessment of professional, personal and human attributes, qualities and attitudes, essential physical structures, equipment and resources. Organizational and administrative processes and functioning, in combination with the above, create the environment and atmosphere, or lack thereof, in which the particular facility's culture of "training and learning" shall be assessed and monitored.

4. TRAINING SITES

Internship training shall take place in the health care and administrative structure established by employing Health Authorities. The health care facilities accredited for this purpose will function at and provide for different levels of patient care.

EMPLOYING HEALTH AUTHORITY

An "employing Health Authority" refers to a public health authority at national, provincial or local level of government and includes organisations which function under its auspices or are largely subsidised by it to provide teaching, training or patient care services.

ACCREDITED FACILITIES

An "accredited facility" refers to a health care facility of any employing Health Authority which, upon application by the Health Authority to the Board to be accredited for the purpose of internship as

prescribed, had been inspected and was found by the Board to comply or provisionally comply with the criteria for accreditation.

LEVELS OF HEALTH CARE

Health care facilities in South Africa and the nature of patient care which they provide, may be classified as follows (see Annexure J for further details):

CATEGORIES OF PUBLIC HOSPITALS

The following are categories of public hospitals:

District Hospitals

District hospitals are categorised into small, medium and large district hospitals with the following number of beds. Small district hospitals with no less than fifty (50) beds and no more than one hundred and fifty (150) beds. Medium size district hospitals with more than one hundred and fifty (150) beds and no more than three hundred (300) beds. Large district hospitals with no less than three hundred (300) beds and no more than six hundred (600) beds.

A district hospital must –

a. Serve a defined population within a health district and support primary health care.
b. Provide a district hospital package of care on a 24-hour basis.
c. Have general practitioners and clinical nurse practitioners providing health services.
d. Provide services that include in-patient and ambulatory health services as well as emergency health services.
e. A district hospital receives outreach and support from general specialists based at regional hospitals.

A district hospital may only provide the following specialist services –

a. Paediatric health services.
b. Obstetrics and Gynaecology.
c. Internal medicine.
d. General Surgery.

Regional Hospitals

A regional hospital must, on a 24-hour basis, provide –

a. Health services in the fields of Internal Medicine, Paediatrics, Obstetrics and Gynaecology, and General Surgery.
b. Health services in at least one of the following specialities –
c. Orthopaedic Surgery
d. Psychiatry
e. Anaesthetiology
f. Diagnostic Radiology
g. Trauma and emergency services
h. Short term ventilation in a critical care unit

Services to a defined, regional drainage population, limited to provincial boundaries and receives referrals from several district hospitals. A regional hospital receives outreach and support from tertiary hospitals. A regional hospital has between four hundred (400) and eight hundred (800) beds.

Tertiary Hospitals

A tertiary hospital –

a. Provides specialist level services provided by regional hospitals.
b. Provides sub-specialities of specialities referred to in paragraph (a).
c. Provides intensive care services under the supervision of a specialist intensivist.
d. Receives referrals from regional hospitals not limited to provincial boundaries.
e. Has between four hundred (400) and eight hundred (800) beds.

Central Hospitals

A central hospital –

a. Must provide tertiary hospital services and central referral services and may provide national referral services.
b. Must provide training of health care providers.
c. Must conduct research.
d. Receives patients referred to it from more than one province.
e. Must be attached to a medical school as the main teaching platform.
f. Must have a maximum of one thousand two hundred (1200) beds.
g. Central referral services are provided in highly specialised units, require unique, highly skilled and scarce personnel and at a small number of sites nationwide.

National referral services –

a. Refer to super-specialised national referral units.
b. Represents extremely specialised and expensive services (e.g. heart and lung transplant, bone marrow transplant, liver transplant, cochlear implants).

Specialised Hospitals

A specialised hospital provides specialised health services like psychiatric services, tuberculosis services, treatment of infectious diseases and rehabilitation services; and has a maximum of six hundred (600) beds.

5. CRITERIA FOR ACCREDITATION OF TRAINERS

TRAINING TEAM

There shall be a team of trainers. Members of such team shall include the following: Subject to the level of facility and care provided, at least one suitably qualified and experienced medical practitioner accredited as specified by the Board. Any registered medical practitioner with at least THREE (3) years of clinical experience may be considered for accreditation as a trainer.

Nurses holding registration with the South African Nursing Council at different levels appropriate to the level of the facility and patient care provided. Other health professionals holding appropriate registration with their statutory Health Councils as required by the level of facility and patient care provided. The personal and professional qualities of members of the team of trainers which shall be assessed with reference to the following:

The presence of a caring ethos by which the facility as such is marked and which shall include an appropriate, empathic atmosphere and respect for people generally amongst team members and for patients in particular.

Clinical competence on the part of all team members.

A high degree of professionalism in performance, patient care and attitudes.

A spirit of commitment to teamwork as a philosophy and approach to patient care.

The existence of appropriate role-models for trainees.

Such personal and professional qualities should be assessed for individuals, the team as such, and as reflected in the functioning of the facility as a unit.

The appropriateness of trainers to serve as role-models shall include assessment of -

a. their disposition (attitude) and ethical behaviour;
b. professional relationships with patients;
c. having and using appropriate communication skills;
d. being sensitive to and reliable in team work;
e. their ability for handling stress;
f. having organisational ability;
g. having ability at resource management;
h. having clinical competence to provide or obtain appropriate health care at the required level.

All members of the training team need to have a letter of appointment from the employing Health Authority specifying their full-time, part-time or honorary duties and responsibilities. Such letter of employment shall specifically also specify the responsibility of that employee in terms of training, supervision and assistance to trainees. Training and supervision by medical practitioners shall be available on call for 24 hours per day, and such availability shall be appropriate for the level of patient care provided.

The accessibility and extent of trainer supervision shall vary according to the experience and competence of trainees and the complexity of the clinical task. In addition to their normal line-management and medico-legal responsibilities, trainers will be co-responsible for the care of patients about whom trainees consult them. Responsibility for training of trainees lies with the proposed Provincial Co-ordinators of Internship Training, Intern Curators and individual trainers.
The number of trainees for whom any trainer may take responsibility may vary according to -

a. the level of trainee competence and experience;
b. the level of the health care facility and nature of its services;
c. the nature and complexity of patient care required.

6. CRITERIA FOR ACCREDITATION OF FACILITIES AND COMPLEXES

Details on the following aspects are to be obtained and assessed:

PHYSICAL STRUCTURES

Nature of the overall and specific environment.
Overall appearance and state of repair.
Accessibility to patients and staff.

Structural planning and organisation of amenities to provide -

a. appropriate patient care;
b. appropriate diagnostic and therapeutic services;
c. a secure, safe and psycho-socially acceptable health care environment for patients and staff.

ACCOMMODATION

Appropriate for in-patients and out-patients. Appropriate for day-time staff on duty. Accommodation, while on call, shall be available for all relevant staff (including interns), appropriate to requirements for availability on call. Appropriate housing for interns should be available, as for the other staff, in relation to environmental accessibility and service requirements.

Appropriate provision for social amenities such as meals, refreshments, relaxation and recreation for staff on duty, on call and on site.

DIAGNOSTIC SERVICES

Access at the appropriate levels of care to diagnostic services such as -

a. radiological and imaging services;
b. pathology laboratory services;
c. side-room facilities; and
d. equipment to be in a proper state of repair.

THERAPEUTIC SERVICES

Access at the appropriate levels of care to therapeutic services such as -

a. availability of basic equipment for the level of care provided;
b. appropriately equipped theatres;
c. appropriate drugs for the level and nature of patient care provided, as listed in the Essential Drug List (EDL) for that level of care;
d. essential consumable and disposable items;
e. availability of up-to-date therapeutic and administrative protocols and guidelines; and
f. equipment to be in a proper state of repair.

SERVICES BY OTHER HEALTH CARE PROFESSIONS

Availability of or access to the diagnostic and therapeutic services rendered by other health care professions at the appropriate level of care required.

COMMUNICATION AND INFORMATION

Reasonable internal and external communication systems appropriate for the level of care required. Access to essential information.

ORGANISATIONAL STRUCTURE

Details of -

a. the number, qualifications and level of experience of full-time, part-time, and honorary medical practitioners employed;
b. the nature and number of other professional staff employed;
c. the nature and number of support staff employed.

DOMAINS OF PATIENT CARE

Details of -

a. the available domains in which patient care services are rendered by the facility;

b. the number of in-patients per domain, admitted per average month;
c. the number of out-patients per domain, treated per average month;
d. the patient profile with reference to demographics, diseases and procedures dealt with.

AVAILABILITY OF APPROPRIATE SYSTEMS FOR PATIENT RECORD-KEEPING

AVAILABILITY AND APPROPRIATE USE OF HEALTH INFORMATICS

AVAILABILITY OF TRANSPORT, INCLUDING AMBULANCE SERVICES, OTHER OFFICIAL TRANSPORT AND PUBLIC TRANSPORT

STRUCTURE AND FUNCTIONING OF THE REFERRAL SYSTEM

The facility's place in the referral chain. The effectiveness of referrals. The method and appropriateness of referrals.

INTERN WORKLOAD

Details of -

a. workload at in-patient and out-patient levels;
b. hours on duty per week;
c. overtime requirements;
d. work rosters;
e. on call duty.

TRAINING PROGRAMME

The appointment of an identified Curator(s) of Internship Training (who should preferably not be the Medical Superintendent of the relevant facility but may be a trainer who serves in the capacity as Curator on a part-time basis), his or her duties, responsibilities and execution thereof. A clearly stated policy on internship training as it applies to the specific facility or complex which shall be in line with the Board's criteria and requirements. An induction and orientation programme for young graduates. A constructive and organised training programme for the following prescribed domains, the requirements of and rotation through which shall be as follows:

General provisions

a. In view of the fact that the emphasis of internship training shall be on training for general practice, such training shall occur in the following fashion:
b. It shall take place in general practice and at that level.
c. It shall be comprehensive in nature.
d. It shall be so planned and structured that training provides for the primary health care approach.
e. The individual's choice of domains and rotations are to be subject to the availability of training posts and a facility's capacity to train in the domain of choice.
f. No part of internship training shall also form part of the prescribed registrar education and training for specialisation.

Specific provisions

See contents of Parts I and II of this Handbook. Specific training programmes are to be available for each of the prescribed domains in which training shall take place. The implementation of training programmes shall -

a. Take place in consultation with relevant stakeholders, including Co-ordinators and Curators of Internship Training;

b. Be subject to inspection by Board-appointed Inspectors of Internship Training who shall report to the Medical Education and Training Committee;
c. Be subject to views expressed and recommendations made by Medical Superintendents, trainers and interns who will specifically be asked to assist in the process of assessing the implementation of these training programmes.
d. Guidelines for training programmes shall be provided by the Board to assist in planning, implementation and assessment of such programmes (see Part II of this Handbook).
e. Training programmes shall continually be subject to revision and adjustments in view of experience gained, new developments and requirements in practice.

ASSESSMENT OF COMPETENCE

Assessment of the professional competence of trainees to practice medicine independently, is a matter which rests with the Board. Thus, provision is to be available for a system of progressive competency evaluation at the end of each period of rotation through every domain (Logbook for Internship Training). The specific provisions for and details of competence assessment are to be assessed in terms of the Board's criteria and guidelines. Competence assessment shall be at the level of a general practitioner; practice orientated; as objective as possible, measurable; and structured to assess professional knowledge, skills, competence, professional thinking and attitudes (including ethics).

The linkage of the Curator(s) of Internship Training at accredited facilities to the Faculty/School of Medicine/Health Sciences in its area of responsibility is to be assessed. The provisions for dealing with any intern who proves to be insufficiently competent in any of the domains assessed, need to be specified in writing. These provisions need to be assessed.

CONFIDENTIAL COUNSELLING SERVICE

A confidential counselling service at each facility or complex of facilities should be available. Assessment of such provision in terms of services provided, availability and effectiveness.

AVENUES FOR REDRESS

Specific provisions are to be available for dealing with any problems or complaints which interns may experience or have pertaining to the nature, contents or quality of the training programme. Interns should have the possibility of directing unresolved issues to the Medical Education and Training Committee.

ANNEXURE J

The levels of Health Care up to August 2011

HUMAN RESOURCES	SERVICES	LEVEL OF CARE	EQUIPMENT AND DRUGS
COMMUNITY HEALTH CENTRE			
- Public Health Care Nurses - Midwives - Medical Officers (full-time and part-time) - Some Senior Medical Officers - Some other health care professionals - Administrative and support staff - At least one public health care nurse or midwife available on call at night	- General polyclinic services for children and adults and people with mental illness or chronic diseases - Ante-natal and maternity services - Casualty services and initial treatment of common emergencies - Up to 30 beds for overnight stay (sleep overs, not formal admissions) - Outreach services - Environmental health services - Access to basic laboratory and radiological services (not necessarily on site) - 24-hour telecommunications and access to transport services	- Comprehensive ambulatory and outreach care - Mainly Level 1 care for people in one part of a Health District - Normally 95% of patients can be treated and sent home, with 5% or less being referred to a hospital	- Basic polyclinic equipment - Drugs as listed in the EDL (Essential Drug List) for primary care - Basic equipment for resuscitation and intravenous therapy

HUMAN RESOURCES	SERVICES	LEVEL OF CARE	EQUIPMENT AND DRUGS
LEVEL I: DISTRICT HOSPITALS			
As for Community Health Centre PLUS: - More medical officers, with one available on call at night - More other health care professionals - More senior nursing and administrative staff - Some visits by specialists	As for Community Health Centre PLUS: - General wards for admissions - Operating theatre services - Diagnostic, radiological and laboratory services - Some specialist out-patients services - Oral health services	- Comprehensive ambulatory care - General practitioner care of in-patients - Receives referrals from, supports and refers back to Community Health Centre's - Mainly Level 1 care for people of one Health District and adjacent areas - 90% of those requiring admission should be fully and appropriately treated there, with 10% or less referred to a Regional Hospital.	As for Community Health Centre PLUS: - Basic equipment for wards and operating theatres - Drugs in the EDL for primary care
LEVEL II: REGIONAL HOSPITALS			

HUMAN RESOURCES	SERVICES	LEVEL OF CARE	EQUIPMENT AND DRUGS
As for District Hospital PLUS: - Specialists in the more common disciplines including: Medicine, Surgery, Paediatrics, Obstetrics and Gynaecology, Anaesthesiology, Mental Health, Orthopaedic Trauma, Otorhinolaryngology - Dentists and other oral health professionals - All of the other health care professions	As for District Hospital PLUS: - Specialised services - A wide range of more complex diagnostic and therapeutic services BUT with far fewer, if any, ambulatory polyclinic services provided - district level services to be available in the area	- Comprehensive hospital care - 24-hour specialist cover on call in many disciplines - Receives referrals form, supports and refers back to several District Hospitals - Mainly Level II care for people from one or more Health Regions of a Province	As for District Hospital PLUS: - Wide range of diagnostic and therapeutic equipment, including radiological services, imaging and usually a CAT scanner - Drugs as specified in EDL for Regional Hospitals
LEVEL III: CENTRAL HOSPITAL			
As for Regional Hospital PLUS: - A range of teams led by specialists in the more common specialities and subspecialities - Some staff in highly specialised units	- Common speciality and subspeciality services - Some highly specialised services (often these will be different in different Central Hospitals) - NO POLYCLINIC OR GENERAL CASUALTY SERVICES	- Highly specialised care - Mainly Level III care for people from several or all Provinces - Receives referrals from, supports and refers back to Regional Hospitals all over South Africa and elsewhere in Southern Africa	As for Regional Hospital PLUS: - A range of highly specialised equipment (often different in different hospitals) - Drug in EDL for Central Hospitals

SPECIALISED HOSPITALS

Hospitals are those that treat only patients with particular conditions. They may be a Specialised District Hospital like many of the TB hospitals, or a Specialised Regional Hospital like a Spinal Injury Hospital.

ACADEMIC/SATELLITE HOSPITALS/DEPARTMENTS/FACILITIES

Any type of hospital may be an academic or satellite hospital if a significant amount of teaching, training and research takes place there AND there is a formal agreement between the relevant employing Health Authority and a tertiary educational institution, as well as recognition as such by the Medical and Dental Professions Board. Such an agreement will normally involve the joint appointment of some staff, the provision of additional space for teaching, provision for more investigations than would otherwise be done, and higher levels of staffing than would be needed to provide only services.

However, continuing medical education, internship training, in-service training and research will also take place in many facilities that are not labelled to be “academic/satellite”.

GOVERNMENT GAZETTE, 12 AUGUST 2011

GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R. 655 **12 August 2011**

NATIONAL HEALTH ACT, 2003

REGULATIONS RELATING TO CATEGORIES OF HOSPITALS

The Minister of Health intends, in terms of section 35 read together with section 90 of National Health Act, 2003, (Act No. 61 of 2003), after consultation with the National Health Council, to make the regulations in the Schedule.

Interested persons are invited to submit any substantiated comments or representations on the proposed regulations to the Director-General: Health, Private Bag X828, Pretoria, 0001, within a period of two months from the date of publication of this notice.

SCHEDULE

Definitions

1. In these regulations any word or expression to which a meaning has been assigned in the National Health Act, 2003, shall have such meaning and unless the context otherwise indicates: -

"post levels and salary scales" mean post levels and salary scales as determined from time to time by the Minister for Public Service and Administration in terms of the Public Service Act, 1994 (Proclamation No. 103 of 1994) as amended.

Categories of public hospitals

2. The following are categories of public hospitals:
(a) district hospital;
(b) regional hospital;
(c) tertiary hospital;
(d) central hospital; and
(e) specialised hospital.

District hospitals

3. (1) District hospitals are categorised into small, medium and large district hospitals with the following number of beds:
(a) small district hospitals with no less than 50 beds and no more than 150 beds;
(b) medium size district hospitals with more than 150 beds and no more than 300 beds; and
(c) large district hospitals with no less than 300 beds and no more than 600 beds.
(2) A district hospital must –
(a) serve a defined population within a health district and support primary health care;
(b) provide a district hospital package of care on a 24 -hour basis;

(c) have general practitioners and clinical nurse practitioners providing health services;
(d) provide services that include in-patient and ambulatory health services as well as emergency health services.
(3) A district hospital receives outreach and support from general specialists based at regional hospitals.

(4) A district hospital may only provide the following specialist services –
(a) Paediatric health services;
(b) obstetrics and gynaecology;
(c) internal medicine; and
(d) general surgery.

Regional hospitals

4. (1) A regional hospital must, on a 24-hour basis, provide –
(a) health services in the fields of Internal Medicine, Paediatrics, Obstetrics and Gynaecology, and General Surgery; and
(b) health services in at least one of the following specialities –
(i) Orthopaedic Surgery;
(ii) Psychiatry;
(iii) Anaesthesiology;
(iv) Diagnostic Radiology;
(c) trauma and emergency services;
(d) short term ventilation in a critical care unit; and
(e) services to a defined, regional drainage population, limited to provincial boundaries and receives referrals from several district hospitals.
(2) A regional hospital receives outreach and support from tertiary hospitals.
(3) A regional hospital has between 400 and 800 beds.

Tertiary hospitals

5. A tertiary hospital –
(a) provides specialist level services provided by regional hospitals;
(b) provides subspecialities of specialities referred to in paragraph (a);
(c) provides intensive care services under the supervision of a specialist intensivist; and
(d) receives referrals from regional hospitals not limited to provincial boundaries; and
(e) has between 400 and 800 beds.

Central hospitals

6. (1) A central hospital –

(a) must provide tertiary hospital services and central referral services and may provide national referral services;

(b) must provide training of health care providers;

(c) must conduct research;

(d) receives patients referred to it from more than one province;

(e) must be attached to a medical school as the main teaching platform; and

(f) must have a maximum of 1200 beds.

(2) Central referral services are provided in highly specialised units, require unique, highly skilled and scarce personnel and at a small number of sites nationwide.

(3) National referral services –

(a) refer to super-specialised national referral units; and

(b) represents extremely specialised and expensive services (e.g. heart and lung transplant, bone marrow transplant, liver transplant, cochlear implants).

Specialised hospitals

7. A specialised hospital –

(a) provides specialised health services like psychiatric services, tuberculosis services, treatment of infectious diseases and rehabilitation services; and

(b) has a maximum of 600 beds.

List of public hospitals

8. The list of public hospitals is attached hereto as an *Annexure* to these regulations.

Categories of private hospitals

9. Private hospitals are categorised into –

(a) for profit private hospitals; and

(b) not for profit private hospitals.

Management of public hospitals

10. (1) Public hospitals must be managed in accordance with national policy as determined from time to time by the Minister in terms of sections 3(1)(c) and 23 (1) of the National Health Act, 2003.
(2) The policy referred to in subregulation (1) shall include:
(a) management structures, post levels and salary scales;
(b) delegation of functions;
(c) list of health establishments; and
(d) hospital boards.

11. The Minister shall publish in the *Gazette* the policy referred to in regulation 10.

Transitional measures

12. Public hospitals that exist at the time of commencement of these regulations and that require time to effect changes to their structures, number of beds, services or any other matter in order to comply with these regulations shall effect such changes within a period, after the commencement of these regulations, as requested by the relevant Member of the Executive Council and approved by the Minister.

DR A MOTSOALEDI, MP
MINISTER OF HEALTH

DESIGNATED PUBLIC HOSPITALS

CENTRAL HOSPITALS

Province	District	Facility	No of beds	Population
Gauteng	Johannesburg	Charlotte Maxeke Johannesburg Academic	1018	6 567 130
	hannesburg	ris Hani/Baragwanath	2888	
	Tshwane Central Health District	Steve Biko	832	3 394 015
	Tshwane Odi Health District	George Mukhari	1652	
Eastern Cape	O R Tambo	Nelson Mandela Academic	507	5 078 975
Free State	Motheo	Universitas	636	2 775 331
Kwazulu Natal	Ethekwini	Inkosi Albert Luthuli	846	3 403 197
		King Edward VIII	922	4 624 618
Western Cape	Cape Town	Tygerberg	1310	3 507 640
		Groote Schuur	945	
Central Total		**10**		**49 991 300**

List of designated public hospitals

Eastern Cape Province

District	Sub-district	Facility level	Facility	No of beds	Population
A Nzo	Maluti	District	Madzikane kaZulu Memorial	267	406 723
	Umzimvubu	District	Mount Ayliff	167	
Amathole	Amahlathi	Specialised TB	Khotsong TB	198	1 803 186
		District	SS Gida	122	
	Buffalo City	District	Bisho	265	
		District	Grey	85	
		District	Nompumelelo (Peddie)	180	
		Regional	Cecilia Makiwane	1000	
		Provincial Tertiary	Frere	850	
		Specialised TB	Fort Grey TB	239	
	Mbhashe	District	Madwaleni	220	
	Mnquma	District	Butterworth	350	
		District	Tafalofefe	284	
		District	Fort Beaufort	70	
		District	Victoria	110	
		Specialised	Tower Psychiatric	600	
		Specialised TB	Winterberg TB	106	
Chris Hani	Emalahleni	District	Glen Grey	208	780 975
	Intsika Yethu	District	Cofimvaba	140	
	Inxuba Yethemba	District	Cradock	72	
		District	Wilhelm Stahl (Middelburg)	83	
		District	Frontier	450	
		Specialised Psychiatric	Komani	440	
	Ngcobo	District	All Saints	310	
		District	Mjanyana	100	
	Sakhisizwe	District	Cela	92	
		District	Elliot	52	
Cacadu	Camdeboo	District	Andries Vosloo	76	438 025
		District	Midland	70	
		Specialised TB	Margery Parkes TB	80	
	Kouga	District	Humansdorp	85	
		Specialised TB	P Z Meyer	57	
	Makana	District	Port Alfred	60	
		District	Settlers	219	
		Specialised Psychiatric	Fort England	313	
		Specialised TB	Marjorie Parrish TB	180	
		Specialised TB	Temba TB	60	
N Mandela	N Mandela A	District	Dora Nginza	570	1 139 032

	N Mandela B	District	Uitenhage	223	
		Specialised TB	Jose Pearson TB	350	
District	**Sub-district**	**Facility level**	**Facility**	**No of beds**	**Population**
		Specialised TB	Orsmond TB	201	
	N Mandela C	Provincial Tertiary	Livingstone	496	
		Provincial Tertiary	Port Elizabeth Provincial	450	
		Specialised Psychiatric	Elizabeth Donkin	163	
		Specialised TB	Empilweni TB	333	
O Tambo	King Dalindyebo	District	Zitulele	146	1 748 624
		Provincial Tertiary	Mthatha General	873	
		Central	Nelson Mandela Academic	507	
		Specialised	Bedford Orthopaedic	180	
		District	Nessie Knight	177	
		District	Dr Malizo Mpehle	135	
		Specialised	St Lucy's	110	
	Nyandeni	District	Bambisana	134	
		District	Canzibe	140	
		District	Isilimela	110	
		District	St Barnabas	340	
	Qaukeni	District	Greenville	100	
		District	Holy Cross	242	
		District	Sipetu	120	
		District	St Patrick's	280	
		District	St Elizabeth's	425	
		District	Taylor Bequest	200	
Ukahlamba	Senqu	District	Empilisweni	93	339 467
		District	Umlamli	73	
Total			**64**		

List of designated public hospitals

Free State Province

District	Sub-district	Facility level	Facility	No of beds	Population
Fezile Dabi	Metsimaholo	District	Metsimaholo (Sasolburg)	133	499 875
	Moqhaka	Regional	Boitumelo	340	
	Ngwathe	District	Parys	84	
		District	Tokollo (Heilbron)	63	
Lejweleputswa	Masilonyana	District	Winbrug	55	694 198
	Matjhabeng	District	Katleho (Virginia)	131	
		District	Thusanong (Odendaalsrus)	126	
		Regional	Bongani (Goldfields)	450	
	Nala	District	Nala	58	
	Tswelopele	District	Mohau	58	
Motheo	Mangaung	District	Botshabelo	135	813 580
		District	Dr J S Moroko	240	
		District	National District	200	
		Regional	Pelonomi	758	
		Central	Universitas	636	
		Specialised Psychiatric	Free State Psychiatric Complex	877	
	Mantsopa	District	Mantsopa (Ladybrand)	57	
T Mofutsanyane	Dihlabeng	District	Phekolong	100	767 678
		Regional	Dihlabeng (Bethlehem)	150	
	Maluti a Phofung	District	Elizabeth Ross	91	
		District	Thebe (Harrismith)	100	
		Regional	Mofumahadi Manapo Mopeli	300	
	Nketoana	District	Nketoana (Reitz)	65	
	Setsoto	District	Itemoheng (Senekal)	55	
Total			**24**		

List of designated public hospitals

Gauteng Province

District	Sub-district	Facility level	Facility	No of beds	Population
Ekurhuleni	Ekurhuleni E1	Regional	Pholosong	300	2 865 602
	Ekurhuleni E2	Regional	Far East Rand	311	
	Ekurhuleni N1	Regional	Tembisa	840	
	Ekurhuleni S1	District	Germiston	300	
		Regional	Tambo Memorial	642	
	Ekurhuleni S2	Regional	Natalspruit	784	
City of Johannesburg Metropolitan	Johannesburg B	Regional	Helen Joseph	485	3 701 528
		Regional	Raheema Moosa	338	
		Specialised	Tara H Moross Centre	141	
	Johannesburg D	Central	Chris Hani/Baragwanath	2888	
	Johannesburg E	Regional	Edenvale	230	
		Specialised	Sizwe Tropical Diseases	286	
	Johannesburg F	District	South Rand	280	
		Central	Charlotte Maxeke Johannesburg Acadmedic	1018	
Metsweding	Nokeng Tsa Taemane	Specialised	Cullinan Rehabilitation	298	214 355
Sedibeng	Emfuleni	District	Kopanong	248	867 623
		Regional	Sebokeng	800	
	Lesedi	District	Heidelberg	126	
Tshwane	Tshwane Central Health	District	Pretoria West	178	2 420 927
		District	Tshwane District	200	
		Regional	Kalafong	857	
		Specialised	Weskoppies	1067	
		District	Mamelodi	400	
		Central	Steve Biko	832	
		Specialised	Tshwane Rehab	79	
	Tshwane North	District	Jubilee	551	
	Tshwane Odi Health	District	Odi	227	
		Central	George Mukhari	1652	
West Rand	Merafong City	Districtt	Carletonville	180	658 733
	Mogale City	District	Dr Yusuf Dadoo	295	
		Regional	Leratong	800	
		Specialised	Sterkfontein	820	
Total			**32**		

List of designated public hospitals

Kwazulu Natal Province

District	Sub-district	Facility level	Facility	No of beds	Population
Amajuba	Emadiangeni	District	Niemeyer Memorial	52	511 589
	Newcastle	Regional	Madadeni	1488	
			Newcastle	340	
eThekwini	eThekwini	District	Osindisweni	245	3 403 195
		District	St Mary;s (Marianhill)	200	
		District	Wentworth	300	
		Central	King Edward VIII	922	
		Regional	Dr Pixiety ka Seme	450	
		Regional	Addington	571	
		Regional	Mahatma Gandhi Memorial	408	
		Regional	Prince Mshiyeni Memorial	1200	
		Regional	R K Khan	543	
		Regional	St Aidans	157	
		Specialised Chronic	Clairwood	426	
		Specialised	Hillcrest	212	
		Specialised Psychiatric	Ekuhlengeni Sanatorium	1200	
		Specialised TB	Charles James TB	220	
		Specialised TB	Don McKenzie TB	220	
		Specialised TB	FOSA TB	187	
		Regional	King George V	930	
		Central	Inkosi Albert Luthuli	846	
iLembe	KwaDukuza	Regional	Stanger	491	626 211
	Maphumulo	District	Umphumulo	146	
		District	Untunjambili	130	
	Ndwedwe	District	Montebello	182	
Sisonke	Gr Kokstad	District	East Griqualand and Usher Memorial	229	501 877
	Ingwe	District	St Apollinaris	155	
	Ubuhlebezwe	District	Christ the King	238	
	Umzimkhulu	District	Rietvlei	239	
		Specialised Psychiatric	Umzimkhulu	440	
		Specialised TB	St Margaret's	80	
Ugu	Hibiscus Coast	District	Murchison	300	760 648
		Regional	Port Shepstone	366	
		Specialised TB	Dunstan Farrell TB	180	
	Umdoni	District	G J Crooke's	300	

District	Sub-district	Facility level	Facility	No of beds	Population
	uMuziwabantu	District	St Andrew's	261	
uMgungundlovu	Richmond	Specialised TB	Richmond chest	364	1 058 086
	The Msunduzi	District	Northdale	385	
		Provincial Tertiary	Grey's	530	
		Regional	Edendale	900	
		Specialised Psychiatric	Fort Napier	450	
		Specialised Psychiatric	Townhill	425	
		Specialised TB	Doris Goodwin TB	113	
	uMngeni	Specialised Psychiatric	Umgeni Waterfall Institute	624	
	uMshwathi	District	Appelsbosch	138	
Umkhanyakude	Hlabisa	District	Hlabisa	308	653 467
	Jozini	District	Bethesda	230	
		District	Mosvold	213	
	Umhlabuyalingana	District	Manguzi	251	
		District	Mseleni	184	
Umzinyathi	Endumeni	District	Dundee	288	512 742
	Msinga	District	Church of Scotland	347	
	Nquthu	District	Charles Johnson Memorial	385	
	Umvoti	District	Greytown	227	
Sisonke	Kokstad	District	East Griqualand and Usher Memorial	229	501 877
	Ingwe	District	St Apolinaris	155	
	Ubuhlebezwe	District	Christ the King	238	
	Umzimkhulu	District	Rietvlei	239	
		Specialised Psychiatric	Umzimkhulu	440	
		Specialised TB	St Margaret's TB	80	
Ugu	Hibiscus Coast	District	Murchison	300	760 648
		Regional	Port Shepstone	366	
		Specialised TB	Dunstan Farrell TB	180	
	Umdoni	District	G J Crooke's	300	
	uMuziwabantu	District	St Andrew's	261	
Uthukela	Emnambitthi	Regional	Ladysmith	448	697 291
	Okhahlamba	District	Emmaus	156	
	Umtshezi	District	Estcourt	311	
Uthungulu	Mthonjaneni	District	KwaMagwaza	141	965 950
	Nkandla	District	Ekhombe	210	

		District	Nkandla	266	
	uMhlathuze	Regional	Lower Umfolozi War Memorial	283	
		Provincial Tertiary	Ngwelezana	859	
	uMalazi	District	Catherine Booth	170	
		District	Eshowe	460	
		District	Mbongolwane	196	
Zululand	Abaqulusi	District	Vryheid	338	849 634
	Nongoma	District	Benedictine	403	
	Ulundi	District	Ceza	265	
		District	Nkonjeni	360	
		Specialised	St Francis	105	
		Specialised TB	Thulasizwe	155	
	uPhongolo	District	Itshelejuba	150	
Total			**72**		

List of designated public hospitals: Limpopo Province

District	Sub-district	Facility level	Facility	No of beds	Population
Capricorn	Aganang	District	W F Knobel	243	1 205 294
	Blouberg	District	Helene Franz	149	
	Lepelle-Nkumpi	District	LebowaKgomo	252	
		District	Zebediela	108	
		Specialised Psychiatric	Thabamoopo	786	
	Molemole	District	Botlokwa	56	
	Polokwane	District	Seshego	180	
		Provincial Tertiary	Mankweng	509	
		Provincial Tertiary	Polokwane	701	
Sekhukhune	Motsoaledi	Regional	Philadelphia	538	1 000 351
		District	Groblersdal	52	
	Marble Hall	District	Matlala	120	
	Tubatse	District	Dilokong	324	
		District	Mecklenberg	105	
	Makhudutamaga	District	Jane Furse	252	
		Regional	St Rita's	400	
Mopani	Ba-Phalaborwa	District	Maphutha L Malatji	100	1 082 087
	Greater Giyani	District	Nkhensani	360	
		Specialised Psychiatric	Evuxakeni	400	
	Greater Letaba	District	Kgapane	262	
	Greater Tzaneen	District	Dr C N Phatudi	200	
		District	Van Velden Memorial	86	
		Regional	Letaba	400	
	Manuleng	District	Sekororo	208	
Vhembe	Makhado	District	Elim	550	1 293 788
		District	Louis Trichardt	52	
		District	Siloam	350	
	Musina	District	Messina	92	
	Thulamela	District	Donald Fraser	349	
		District	Malamulele	256	
		Regional	Tshilidzini	538	
		Specialised Psychiatric	Hayani	390	
Waterberg	Bela-Bela	District	Warmbaths	133	666 664
	Lephalale	District	Ellisras	130	
		District	Witpoort	70	
	Modimole	District	F H Odendaal	166	
	Mogalakwene	District	George Masebe	260	
		District	Voortrekker Memorial	91	
		Regional	Mokopane	273	
	Thabazimbi	District	Thabazimbi	112	
Total			**40**		

List of designated public hospitals

Mpumalanga Province

District	Sub-district	Facility level	Facility	No of beds	Population
Ehlanzeni	Bushbuckridge	District	Matikwana	178	1 563 857
		District	Tintswalo	423	
		Regional	Mapulaneng	252	
	Mbombela	Provincial Tertiary	Rob Ferreira	301	
		Regional	Themba	623	
		Specialised	Bongani	50	
	Nkomazi	District	Shongwe	350	
		District	Tonga	250	
	Thaba Chweu	District	Lydenburg	100	
		District	Matibidi	100	
		District	Sabie	99	
	Umjindi	District	Barberton	227	
		Specialised TB	Barberton TB	150	
G Sibande	Albert Luthuli	District	Carolina	80	943 137
		District	Embhuleni	220	
	Govan Mbeki	District	Bethal	233	
		District	Evander	76	
	Lekwa	District	Standerton	219	
		Specialised TB	Standerton TB	150	
	Mkhondo	District	Piet Retief	227	
	Msukaligwa	Regional	Ermelo	200	
		Specialised TB	Sesifuba TB	56	
	Pixley Ka Seme	District	Amajuba Memorial	105	
Nkangala	Dr J S Moroka	District	Mmametlhake	55	1 128 194
	Emalahleni	Provincial Tertiary	Witbank	349	
		Specialised TB	Witbank Specialised TB	226	
	Steve Tshwete	District	Middelburg	349	
	Thembisile	District	KwaMhlanga	148	
Total			**28**		

List of designated public hospitals

North West Province

District	Sub-district	Facility level	Facility	No of beds	Population
Bojanala Platinum	Kgetleng River	District	Koster	50	1 328 721
	Madibeng	District	Brits	215	
	Moses Kotane	District	Moses Kotane	232	
	Rustenburg	Provincial Tertiary	Job Shimankana Tabane	390	
Dr K Kaunda	Maquassi Hills	District	Nic Bodenstein	100	893 818
	Matlosana	Provincial Tertiary	Klerksdorp/Tshepong	1015	
	Tlokwe	Regional	Potchefstroom	335	
		Specialised Psychiatric	Witrand Psychiatric	982	
Ngaka Modini Molema	Ditsobotla	District	General de la Rey	61	797 108
		District	Thusong	300	
	Mafikeng	District	Gelukspan	350	
		Regional	Mafikeng Provincial	492	
		Specialised Psychiatric	Bophelong Psychiatric	312	
	R Moiloa	District	Lehurutshe	105	
		District	Zeerust	84	
Ruth Segomotsi Mompati	Greater Taung	District	Taung	468	456 347
	Kagisano	District	Ganyesa	60	
	Mamulsa	District	Schweizer-Reneke	67	
	Naledi	Regional	Vryburg	120	
Total			**19**		

List of designated public hospitals

Northern Cape Province

District	Sub-district	Facility level	Facility	No of beds	Population
Frances Baard	Sol Plaatjie	Provincial Tertiary	Kimberley	604	375 167
		Specialised TB and Mental Health	West End	147	
		Specialised (Rehabilitation)	Kimberley Rehab Centre	90	
	Phokwane	District	Hartswater	60	
J T Gaestsewe	Ga-Segonyana	District	Kuruman	69	216 419
		District	Batlharos	214	
Namakwa	Hantam	District	Calvinia	51	125 035
	Nama Khoi	District	Springbok	77	
Pixley ka Seme	Emthanjeni	District	De Aar	51	191 783
	Umsombovu	District	Colesberg	45	
Siyanda	!Khara Hais	Regional	Upington	186	244 883
	Tsantsabane	District	Postmasburg	45	
Total			**12**		

List of designated public hospitals: Western Cape Province

District	Sub-district	Facility level	Facility	No of beds	Population
Cape Town	Eastern	District	Eerste River	100	3 507 640
		District	Helderberg	162	
	Khayelitsha	District	Khayelitsha	230	
	Klipfontein	District	G F Jooste	184	
	Mitchells Plain	District	Mitchells Plain Private	230	
		Specialised Psychiatric	Lentegeur	740	
	Northern	Specialised TB	Brooklyn Chest	349	
	Southern	District	False Bay	65	
		District	Victoria	172	
		Specialised	Red Cross War Memorial Children's	290	
		Specialised TB	DP Marais	260	
	Tygerberg	District	Karl Bremer	372	
		Central	Tygerberg	1310	
		Specialised Psychiatric	Stikland	318	
	Western	Central	Groote Schuur	945	
		Regional	Mowbray Maternity	205	
		Regional	Somerset	334	
		Specialised	Western Cape Rehab Centre	208	
		Specialised Psychiatric	Alexandra	300	
		Specialised Psychiatric	Valkenberg	420	
Cape Winelands	Breede Valley	District	Robertson	52	742 766
		Regional	Worcester	275	
		Specialised TB	Brewelskloof TB	368	
	Drakenstein	Regional	Paarl	369	
		Specialised TB	Sonstraal TB	90	
	Stellenbosch	District	Stellenbosch	99	
	Witzenberg	District	Ceres	104	
Central Karoo	Beaufort West	District	Beaufort West	86	65 361
Eden	George	Regional	George	303	548 482
		Specialised TB	Harry Comay TB	180	
	Hessequa	District	Riversdale	95	
	Knysna	District	Knysna	160	
	Mossel Bay	District	Mossel Bay	98	
	Oudtshoorn	District	Oudtshoorn	189	
Overberg	Swellendam	District	Swellendam	51	248 996
	Theewaterskloof	District	Caledon	71	
West Coast	Matzikama	District	Vredendal	75	341 876
	Saldanha Bay	District	Vredenburg	80	
	Swartland	District	Swartland	85	

		Specialised TB	Malmesbury Infectious Diseases	55	
Total			**40**		

PROFESSIONS COUNCIL OF SOUTH AFRICA

MEDICAL AND DENTAL BOARD

ACCREDITED INTERNSHIP HOSPITAL

GAUTENG

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Head of Health	1755	Gauteng Department of Health Private Bag X085 **MARSHALLTOWN** 2107	Provincial Coordinator: Dr Ntsakisi Maluleke Email: Ntsakisi.Maluleke@gauteng.gov.za Ntsakisi.Masinga@gauteng.gov.za Tel: 011 355 3265 Cell: 072 483 2253 Fax: 011 355 3401
Chris Hani/Baragwanath Hospital	392	P O Bertsham **SOWETO** 2013	Dr Percy Selepe - Acting CEO Email: Mkhulu.Selelpe@gauteng.gov.za Cel: 078 935 1446 Office: 011 933 0180 Medical Manager: Dr Nita Soma Email: Nita.Soma@gauteng.gov.za Cell: 082 557 2200 Intern Curator: Dr K Kgomo (1st year interns) Email: kkgomo@gmail.com Cell: 071 521 4880 Intern Curator: Dr Kabir (2nd year interns) Email: Cell: 0835834934

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Edenvale General Hospital	30	Private bag X 1005 **EDANVALE** 1610	CEO: Dr Z G Zitha Email:ZakheleGoodman.Zitha@gauteng.gov.za Tel: 011 321 6157 Cell: 082 749 3132 Clinical Manager: Dr D R Maluleka Email: Donald.maluleke@gauteng.gov.za Tel: 011 321 6082 Cell: 082 489 9244 Intern Curator: Dr C Naidoo Email: casnaidoo1@gmail.com Tel: 011 321 6031 Cell: 083 280 0218
Helen Joseph/ Rahima Moosa Mother and Child Hospital Complex	145 (Actual employed 154)	Private Bag X20 **NEWCLARE** 2112	Helen Joseph Hospital (Acting)CEO: Dr Rodney Pheto Email: rodney.pheto@gauteng.gov.za Tel: 011 489-0306/1087 Cell: 071 492 4727 PA: Miss Nomakhwezi Mjada Nomakhwezi.Mjada@gauteng.gov.za Office Num: 011 489 1087 Cell Number: 067 427 7777 Clinical Manager: Dr Manape Kgopa Email: manape.kgopa@gauteng.gov.za Contact details: 0718996471

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Rahima Moosa Mother and Child Hospital			Clinical Manager: Dr Sehularo Gaelejwe Email:Sehularo.Gaelejwe@gaunteng.gov.za Intern Curator: Dr M Edoo Email: emariamedoo@yahoo.com; mariam@edoo.mu Cell: 0725055313 CEO: Dr Arthur Manning Email: arthur.manning@gauteng.gov.za Tel: 011 470-9030 Cell: 084 697 8354 Clinical Manager: Dr Frew Benson Email: Frew.Benson@gauteng.gov.zaa Tel: 011 470-9030/1 Cell: 082 372 4199 Intern Curator: Prof Ashraf Hassen Coovadia Email: Ashraf.Coovadia@wits.ac.za Tel: 011 470 9284/011 470 9100/ Cell: 082 927 9097
Charlotte Maxeke Johannesburg Academic Hospital	128	Private Bag X39, Johannesburg 2000	CEO: Ms G Bogoshi Email: Gladys.bogoshi@gauteng.gov.za 011 488 4777/3792 Cell: 082 927 3565 Medial Manager: Dr J Punwasi Email: Jayshina.Punwasi@gauteng.gov.za

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
			Tel: 011 488 4777/ 3792 Cell: 064 631 5538 Intern Curator: Prof G Demetriou, Email: georgiademetriou@hotmail.com Cell: 083 288 7320
Thelle Mogoerane Regional Hospital	80		Acting CEO: Dr M M Malaka Email: Michael.Malaka@gauteng.gov.za Tel: 011-5900298 Cell: 083 300 4112 Clinical Manager: Dr Ndobe Email: Cell: 082 356 5703 Intern Curator: Dr N Sibisi-Zimu Email:drnelli.sibisi@gmail.com; nelisiwe.sibisi@gauteng.gov.za Tel: 011 590 0305 Cell: 083 270 7188
Far East Rand Hospital	44	Private Bag X50 **SPRINGS** 1560	CEO: Mr Sonwabo Lindani Email: sonwabo.lindani2@gauteng.gov.za Cell: 073 401 3031 Medical Manager: Dr PS Lobo Email: piema.lobo@gauteng.gov.za Cell: 082 565 5621 Inten Curator: Dr E. Legoale

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
			Email: drlegoale@gmail.com Cell: 082 704 7349
Pholosong Hospital	60	Private Bag X 4 **BRAKPAN** 1550	CEO: Dr N Makgana Email: nthabiseng.makgana@gauteng.gov.za Tel: 011 812 5152/5163 Cell: 060 712 8912 PA Email address: Nompumelelo.mdluli@gauteng.gov.za Clinical Manager: Dr H Mlahleki Email: hlomile.mlahleki@gauteng.gov.za Tel: Cell: Clinical Manager: Dr Boitumelo Pitso Intern Curator: Dr Dia Diop Email: Dieynaba.dia@gmail.com Tel: 0118125162 Cell:082 741 0450
Tambo Memorial/Bertha Gxowa Training Complex	112	Private Bag X 2 **BOKSBURG** 1460	CEO: Mr Z Ndabula Email: Zenzo.Ndabula2@gauteng.gov.za Tel: 0118988318 Cell: 082 376 9564 Clinical Manager: Dr K Shezi Email: Khulekani.Shezi@gauteng.gov.za

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
			Tel: 011 898 8320/2 Cell: Intern Curator: Dr S Carim Email: samcarim@webmail.co.za: Tel: 011 898 8046/9 Cell: 073 786 2082
Bertha Gxowa Hospital		Private Bag X 1035 **GERMISTON** 1400	CEO: Dr N N Mtshali-Hadebe Email: Nokwethemba.Hadebe@gauteng.gov.za Tel: 011 089 8567/69 Cell: 082 040 0460 Clinical Manager: Dr EK Ncholo/ Dr E M Sithebe Email: kgotso.Ncholo@gauteng.gov.za/ musawe02@yahoo.com Tel: 011 089 8569 Cell: 082 043 9511 / 082710 6678
Tembisa Provincial Tertiary hospital	104	Private Bag X7 **OLIFANTSFONTEIN** 1665	CEO: Dr V Mthunzi Email: Vusi.Mthunzi@gauteng.gov.za Tel: 011 923 2320/2100 Cell: 082 828 4061 Clinical Manager: Dr S P Mbeleki Email: sasiwe.mbeleki@gaugeteng.gov.za Tel: 011 923 2053 Cell: O827888502

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
			Intern Curator: Dr W H Y Wijnant Email: Wim.Wijnant@gauteng.gov.za Tel: 011 923 2226 Cell: 072 713 2257
Dr George Mukhari Academic Hospital	160	Private Bag X422 **PRETORIA** 0001	CEO: Dr Lucas Ndlovu Email: Lucas.ndlovu@gauteng.gov.za Clinical Executive: Dr JS Mangwane Email: joseph.mangwane@gauteng.gov.za Cell: 0835834934 Dr Freddy Kgongwana Email: Freddy.kgongwana@gauteng.gov.za Tel: 012 529 3221 Cell: 0720574593 Clinical Manager: Dr C Holm Email: Christene.Holm@gauteng.gov.za Tel: 0125293691 Cell: 0762270751 Intern Curator: Prof SS Golele Email: Samuel.golele@smu.ac.za Cell: 0826031527
Jubilee Hospital		Private Bag X 442 **HAMMANSKRAAL** 0400	Dr OB Modise(Acting CEO) Email: Olebogeng.Modise@gauteng.gov.za

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
			Tel: 0127179336 Cell: 082 968 3222 Acting Clinical Manager: Dr MJ Mokwena Email: juliet.mokwena@gauteng.gov.za Tel: 0127179338 Cell: 082 824 2821 Intern Curator: Dr MA Nkoane Email: dibunk5@gmail.com Cell: 072 435 8970
Steve Biko Academic Hospital/ Tshwane District Hospital Training Complex	128	**Private Bag X 169** **PRETORIA** **0001**	CEO: Dr M Mathebula Email: Mathabo.Mathebula@gauteng.gov.za Tel: 012 354 2222 Cell: 082 907 09730 Clinical Manager: Dr T Fisher (acting) Email: trevor.fisher@gauteng.gov.za Tel: 012 354 2336 Cell: 076 865 0816 Intern Curator: Dr M J Heystek Email: mheystek@mweb.co.za Tel: 012 354 5959/ 60303 Cell: 082 853 6216
Kalafong Provincial Tertiary hospital	140	Private Bag X 396 **PRETORIA**	(CEO) : Dr S Matjila Email: Sello.Matjila@gauteng.gov.za

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
		0001	Email: Tel:012 318 6503 Cell: O769433048 Clinical Manager: Dr K Htwe Email: Htwe.Khin@gauteng.gov.za Tel: O123186502 Cell: 0827729966 Intern Curator : Dr Paballo Theletsane - paballotheletsane@gmail.com Cell: 063 682 5397
SAMHS: NO 1 Military Hospital	24	Private Bag X 1026 **THABA TSWANE** 0143	CEO: Lieutenant General (Dr) N.P. Maphaha Email: npmaphaha@2military.co.za Tel: 012 314 0001 Clinical Manager: Col (Dr) R A Maboe Email: radineo@gmail.com Tel: 012 314 0703 Intern Curator: Dr KH Masoga (from 01/02/2023) Email: drkhmasoga@gmail.com Cell: 0845007806
Sebokeng Regional & Kopanong District Hospital	104	Private Bag X 058 **VANDERBIJLPARK** 1980	CEO (Sebokeng): Ms. Makibiti Madolo Email: Makibiti.Madolo@gauteng.gov.za Tel: 016 930 3306

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
			Cell: 0823749560 Clinical Manager: Dr. N.A. Msibi (Medical and Maternal) Email: nomuso.Msibi@gauteng.gov.za Tel: 0169303304 Cell: 082 378 7563 Intern Curator: Dr S Ndweni Emai: sibongile.ndweni@gauteng.gov.za Cell: 083 487 9135 Intern Curator: Dr. O.P. Mashele Email: Oupa.Mashele@gauteng.gov.za Cell: 082 787 2504 CEO:(Kopanong District) Dr Kgomojoo Email: Maselloane.Kgomojoo@gauteng.gov.za Tel: 016-4287112 Cell: 0827724132 Clinical Manager: Dr. P. Mabena Email: Percy.Mabena@gauteng.gov.za Tel: 016-4287112 Cell: 0825558036
West Rand Hospital (Leratong Hospital & Dr Yusuf Dadoo Hospital)	72	Private Bag X 2078 **KRUGERSDORP** 1740	CEO: Dr D P Moloi (Leratong Hospital) Email: Dieketseng.Moloi@gauteng.gov.za Tel: 011 411 3531/011 411 3508 Cell: 081 044 6023

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
			PA to CEO: Julie van Eck Julie.VanEck@gauteng.gov.za Medical Manager: Dr R Phanzu Email: Roger.Phanzu@gauteng.gov.za Tel: 011 411 3508 Cell: 083 446 6960 Intern Curator: Dr F Rossouw Email: rossera@vodamail.co.za Tel: 011 411 3508 Cell: 082 37 8490 fionaerasmus31@gmail.com ; Constance.kgophane@gauteng.gov.za
Mamelodi regional Hospital	32		Dr N Soe (CEO) Email: naing.soe@gauteng.gov.za Tel: 012-841 8306/7 Cell: 083 573 7113 Clinical Manager: Dr Busisiwe Mankge Email: busisiwe.mankge@gauteng.gov.za Tel: O12 841 8305 Cell: 079 694 0974 Intern Curator/s: Dr VA Annor / Dr NWS Serudu Cell: 072 237 1765

KWAZULU NATAL

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Head office The Head of Health	1283	The Head of Health Department of Health Private Bag X 9051 **PIETERMARITZBURG** 3200	Provincial Co-ordinator: Mrs R Erasmus Email: Rolize.Erasmus@kznhealth.gov.za Tel: 033 395 2742 Cell: 082 773 3574
Port Shepstone Regional Training Complex	62	Private Bag X 5706 **PORT SHEPSTONE** 4240	CEO Ms BC Ndlovu Email: bawinile.ndlovu@kznhealth.gov.za Tel: 039 688 6229 Cell: 066 488 0191 Medical Manager: Dr P B Dlamini Email: busi.dlamini@kznhealth.gov.za Cell: 083 414 2261 / 082 325 0787 Intern Curator: Dr Panajatovic Email: miljenko.panajatovic@kznhealth.gov.za Tel: 039 688 6147 Cell: 083 262 2559
Murchison Hospital		Private Bag X 701 **PORT SHEPSTONE**	CEO: Dr Maureen Nxumalo Email: Maureen.Nxumalo@kzn.gov.za

		4240	Tel: 039 687 7311 Clinical Manager: Dr Ordoli Email: ordoli.dibibi@kzn.gov.za
	NUMBER OF ACCREDITED INTERN POST	**POSTAL ADDRESS**	**CONTACT DETAILS**
Pietermaritzburg Hospital Complex	254	Edendale Hospital Private Bag X 509 **PLESSISLAER** 3216	CEO: Mr Brian M Shezi Email: Brian.Shezi2@kznhealth.gov.za Tel: 033 395 4040 Cell: 063 251 9344 Medical Manager: Dr NMT Gumede Email: nhlakanipho.gumede@kznhealth.gov.za Tel: 033 395 4005 Cell: 078 570 2519 Intern Curator: Dr ES Marais Email: eben.marais@kznhealth.gov.za Tel: 033 897 3318 Cell: 083 294 1747
Grey's Hospital		Private Bag X 9001 **PIETERMARITZBURG** 3201	CEO: Dr K B Bilenge Email: ben.bilinge@kznhealth.gov.za Tel: 033 897 3320 Senior Manager: Medical Services: Dr L Naidoo Email: longandran.naidoo@kznhealh.gov.za Tel: 033 897 3318 Intern Curator: Dr Ramnath

			Email: jajanth.ramnath@kznhealth.gov.za Tel: 033 897 3324
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Ladysmith Provincial Hospital	68	Private Bag X 9928 **LADYSMITH** 3370	Acting CEO: Dr M Pule Email: puleme@icloud.com Tel: 036 637 2111 066 372 2525 082 830 7704 Clinical Manager: Dr M Pule Tel: 036 637 2111 Cell no. 066 372 2525 082 830 7704 Email address: mokhethi.pule@kznhealth.gov.za; puleme@icloud.com
Addington/Mahatma Gandhi Memorial Hospital Complex	160	P O Box 977 **DURBAN** 4000	CEO: Dr A Aron Email: Alicia.Aron@kznhealth.gov.za Tel: 031 327 2970 Clinical Manager: Dr C Persad (Mahatma Gandhi) Email: Nancy.bridgemohun@kznhealth.gov.za Tel: 031 502 1719 Intern Curator: Dr MMF Ansermeah Email: Maseeha.Ansermeah@kznhealth.gov.za Tel: 072 669 1530

Mahatma Gandhi Memorial hospital		Private bag X 13 **MOUNT EDGECOMBE** 4300	Acting CEO: Mr LS Maphumulo Email: Siboniso.maphumulo@kznhealth.gov.za Tel: 031 502 1719 Clinical Manager: Dr C Persad Email: Nancy.bridgemohun@kznhealth.gov.za Tel: 031 502 1719 Intern Curator: Dr DH Rungan Email: Devandiran.rungan@kznhealth.gov.za Tel: 031 502 1719
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Durban Hospital complex	132	King Edward VIII Hospital Private Bag **CONGELLA** 4013	CEO: Dr T Mayise Email: thami.mayise@kznhealth.gov.za Tel: 031 360 3015 Intern Curator: Dr M Rankin Email: mario.rankin@gmail.com Tel: 031 360 3329 Cell: 0731421476 Acting Clinical Manager: Dr Sivi Moodley Email: sivi.moodley@kznhealth.gov.za Tel: 031 360 3020
Prince Mshiyeni Memorial Hospital	168	Private Bag X 07 **MOBENI**	CEO: Mr G Khawula Email: Khawula.Gabrielle@kznhealth.gov.za

		4060	Tel: 031 460 5001 Acting Clinical Manager: Dr M Aung Email: myint.aung@kznhealth.gov.za Tel: 031 907 8317 Cell: 084 845 7707
R K Khan Hospital	117	Private Bag X 004 **CHATSWORTH** 4030	Acting CEO: Dr Linda Sobekwa Email: linda.sobekwa@kznhealth.gov.za Tel: 031 459 6266 / 064 850 6437 Clinical Manager: Dr G M Govender Email: govender.gm@kznhealth.gov.za Tel: 031 459 6266 / 082 821 9229 Intern Curator: Dr G M Govender Email: govender.gm@kznhealth.gov.za Tel: 031 459 6266 / 082 821 9229
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
General Justice Gizenge Mpanza (former Stanger) Hospital	94	Private Bag X 10609 **STANGER** 4450	Acting CEO and Clinical Manager: Dr G Lopez Email: Gustavo.lopez@kznhealth.gov.za Tel: 032 437 6015 Intern Curator: Ria Naidoo Email: ria.naidoo@kznhealth.gov.za Tel: 032 437 6000 Cell: 083 564 5444

Madadeni Hospital /Newcastle Provincial Hospital Complex (Charles Johnson, Memorial Hospital, Vryheid Hospital, Dundee Hospital, Dannhauser CHC)	88	Private Bag X6642 **NEWCASTLE** 2940	CEO: Mrs HSL Khanyi Email: Happy.Khanyi@kznhealth.gov.za Tel 034 328 8000 PA: Mr Anesh Bharat Email: Anesh.Bharat@kznhealth.gov.za . Clinical Manager: Dr H Hlela Email: Hlengiwe.Hlela@kznhealth.gov.za Tel: 034 374 9221 Intern Curator: Dr AYB Lamina Email: abiodunlamina@gmail.com Tel:
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Newcastle provincial Hospital		Private Bag X 6653 **NEWCASTLE** 2940	CEO: Mrs T B T Sakyi Email: Thabisile.Sakyi@kznhealth.gov.za Tel: 034 328 0000/26 Medical Manager: Dr Xolani Nene Email address: Nene.Xolani@kznhealth.gov.za Cell: 0787298734 Dr R Nyombayire Nyombayire@kznhealth.gov.za Tel: 034 328 0000/55

			Intern Curator: Dr B B Xulu Email: Brian.Xulu@kznhealth.gov.za Tel: 034 328 0000
Ngwelezane Hospital /Umphu Health Clinic	88	Private Bag X 20021 **EMPANGENI** 3880	CEO: Mrs Nqobile Mkhwanazi Email: nqobile.mkhwanazi@kznhealth.gov.za Cell: 083 446 2752 Tel: 035 - 901 7260/7273 Medical Manager: Dr Rampane S Moeketsi Email: rampane.moeketsi@kznhealth.gov.za Cell: 083 788 4122 Intern Curator: Dr I Mwachukwu Email: innocent.nwachukwu@kznhealth.gov.za Cell: 072 130 2557
Dr Pixley Ka Isaka Seme Memorial Hospital	40		CEO: Dr Jimmy M Mthethwa Email: Jimmy.Mthethwa@kznhealth.gov.za Cell: 060 789 7323 Tel: 063 251 8211 Medical Manager: Dr Hlengiwe Hlela Email: hlengiwe.hlela@kznhealth.gov.za Cell: 082 469 3165 Intern Curator: Dr Ntlekzazi Mpuku Email: ntlekazi.mpuku@kznhealth.gov.za Cell: 073 964 4436

LIMPOPO

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Head office The Head of Health Department of Helath and Welfare	404	Private Bag X9302 **POLOKWANE** 0700	Provincial co-ordinator Dr Musa Eileen Setati Email: musasono@yahoo.com Tel: 0796207335
Warmbaths Hospital	12	Private Bag x 1618 **BELA BELA** 0480	CEO: Ms. Angela Manaka Cell: 083 661 8802 Email: Angela.Manaka@dhsd.limpopo.gov.za Clinical Manager: Dr.Dan Sithole Cell: 082 788 1459 Email: danmapikwa@gmail.com Inter Curator: Dr Thobejane BK Cell: 076 439 4464 Email: b.kthobejane@yahoo.com
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Mokopane Hospital	56	Private Bag x 2466	CEO: Ms.Leah Magagane

		MOKOPANE 0600	Cell: 076 189 4061 / 063 692 9311 Email: Leah.Magagane@dhsd.limpopo.gov.za Clinical Manager: Dr BM Khosa Cell: 071 528 8875 Email: vesper868@gmail.com Intern Curator: Dr T D Pitse Cell: 078 849 5560 / 083 442 9906 Email: thebepitse@gmail.com
Pietersburg/Mankweng-Seshego Hospital	152	Private Bag X1117 **SOVENGA** 0727	***MANKWENG*** ACTING CEO: Dr S Muila Cell: 072 559 0935 Email: seshokamuila@gmail.com Clinical Manager: Dr.Seshoka Muila Cell: 072 599 0935 Email: seshokamuila@gmail.com Intern Curator: Dr K Ngoepe Cell: 072 679 7351 Email: kangoepe@gmail.com
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
			POLOKWANE Acting CEO: Dr MC Masipa Email: mcmasipa@outlook.com

			Cell: 081 494 6995 Email: pandelaner@gmail.com Clinical Executive Manager: Dr.Jeniva Morifi Cell: 076 410 7055 Email: morifijk@gmail.com Rapudi.Morifi@dhsd.limpopo.gov.za intern curator: Dr K Moabelo Cell: 072 264 2718 Email: koenamoabelo@rocketmail.com
Tshilidzini Hospital/ Donald Fraser/Malamulele Training Complex	44	Private Bag X924 **SHAYANDIMA** 0945	CEO: Ms Marubini A Nndwambi Email: Marubini.nndwambi1@gmail.com Marubini.Ndwammbi@dhsd.limpopo.gov.za Cell: 063 628 6503 Clinical Manager: Dr N M Ndwambi Cell: 072 848 8633 Email: ndwambi@gmail.com Intern Curator: Dr NF Nemaguvhuni Cell: 079 746 5773 Email: francinemaguvhuni@gmail.com
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Elim Hospital	20	Private Bag X 312 **ELIM** 0960	CEO: Mr P M Matodzi Email: pfuluwani.matodzi@gmail.com Pfuluwani.Matodzi@dhsd.limpopo.gov.za Tel: 082 223 0064 Clinical Manager: Dr MS Mushudu

			Email: mushadus@yahoo.com Tel: 0827045703 Intern Curator: Dr Tendani R Tharini Cell: 076 747 4672 Email: tendanirhoda@yahoo.com
Letaba Hospital	48	Private Bag X 1430 **LETABA** 0870	CEO: Ms VJ Ragolane Email:ragolanev@gmail.com; Victoria.Ragolane@dhsd.limpopo.gov.za Cell: 078 200 8774 Tel: 078 278 4784; 081 334 4174 Clinical Manager: Dr MMM Ramothwala Email: mmmramothwala@gmail.com Michael.Ramothwala@dhsd.limpopo.gov.za Cell: 071 920 1039 Intern Curator: Dr T M Mathabatha Cell: 078 429 1471 Email: tebatjom@gmail.com
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
St Rita's Hospital	24	Private Bag X 1303 **GLEN COWIE** 1060	CEO: Mr MA Mahloele Cell: 071 861 9824 Email: Mokganomahloele@gmail.com Medical Manager: Dr SC Phasha Cell: 079 765 5130 Email:

			Intern Curator: Dr TS Nkadimeng Cell: 076 839 1352 Email: thabenkadimeng@yahoo.com
Lebowa Kgomo Hospital	24	Private Bag X 14 **CHUENESPOORT** 0745	CEO: Mr Mohale Seepe Cell: 082 990 7075 Email: mohaleseepe4@gmail.com Acting Senior Clinical Manager: Dr Reneilwe Mathe Email: mathereneilwe008@gmail.com Cell: 082 492 3659 Intern Curator: Dr Phathu Ramunenyiwa Cell: 082 541 1848 / 0825417873 Email: abnerdr@gmail.com

MPUMALANGA

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
The Head of Health Department of Health and Welfare **MPUMALANGA**	240	Private Bag X 11285 **MBOMBELA** 1200	Provincial Coordinator: Dr T Z Zondo Cell No: 072 380 2116 Email : lerato.motjale@gmail.com
Witbank Hospital	72	Private Bag X 7206 **EMALAHLENI** 1035	CEO: Mrs. KAP Madonsela Email: ZaleM@mpuhealth.gov.za Cell No. 082 657 5554 Tel: 013 653 2151 Clinical Manager: Dr. Mahlane Phalane Email: phalanem@mpuhealth.gov.za Cell No. 071 505 2326 Tel: 013 653 2519 Intern Curator: Dr Charles Bondo Email: Charles.bondo@up.ac.za Cell No. 082 941 1088 Tel: 013 653 2304
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Rob Ferreira Hospital	80	Private Bag X 11223 **NELSPRUIT** 1200	Acting CEO: Mrs F Nyathi Email: fridahnya@mpuhealth.gov.za 071 682 6396

			Senior Clinical Manager: Dr TP Mabina Email: TefoM@mpuhealth.gov.za Tel: 083 976 0588 / 081 041 5995 Intern Curator: Dr Joshua Danha Email: joshuadanha@yahoo.com Tel: 064 143 2979
Themba Hospital	56	Private Bag X 1002 **KABOKWENI** 1245	CEO: Mr M J Shabangu Email: Mduduzi@mpuhealth.gov.za Tel: 013 796 1580 Senior Clinical Manager: Dr Dhlodlo Email: bontled@mpuhealth.gov.za; dhlodhlobontle74@gmail.com Cell: 0814900104\ 013-7969408(Work) Intern Curator: Dr Musampa Email: jimousca@yahoo.fr
Mapulaneng Hospital	2	Private Bag X 9305 **BUSHBUCKRIDGE** 1280	Acting CEO: Ms Makhura R.R Email: RosinaM@mpuhealth.gov.za Tel: 013 799 0214 Cell: 082 336 1472 Clinical Manager: Dr A Maebela Email: karaboeggs@gmail.com Tel: 013 799 0214 Cell: 071 599 9785 Intern Curator: Dr M.G Zondi Email: mgzondi02@gmail.com

			Tel: 013 799 0214 Cell: 0786395966

NORTHERN CAPE

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
The Head of Health Department of Health	96	Private Bag X 5049 **KIMBERLEY** 8300	Provincial Coordinator: Ms Z Kowarjee zkowarjee@ncpg.gov.za Tel: 053 802 2147
Robert Mangaliso Sobukwe/Prof Z K Mathews/Galeshewe Day/West End/ training complex	96	Private Bag X 5021 **KIMBERLEY** 8300	Acting CEO: Dr A Kantani Email: Akantani@ncpg.gov.za Tel: 053 802 2124 Clinical Manager: Dr S Joubert Email: sjoubert@ncpg.gov.za Tel: 082 899 2629 / 053 802 2147 Intern Curator: Dr Maireen Kemp Email: maijke@gmail.com Tel: 053 802 2147 Cell: 082 899 2692 Intern Curator: Dr A. Nair Email: arunamoi@gmail.com Tel: 053 802 2311 Cell: 072 988 3872

NORTHWEST

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Northwest Head office The Chief Director for Health Service Delivery Department of Health and Social Welfare Northwest	391	Private Bag X 2068 **MMABATHO** 8618	Provincial Coordinator: Dr S Abizu Email: dr.abizu@gmail.com Cell: 072 252 9675
Mafikeng: Thusong/GDLR: Gelukspan: Lehurutshe/Zeerust	64	Private Bag X2031 **MAFIKENG** 8670	CEO: Ms Nonzaliseko Mendela Email: ikotsedi@nwpg.gov.za Tel: 081 006 3222 Clinical Manager: Dr Maliso Norman Mabote Email: mabote22@gmail.com Cell: 082 633 1798 Tel: 018 383 6404 Intern Curator: Dr Gladstone Ramodimo Masupye Email: drmasupye@gmail.com Cell: 072 771 5296
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
	95	Private BagX 82079	CEO: Ms G Tlhapi

Job Shimankana Tabane Provincial Hospital		**RUSTERNBURG** 0300	Email: GTlhapi@nwpg.gov.za Tel: 067 3867510 Clinical Managers: Dr GM Maesela Email: GMaesela@nwpg.gov.za Tel: 081 858 3578 Dr V V Simmons Email: VSimmons@nwpg.gov.za Tel: 072 4314287 Intern Curators: Dr T Phakoane Email: phakoane@yahoo.com Tel: 072 580 4029 Dr C Gofhamodimo Email: ckgofha@gmail.com Tel: 082 4446429
Klerksdorp/Tshepong/Nic Bodenstein Hospital/ Matlosana Training Centre	128	Private Bag X14 **KLERKSDORP** 2570	CEO: Dr T Madonsela Email: thulanemadonsela@nwpg.gov.za Tel: 083 378 1201 (Medical Managers) Dr Mpho Dikhing-Mahole (Senior Clinical Manager): Email: MDikhing@nwpg.gov.za Cell: 082 566 1146 Dr David Leburu – Clinical Manager) Email: dleburu@nwpg.gov.za Cell: 067 789 2539

			Dr Israel Mahume (Klerksdorp-Tshepong) 082 224 5188 Dr Isaac Wana (Witrand) 060 504 3369 Dr Mphela (Nic Bodenstein) 076 411 191 Intern Curators Dr Chitta R Das Email: CDas@nwpg.gov.za Cell: 072 993 4565 Dr E Knipe Email: epinkeste@gmail.com Cell: 071 107 7220 Dr S Pillay Email: Shivani.pillay86@gmail.com Cell: 084 581 7665 Dr Tshepho Bodiba Cell: 076 941 1258 & 072 993 4565 Email: tbodiba@gmail.com
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Potchefstroom/Witrand/ J B Marias Training Complex	80	Private Bag X938 **POTCHEFSTROOM** 2520	Acting CEO: Dr Michael M Shakung Email: mshakung@nwpg.gov.za; mshakung@gmail.com Tel: 082 391 0706 Clinical Manager: Dr Dirisa Semakula Email: semakula789@gmail.com; dsemakula@nwpg.gov.za Tel: 078 032 8976

			Intern Curator: Dr JP Lubinda Kasanda Cell number: 072 951 1599 /~~07630944061~~ 063 544 1927 Email: lubindakasanda@yahoo.co.uk
Joe Morolong Memorial/Taung hospital Complex	24	Private Bag X4 **VRYBURG** 8600	CEO: Ms AP Tlou Email address: ATlou@nwpg.gov.za Cell: 082 534 6689 PA: J.Khwele@nwpg.gov.za Tel: 053-928 9100 Acting Clinical Manager/ Intern Curator: Dr JJ Fourie Email: jfourie@nwpg.gov.za Tel: 053 928 9064 Cell: 081 021 0350 Intern Curator: Dr O Olu-Taiwo Email: drlilianolutaiwo@gmail.com Cell: 078 422 9308

WESTERN CAPE

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Head Office The Head of Health Department of Health Provincial Administrative of Western Cape	798	P O Box 2060 **CAPE TOWN** 8000	Provincial coordinator: Ms Carol Dean Email: Carol.dean@westerncape.gov.za Tel: 021 918 1565 As from June 2021 Provincial coordinator: Appointment to be confirmed. In the interim: Andre Luck: Deputy Director: People Development Email: Andre.Luck@westerncape.gov.za Tel: 021 483 2662 /+27 64 684 2190
Groote Schuur/ Red Cross War Memorial	206	Private Bag **OBESERVATORY** 7925	CEO: Dr B Patel Email: Bhavna.Patel@westerncape.gov.za Tel: 021 404 3178 Clinical Manager: Dr Sadia Murray Email: sadia.murray@westerncape.gov.za Tel: 021 404 4469 Intern Curator: Prof Mark Sonderup Email: mark.sonderup@uct.ac.za Contact person Ms Nadine Ross 0214046241
Tygerberg Hospital Training Complex	168	Private Bag X3 **TYGERBERG**	CEO: Dr Matodzi Mukosi Email: Matodzi.Mukosi@westerncape.gov.za

		7505	Cell: 083 959 5599 Tel: 021 938 4136 Clinical Manager: Dr P. Ciapparelli Email: paul.ciapparelli@westerncape.gov.za Cell: 0837537459 Tel: 021 938 4325 Intern Curator: Dr Roshni Mistry Cell: 083 414 8246 Email: Roshni.Mistry@westerncape.gov.za Tel: 0219386267
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**NAME OF CENTRE**
New Somerset Hospital	49	Private Bag **GREEN POINT** 8051	Chief Medical Superintendent: Dr D Stoke Email: Donna.Stokes@westerncape.gov.za Tel: 021 402 6911 Fax 021 402 6000 Clinical Manager: Dr Jacques Hendricks Email: Jacques.Hendricks@westerncape.gov.za Tel 021 402 6479 Cell 082 7730 978 Intern Curator: Dr Margit Mihalik (on maternity until May 2024) Email: margit.mihalik@hotmail.com Tel: 082 559 6079 / 021 402 6485 Dr Iman Petersen, has been appointed as an Intern Curator until May 2024 Dr Petersen's contact details:

			Email: Imanpza@gmail.com
Khayelitsha Hospital	40	c/o Steve Biko and Walter Sisulu Drives Private Bag X6 **KHAYELITSHA** 7784	CEO: Dr David Binza Email: David.Binza@westerncape.gov.za Tel: 021 360 4520/4490 Clinical Manager: Dr K Moodley Email: Kitesh.Moodley@westerncape.gov.za Tel: 0213604500 Intern Curator: Dr Moses Witbooi Email: moses.witbooi2@westerncape.gov.za Tel: 021 360 4384
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**NAME OF CENTRE**
Mitchells Plain Hospital	52	Private Bag X9 **MITCHELLS PLAIN** 7789	CEO: Mr Evan Swart Email: evan.swart@westerncape.gov.za Tel: 082 767 2315 Clinical Manager: Dr Jacek Marszalek Email: jacek.marszalek@westerncape.gov.za Cell number: 072 830 8585 Tel: 021 377 4779 Intern Curator: Dr Zunique George Email: Zunique.George@westerncape.gov.za Tel: 072 164 3937
	60	Private Bag X2	CEO: Mr Jonathan Vaughan

Victoria Hospital - Southern/Western Sub structure		**PLUMSTEAD** 7801	CEO: Mr Jonathan Vaughan Email: Jonathan.Vaughan@westerncape.gov.za Tel: 021 799 1234 Clinical Manager: Dr Graeme Dunbar Email: Graeme.Dunbar@westerncape.gov.za Tel: 0217991183 Acting Intern Curator: Graeme Dunbar Email: Graeme.Dunbar@westerncape.gov.za Tel: 021 799 1211 Dr Katy Murie, Family Medicine Intern Curator, SW Substructure Email address: Katie.Murie@westerncape.gov.za
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
SAMHS: Western Cape Medical Command: No 2 Military Hospital	16	Private Bag X4 **WYNBERG** 7800	Acting CEO: Lt Col Riaz Ismail SO1 Force Preparation 2 Military Hospital 021 799 6120 Cell number is 0824499200
			Intern Curator: Matolweni LO Email: luzukoo@yahoo.com Tel: 021 799 6118 Cell: 083 438 8841 Assistant Intern Curator Dr Parker L

			Tell: 021 799 6396 Cell: 082 414 5455 Capdoc.2mil@gmail.com
Karl Bremer/Tygerberg/Kraaifontein Hospital	36	Private Bag X1 **KARL BREMER** 7531	CEO: Dr Jonathan Lucas Email: Jonathan.Lucas2@westerncape.gov.za Tel: 021 918 1911 Dr Barry Smith – Medical Manager Email: Barry.Smith@westerncape.gov.za Intern Curator: Dr M Wates Email: matk.wates@westerncape.gov.za
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Paarl Hospital	56	Private Bag X3012 **PAARL** 7620	CEO: Mr Francois Van der Watt Email: Francois.vanderwatt@westerncape.gov.za Tel: 021 860 2508 Clinical Manager: Dr Stephanus Fourie Email: stephanus.fourie@westerncape.gov.za Tel: 021860 2865 Fax: 021 872 4841
Helderberg Hospital	28	Private Bag X2 **SOMERSET WEST** 7130	CEO: Mrs Sharon Leo Email: Sharon.leo@westerncape.gov.za Tel: 021 850 4704 Clinical Manager: Dr Werner Viljoen

			Email: wernerviljoen@telkomsa.net Tel: 0218504763 Intern Curator: Dr Marina Klocke Email: marina.klocke@westerncape.gov.za
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
George hospital and Garden Route	51	Private Bag X6534 **GEORGE** 6530	CEO: Dr M Vonk Email: Michael.Vonk@westerncape.gov.za Tel: 044 802 4533 / Cell no. 0799763833 Manager: Medical Manager: Dr Tian Koen Email: tian.koen@westerncape.gov.za Tel: 044 802 4535 / Cell no. 0845049448 Intern Curator: Dr Chanel Changfoot Cell: 084 303 2509 Email: chanel.changfoot@westerncape.gov.za
Worcester hospital and Breede Valley Sub-district	36		Acting CEO: Ms Sorina Jafha Email: Sorina.Jaftha@westerncape.gov.za Tel: 023 348 1113 Intern Curator: Dr Marlize Kunneke Email: Marlize.Kunneke@westerncape.gov.za Tel: 023 348 1218 Intern Curator: Dr Chris Verster Email: Chris.Verster@westerncape.gov.za Tel: 023 348 6475

EASTERN CAPE

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Department for Health and Welfare Eastern Cape Province	534	Private Bag X0038 **BISHO** 5608	Provincial Coordinator: Mrs N Kweleta Email:Noludumo.Kweleta@echealth.gov.za; noludumokweleta12@gmail.com Tel: 040 608 0826
Port Elizabeth Hospital Complex (including Livingstone/Dora Nginza)	208	Livingstone/Dora Nginza Hospital Complex Private bag **KORSTEN** 6014	CEO: Dr M Xhamlashe Email: mxhamlashe@gmail.com Tel: 041 405 2275 Cell: 083 378 2211 Medical Manager: Dr A C Rossouw Email: stacy.rossouw@gmail.com Tel: 041 405 2100/2101 Cell: 071 444 1151 Intern Curator: Dr J Black Email: docjohnblack@gmail.com Tel: 041 406 4284 Cell: 083 378 0911
Port Elizabeth Provincial Hospital		Private Bag X 0003 **PORT ELIZABETH** 6000	CEO: Dr T Madonsela Email: thulane.madonsela@echealth.gov.za Tel: 041 405 2275 Fax: 041 405 2186

			Clinical Manager: Robyn May Email: Robyn.May@echealth.gov.za
NAME OF CENTRE	**NUMBER OF ACCREDITED INTERN POST**	**POSTAL ADDRESS**	**CONTACT DETAILS**
Uitenhage Provincial Hospital	30	Private Bag X 36 **UITENHAGE** 6630	CEO: Ms Klassen Email: Marilyn.klassen@echealth.gov.za Tel: 041 995 1130 Fax: 041 966 1413 Clinical Manager: Dr G B Walsh Email: walshgladwin@yahoo.com Tel: 041 995 1130 Intern Curator: Dr F Zietsman Email: froncois481014@gmail.com Tel: 041 995 1356
East London Hospital Complex Cecilia Makiwane Hospital	184	Private Bag X 13003 **CAMBRIDGE** 5207	Acting CEO - Email: cmhceo6@gmail.com Tel: 043 708 2372/2300 Intern Curator: Dr A Mahlunge Email: ashleymahluge@yahoo.com Tel: 043 708 2169/2130 Senior Manager: Medical Services - Dr Yose-Xasa Tel: 043 708 2132/2300 Email: bongiwe.yose-xasa@echealth.co.za

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Frere Hospital		Private Hospital **EAST LONDON** 5200	Acting CEO: Dr James Thomas Email: james.thomas@echealth.gov.za Tel: 043 709 2360 Acting Clinical Manager: Mrs Joy Scholl Email: Joy.scholl@echealth.gov.za Tel: 043 709 2135 Intern Curator: Dr Dulgies Fleitas Rivero-Narkebien Email: dfrivero14@gmail.com Tel: 0828221579
Mthatha Academic Hospital Complex (Nelson Mandela Academic)	112	Private Bag X 5014 **MTHATHA** 5100	CEO: Dr V Mankahla Email: mankahla@gmail.com Tel: 083 654 7566 Clinical Manager: Dr Mpumzi Mdledle Email: mpumzilemdledle@gmail.com Tel: 060 557 9695 Intern Curator: Dr P Nxiweni Email: puts.nxiweni@gmail.com Tel: 066 303 9174 Intern Curator: Prof P Yogeswaran Email: yogip3@gmail.com Tel: 083 378 0798

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Nelson Mandela Academic Hospital		Private Bag X5152 **UMTATA** 5100	CEO: Mrs Makwedini Email: Langashappy@gmail.com Tel: 083 378 0141 Clinical Manager: Dr T Madiba Email: Madiba.mbuyiswelo@gmail.com Tel: 083 303 2592 Intern Curator: Dr P Z Nxiweni Email: puts.nxiweni@gmail.com Tel: 0663039174

FREE STATE

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Head Office The Head of Health	285	Department of Health and Welfare P O Box 517 **BLOMFONTEIN** 9300	Provincial Co-ordinator: Dr E Reji Email: e_reji@outlook.com Tel: 051 408 1164/ 051 408 1814 Cell number: 0712662676
Pelonomi Complex /Bloemfontein Academic Hospital Complex	144	National Hospital Private Bag X20598 **BLOEMFONTEIN** 9300	CEO: Mrs Ramodula Email: Ramodulabs@fshealth.gov.za Tel: 051 403 9601 Clinical Manager: Dr Malek Email: Malekm@fshealth.gov.za Tel: 051 403 962
Pelonomi Hospital		Private Bag X20581 **BLOMFONTEIN** 9300	CEO: Mr B Ramadula Email: ramadulabs@fshealth.gov.za Tel: 051 405 1929/28 Clinical Manager: Dr R Bnganga Email: bengangaba@fshealth.gov.za Tel: 051 405 1936/42 Intern Curator: Dr G P Matshediso Email: MatshediGP@fshealth.gov.za Tel: 051 405 1936

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Universities Hospital		Private Bag X20598 **BLOEMFONTEIN** 9300	Acting: CEO: Dr Rita Nathan Email: nathanr@universitas.fs.gov.za Tel: 051 405 3868 Acting Clinical Manager: Dr B A Benganja Email: BenganjaBA@universitas.fs.gov.za Tel: 051 405 3868
SAMHS: Free tate Medical Command		Private BagX 40003 **TEMPE** 9318	CEO: Colonel W C Hendricks Tel: 051 402 2202 Clinical Manager: Dr L C Fosa Email: drfosa1967@gmail.com Tel: 051 402 2205 Intern Curator: Dr L C Fosa
Bongani/Thusanang Primary Health Care centre	35	Private Bag X29 **WELKOM** 9460	CEO:Ms S Noge Email: noges@fshealth.gov.za; nogesesi@gmail.com Tel: 057 916 8004/1/5 Cell: 066 471 4423 Clinical Manager: Dr R L Mkatsane Tel: 057 916 8001 Cell: 076 044 3020 Email: MkatsaneRL@fshealth.gov.za

NAME OF CENTRE	NUMBER OF ACCREDITED INTERN POST	POSTAL ADDRESS	CONTACT DETAILS
Boitumelo Regional Hospital	34	Private Bag X47 **KROONSTAD** 9500	CEO: Me B Mtimkulu Email: mtimkuluds@fshealth.gov.za Tel: 056 216 5380 Cell: 072 201 9187 Clinical Manager: Dr K Mahasa Email: mahaskm@fshealth.gov.za Cell: 082 211 6379
Dihlabeng Hospital	40	Private Bag X3 **BETHLEHEM** 9700	CEO: Mr T E Makume Email: makumet@fshealth.gov.za Tel: 058 303 5331 Cell: 066 476 0680 Clinical Manager: Dr WJ Selfridge Email: selfridgeWJ@fshealth.gov.za Tel: 058 303 5331 Cell: 083 962 8447 Intern Curator: Dr SJ Kearns Email: kearnsira@gmail.com Cell: 083 630 2076
Mofumahadi Manapo Mopeli Regional Elizabeth Ross Hospital Complex	32	Private Bag X820 **WITSIESHOEK** 9870	CEO/Medical Manager: Mr FC Moloi Email: Clinical Manage: Dr J S Moloi Email: drsjmoloi@gmail.com

			Cell: 082 779 2992 or 072 9999 608 Intern Curator: Dr LV Torriente

ANNEXURE L

1 INTRODUCTION OF THE TWO YEARS OF INTERNSHIP TRAINING

. INTRODUCTION

Over the last 10 years, the Medical and Dental Professions Board has introduced the two-year internship programme. This document contains some background information on this process and the outcome thereof, specifically with reference to internship training.

2. FIRST PROPOSALS FOR A REVIEW OF THE SYSTEM OF INTERNSHIP TRAINING

Internship training in medicine was first introduced in South Africa during the 1950's. At that stage, the then students in medicine, felt that the introduction of internship training was resulting in adverse effects on their professional lives. However, internship training was nevertheless introduced, and the then South African Medical and Dental Council took responsibility for conducting and overseeing that programme. Today nobody argues about the need for internship training.

During the early 1990's growing concerns were, however, raised by various disciplines, especially Anaesthesiology and Orthopaedics, about the effectiveness of the system of internship training, especially in those disciplines. Serious questions were also asked about whether or not the original goals of internship training were being achieved, namely, to assist young graduates to obtain hands-on experience under supervision in "approved" hospitals as clinical preparation for entering medical practice. Questions were asked as to whether internship training was not merely a replica of the year of student-internship with interns being mainly used as work-units and additional hands to perform very minor duties that could easily be performed by much lesser qualified persons.

Furthermore, the nature of the rotations through the different disciplines, were severely questioned as these were regarded to result in inadequate exposure of interns to the practice of medicine in the main and most relevant disciplines. Interns could, for example, spend six months each in Medicine and Surgery with no exposure to Paediatrics and Obstetrics and Gynaecology that would probably make up 80 % or more of their practice as general practitioners.

Discussions on a review of the curriculum in medicine and subsequent internship training were ongoing in the Medical and Dental Education Committee of the time. Special impetus in this regard resulted from a *Memorandum on Internship Training: A Case for a Re-Look* that was submitted in November 1993 by Prof A F Malan, member of the then Internship Committee and a present Inspector of Internship Training.

The Medical and Dental Education Committee agreed to a review and the following aspects, amongst others, would serve as guidelines for the proposed investigation into internship training, namely –

a. to re-assess the original aims and objectives of the years of student internship and internship training;
b. to determine whether the original aims and objectives were being met and whether or not the year of student internship and internship training supplement or duplicate each other;
c. to determine specifically what the educational components of internship training should be, whether these objectives were being met in practice and whether or not interns were being regarded and treated as merely service deliverers or as trainee medical practitioners;
d. to assess the existing policies, criteria and procedures for the certification and re-certification of hospitals for internship training (since referred to as accreditation);
e. to investigate the existing conditions of employment and the working conditions pertaining to interns;
f. on the basis of the above, and in view of the policy of community service rendering, to investigate the need, or not, for a second year of compulsory internship.

Although the then Internship Committee made some progress towards undertaking the proposed research, various administrative problems prevented finalisation of that project. Despite this fact, the Medical and Dental Education Committee and subsequently also the Technical Group on the New System of Registration and Vocational Training in Medicine, continued to look at medical education which they regarded to be an ongoing process of life-long learning which would in future be based on four major pillars.

Firstly, it would commence with undergraduate education and training which it recommended should be fully restructured to extend over a minimum period of five years. That curriculum would differ considerably from the previous model and would mainly be integrated, student-centred, problem-based with a focus on self-directed learning and community-based outcomes. The degree in medicine should be awarded after successfully passing the fifth year of study.

Secondly, it was recommended that internship should indeed be expanded by adding two additional years of what was then referred to as “vocational training”. That proposal was subsequently rescinded and replaced by a resolution to introduce a two-year period of internship training with a better structured programme of rotations which would ensure exposure of interns to the main disciplines, later referred to as domains. The expression “domain” was used in order to distinguish between disciplines for speciality education and training and domains as a broader and more general concept for the purpose of internship training. The domain of Surgery could, therefore, include the different “cutting” disciplines and not only General Surgery.

It was the view of the said bodies that the year of student-internship should be replaced by the first year of postgraduate internship training, while the present year of internship training would become the second year of such training.

Thirdly, life-long education and training could proceed via preparation for practicing as a family physician or as a specialist and even a subspecialist in medicine.

The fourth leg of ongoing education and training would be what has since become known as the system of continuing professional development (CPD).

3. PROPOSAL TO INTRODUCE A PERIOD OF VOCATIONAL TRAINING

As referred to in the preceding paragraph, part of the consideration for a review of the period of internship training, was the proposal to introduce a period of vocational training which, together with internship training, would extend over three years. The Technical Group to which reference was made previously, conducted extensive consultations with a wide variety of stakeholders during the period 1996/1997. For this purpose, the Chairperson of that Group, Prof C J C Nel, together with other members, visited major centres such as Pretoria, Bloemfontein, Cape Town and Durban. Discussions were held with representatives of student bodies and Faculties of Medicine of each of the relevant teaching institutions. In fact, during that period, it was realised that a more permanent relationship should be established between the then Medical Education and Registration Committee, subsequently referred to as the Committee, and the Junior Doctors Association of South Africa. JUDASA has since, until the present, enjoyed full membership of the said Committee and thus, via its representative, has indeed participated in the further development of the proposals pertaining to internship training.

Apart from having heard oral submissions, the Technical Group also received a large volume of written comments from stakeholders, again including individual students and parents of students, amongst others.

Based upon all of its deliberations, as well as the verbal and written comments received, the Technical Group on the New System of Registration and Postgraduate Vocational Training in Medicine, submitted its full report to the then Interim National Medical and Dental Council of South Africa in October 1997. At that occasion, the Interim Council resolved that –

a. the minimum period of undergraduate education and training in medicine be reduced from six to five years;
b. a two-year period of vocational training be introduced to replace the year of student-internship and internship training (that terminology was subsequently revised to again refer to internship training which should extend over two years);
c. the total period of undergraduate education and training in medicine should not exceed eight (8) years.

The draft Regulations to provide for various aspects of the new system of registration, including the minimum five-year undergraduate curriculum and the two-year period of internship training were, in fact, agreed to by the Interim Council in March 1998 and thereafter submitted to the Department of Health for approval and promulgation.

Those Regulations were subsequently published in the Government Gazette for general comments, again allowing for consultation and input to be made. Little if any comments on the proposed extended period of internship training were received at that stage.

During later meetings between the Department of Health, Faculties/Schools of Medicine and this Board it came to light that not all Faculties/Schools would introduce a five-year programme, while one University decided to introduce the curriculum in Medicine as a graduate programme based on an initial undergraduate course such as a general BSc degree. Notwithstanding these differences, it was eventually agreed that two years of internship training were required, irrespective of the duration of the academic course for a qualification in medicine.

4. REASONS FOR INTRODUCING A TWO-YEAR PERIOD OF INTERNSHIP TRAINING

Earlier on in this document reference was made to the fact that various disciplines and individuals, such as Prof A F Malan, some twenty years ago, raised particular concerns about the inadequacies of internship training as it was then structured and implemented. It was agreed that the rapid developments in medicine and the limited exposure of interns to the broad spectrum of major domains in practice, highlighted the need for a complete revision of the current system.

This view was supported by the fact that during the inspection process for accreditation of training facilities, it had become abundantly clear that in many instances the training of interns was of a sub-optimal standard.

Since then, the Subcommittee for Internship Training, again reviewed the implementation of the original proposals for the rotations during the two-year period of training. Obviously, the demands for exposure to the different domains are such that even two years of internship training would be inadequate to comply with those demands. For example, the major domains such as Medicine held the view that exposure should be for at least six months in order to be of proper value to the individual's professional development. Furthermore, it was said that limited exposure to Anaesthesiology of even two months, instead of the present two weeks, would be dangerous in that it might create the impression or illusion that the intern was thereafter ready at the end of that period to successfully practice that discipline, which of course, is not the case.

Over the years the Internship Subcommittee continued to adapt the programme to its present format. For example, the domain of Mental Health was initially incorporated within the domain of Family Medicine. This was because there was concern that adequate supervision may not be available in all accredited facilities in psychiatry. However, a separate domain of psychiatry for a period of one month was introduced subsequently when the college of psychiatrists motivated for the same and ensured of adequate supervision in that domain in all the accredited facilities.

6. REVIEW OF THE TWO YEARS INTERNSHIP IN THE LAST 10 YEARS

Guidelines on the nature and content of the exposure of interns during the rotations are specified in detail in Part II of this Handbook.

This *Handbook* and a complete review of the system of accreditation of facilities for internship training have resulted from those initial proposals to improve the system in order to better equip young graduates for their careers in medicine and to provide competent and appropriate health care to patients.

The Board is fully aware of the fact that many aspects of internship training still need to be improved. Not all of these aspects such as staff shortages can be resolved easily. Nevertheless, considerable progress was made, and the Board and its Committee will continue to work for a system which will serve medicine and health care in South Africa in the best possible manner. It is for this reason that the two years internship should be formally be reviewed. The results of the review can be used to further adapt the programme to ensure that it continue to address the healthcare need for our population.

PRETORIA

DATE: October 2018

ANNEXURE M

MEDICAL AND DENTAL PROFESSIONS BOARD

CRITERIA FOR THE APPOINTMENT OF EVALUATORS OF INTERNSHIP TRAINING

BACKGROUND INFORMATION PERTAINING TO INTERNSHIP TRAINING

1. VISION OF INTERNSHIP TRAINING AND ACCREDITATION OF SUCH TRAINING

The main objective of internship training is to provide practitioners holding registration as an intern in medicine with opportunities to further develop their competence by providing them with knowledge, skills, appropriate behaviour patterns and professional thinking, and to gain insight, understanding and experience in patient care to equip them to function as safe and independent general practitioners. Training, therefore, shall be comprehensive, address shortcomings of the current system and provide for and be complementary to the future health care system presently being developed for South Africa. The primary health care approach shall play a significant role during the period of internship training.

The primary health care approach is a developmental approach that emphasises community participation and empowerment, inter-sectoral collaboration and cost-effective care, as well as the integration of preventive, promotive, curative and rehabilitative services. The primary health care approach does not, therefore, define a level of care, but is more appropriately to be viewed as a philosophy of the promotion of health and the provision of health care at all levels of service.

Against this background, internship training shall be a properly planned and an ongoing process; be offered as an integrated system; and be undergone only at facilities and complexes accredited by the Board. Facilities and supervisors of training shall be subject to regular accreditation visits or inspections and adherence to the prescribed criteria.

The Regulations relating to the registration and training of interns in medicine (No. R992 of Act No. 56 of 1974) stipulates that internship training commencing after 30 June 2006 shall be of not less than twenty four months' duration, and, where it is broken or interrupted, it shall consist of periods which, when added together, are not less than twenty four months in total, including vacation leave not exceeding one month's duration per annum and sick leave not exceeding two months' duration and shall comply with criteria laid down by the Board from time to time.

Internship Training shall commence not later than one year from the date of fulfilment of the requirements of the degree in medicine.

The period of twenty-four months of internship training shall be completed within a period of three years from the date of having been registered in terms of section 17 of the Act as an intern in medicine.

Accreditation for internship training, therefore, is the process whereby the Board, on the basis of specified criteria, evaluates and assesses facilities and complexes as being appropriate in terms of training teams, ethos, as well as physical structures and resources to provide such training and, if found to comply or provisionally comply, accredits them for internship training.

Accreditation of facilities for the purpose of internship training shall be the sole responsibility of the Board and it shall be the Board's prerogative to grant or not to grant, or provisionally to grant accredited status to any facility or, should circumstances require, to withdraw such status.

Regular visits/evaluations by the Board to accredited facilities will be arranged to ensure that the accredited facility is adequately fulfilling its training function and, if not, such status may be withdrawn.

Visits/evaluations at accredited facilities are carried out by Evaluators of Internship Training appointed by the Board for this purpose. Liaison between the Evaluators and Provincial Co-ordinators of Internship Training, appointed by the Provincial Health Authorities, will aid the planning, conducting, as well as an appreciation of the importance of such visits/evaluations.

For this purpose, Medical Superintendents/CEO's/Hospital Managers are required to provide the Board with detailed information on the prescribed forms during a visit/evaluation. This information must be the result of a self-analysis in terms of the Criteria of Accreditation of Facilities (as contained in the Guidelines for Internship Training). This information is essential and forms the basis for the assessment of a facility by the Evaluators of Internship Training.

The purpose of an evaluation is to ascertain that interns in medicine are receiving proper training as specified in the Guidelines for Internship Training.

Evaluators of Internship Training are urged to keep in contact with the Medical Superintendent/CEO/Medical Manager and Intern Curator. They will appreciate your interest and it will assist in ensuring that necessary improvements are brought about.

2. MAJOR PARTNERS IN IMPLEMENTATION

In order to achieve the above objectives in the best interest of interns, the Medical and Dental Professions Board, the employing Health Authorities and the Faculties/Schools of Medicine/Health Sciences all have an important role to play.

The Board, in terms of its statutory function, must protect the interests of the public by establishing and maintaining standards of education, training, practice, conduct and behaviour.

The Health Authorities as responsible employers have a duty to ensure that the interns in medicine receive appropriate in-service training in order to help to continually improve the standard of service to the public.

Faculties/Schools of Medicine/Health Sciences must provide broadly based support to assist the Board and employing Health Authorities to develop and maintain appropriate and professionally sufficient training programmes, to assist in the training of supervisors and to be accessible as sources of professional knowledge, consultation and advice.

3. EMPHASIS OF ACCREDITATION

FOCUS ON SUPERVISORS

Internship training is intended to train medical graduates to practise as competent and safe general practitioners. Accreditation for such training shall primarily be directed at assessing the existence within facilities of a culture and atmosphere of "training and learning", a caring ethos and competent patient care. The quality of the training team is of prime importance.

TEAM APPROACH WITH TRAINING

Internship training for medicine is a professional matter and training, therefore, is the responsibility of adequately qualified, experienced and competent medical practitioners. However, assessment for accreditation requires an acknowledgement of the need for and nature of a multi-disciplinary team approach in the rendering of high-quality patient care. Assessment, therefore, shall evaluate the quality of such team work and the opportunities which it offers for multi-professional interchange in training.

TRAINING COMPLEXES

Many facilities will be accredited by the Board as parts of complexes and not in isolation. Members of the training team may be based at different facilities within each complex. The relevant trainer would, however, retain overall responsibility, whether stationed elsewhere or not.

COMPREHENSIVE NATURE OF ACCREDITATION

Against this background, the assessment leading to accreditation for internship training shall be comprehensive. It will include an ongoing self-analysis by the applying facility, information gathering and the assessment of professional, personal and human attributes, qualities and attitudes, essential physical structures, equipment and resources. Organisational and administrative processes and functioning, in combination with the above, create the environment and atmosphere, or lack thereof, in which the particular facility's culture of "training and learning" shall be assessed and monitored.

4. TRAINING SITES

Internship training shall take place in the health care and administrative structure established by employing Health Authorities. The health care facilities accredited for this purpose will function at and provide for different levels of patient care.

EMPLOYING HEALTH AUTHORITY

An "employing Health Authority" refers to a public health authority at national, provincial or local level of government and includes organisations which function under its auspices or are largely subsidised by it to provide teaching, training or patient care services.

ACCREDITED FACILITIES

An "accredited facility" refers to a health care facility of any employing Health Authority which, upon application by the Health Authority to the Board to be accredited for the purpose of internship as prescribed, had been inspected and was found by the Board to comply or provisionally comply with the criteria for accreditation.

LEVELS OF HEALTH CARE

Health care facilities in South Africa and the nature of patient care which they provide, may be classified as follows (see Annexure I for further details):

Central (Level III) Facilities

These facilities will receive referrals from and will provide specialist and subspecialist support to a number of regional facilities. Most of the health care services which they provide will be Level III care, which requires the expertise of clinicians working in recognised specialities and subspecialities (as specified in the Regulations relating to the Specialities and Subspecialities in Medicine and Dentistry).

Regional (Level II) Facilities

These facilities will normally receive referrals from and provide specialist support to a number of district facilities. Most of the health care which they provide will be Level II care, which requires the expertise of specialist-led teams. Most regional facilities, however, will also provide some Level I health care services.

District (Level I) Facilities

These facilities will normally receive referrals from and provide support by general practitioners to community health centres and clinics. Most of the health care which they provide will be Level I care, delivered by general practitioners, medical officers or primary health care nurses in the absence of a specialist, but may have the services of a practitioner registered as Family Medicine. Services will include polyclinics, casualty services, general wards, and maternity units.

Specialised Facilities

These facilities will provide care only for certain specified groups of patients. They will include psychiatric and TB facilities, as well as specialised spinal injury and acute infectious disease facilities.

5. CRITERIA FOR ACCREDITATION OF FACILITIES AND COMPLEXES

Details on the following aspects are to be obtained and assessed:

PHYSICAL STRUCTURES

a. Nature of the overall and specific environment.
b. Overall appearance and state of repair.
c. Accessibility to patients and staff.
d. Structural planning and organisation of amenities to provide -
    i. appropriate patient care;
    ii. appropriate diagnostic and therapeutic services;
    iii. a secure, safe and psycho-socially acceptable health care environment for patients and staff.

ACCOMMODATION

a Appropriate for in-patients and out-patients.
b. Appropriate for day-time staff on duty.
c. Accommodation, while on call, shall be available for all relevant staff (including interns), appropriate to requirements for availability on call.
d. Appropriate housing for interns should be available, as for the other staff, in relation to environmental accessibility and service requirements.
e. Appropriate provision for social amenities such as meals, refreshments, relaxation and recreation for staff on duty, on call and on site.

DIAGNOSTIC SERVICES

Access at the appropriate levels of care to diagnostic services such as -

a. radiological and imaging services;
b. pathology laboratory services;
c. side-room facilities; and equipment to be in a proper state of repair.

THERAPEUTIC SERVICES

Access at the appropriate levels of care to therapeutic services such as -

a. availability of basic equipment for the level of care provided;
b. appropriately equipped theatres;
c. appropriate drugs for the level and nature of patient care provided, as listed in the Essential Drug List (EDL) for that level of care;
d. essential consumable and disposable items;
e. availability of up-to-date therapeutic and administrative protocols and guidelines; and equipment to be in a proper state of repair.

SERVICES BY OTHER HEALTH CARE PROFESSIONS

Availability of or access to the diagnostic and therapeutic services rendered by other health care professions at the appropriate level of care required.

COMMUNICATION AND INFORMATION

Reasonable internal and external communication systems appropriate for the level of care required.

Access to essential information.

ORGANISATIONAL STRUCTURE

Details of -

a. the number, qualifications and level of experience of full-time, part-time, and honorary medical practitioners employed;
b. the nature and number of other professional staff employed;
c. the nature and number of support staff employed.

DOMAINS OF PATIENT CARE

Details of -

a. the available domains in which patient care services are rendered by the facility;
b. the number of in-patients per domain, admitted per average month;
c. the number of out-patients per domain, treated per average month;
d. the patient profile with reference to demographics, diseases and procedures dealt with.

AVAILABILITY OF APPROPRIATE SYSTEMS FOR PATIENT RECORD-KEEPING

AVAILABILITY AND APPROPRIATE USE OF HEALTH INFORMATICS

AVAILABILITY OF TRANSPORT, INCLUDING AMBULANCE SERVICES, OTHER OFFICIAL
TRANSPORT AND PUBLIC TRANSPORT

STRUCTURE AND FUNCTIONING OF THE REFERRAL SYSTEM

a. The facility's place in the referral chain.
b. The effectiveness of referrals.
c. The method and appropriateness of referrals.

INTERN WORKLOAD

Details of -

a. workload at in-patient and out-patient levels;
b. hours on duty per week;
c. overtime requirements;
d. work rosters;
e. on call duty.

TRAINING PROGRAMME

a. The appointment of an identified Curator(s) of Internship Training (who should preferably not be the Medical Superintendent of the relevant facility but may be a trainer who serves in the capacity as Curator on a part-time basis), his or her duties, responsibilities and execution thereof.
b. A clearly stated policy on internship training as it applies to the specific facility or complex which shall be in line with the Board's criteria and requirements.
c. An induction and orientation programme for young graduates.
d. A constructive and organised training programme for the following prescribed domains, the requirements of and rotation through which shall be as follows:

General provisions

In view of the fact that the emphasis of internship training shall be on training for general practice, such training shall occur in the following fashion:

a. It shall take place in general practice and at that level.
b. It shall be comprehensive in nature.
c. It shall be so planned and structured that training provides for the primary health care approach.
d. The individual's choice of domains and rotations are to be subject to the availability of training posts and a facility's capacity to train in the domain of choice.
e. No part of internship training shall also form part of the prescribed registrar education and training for specialisation.

Specific provisions

See contents of Parts I and II of this Handbook.

a. Specific training programmes are to be available for each of the prescribed domains in which training shall take place.
b. The implementation of training programmes shall -
    i. take place in consultation with relevant stakeholders, including Co-ordinators and Curators of Internship Training;
    ii. be subject to inspection by Board-appointed Inspectors of Internship Training who shall report to the Medical Education and Training Committee;
    iii. be subject to views expressed and recommendations made by Medical Superintendents, trainers and interns who will specifically be asked to assist in the process of assessing the implementation of these training programmes.
c. Guidelines for training programmes shall be provided by the Board to assist in planning, implementation and assessment of such programmes (see Part II of this Handbook).
d. Training programmes shall continually be subject to revision and adjustments in view of experience gained, new developments and requirements in practice.

ASSESSMENT OF COMPETENCE

a. Assessment of the professional competence of trainees to practise medicine independently, is a matter which rests with the Board. Thus, provision is to be available for a system of progressive competency evaluation at the end of each period of rotation through every domain (Logbook for Internship Training).
b. The specific provisions for and details of competence assessment are to be assessed in terms of the Board's criteria and guidelines. Competence assessment shall be at the level of a general practitioner; practice orientated; as objective as possible; measurable; and structured to assess professional knowledge, skills, competence, professional thinking and attitudes (including ethics).
c. The linkage of the Curator(s) of Internship Training at accredited facilities to the Faculty/School of Medicine/Health Sciences in its area of responsibility is to be assessed.
d. The provisions for dealing with any intern who proves to be insufficiently competent in any of the domains assessed, need to be specified in writing. These provisions need to be assessed.

CONFIDENTIAL COUNSELLING SERVICE

a. A confidential counselling service at each facility or complex of facilities should be available.
b. Assessment of such provision in terms of services provided, availability and effectiveness.

AVENUES FOR REDRESS

a. Specific provisions are to be available for dealing with any problems or complaints which interns may experience or have pertaining to the nature, contents or quality of the training programme.
b. Interns should have the possibility of directing unresolved issues to the Medical Education and Training Committee.

6. SPECIFIC CRITERIA TO BE CONSIDERED WITH THE APPOINTMENT OF EVALUATORS FOR INTERNSHIP TRAINING

Definitions

"Act" means the Health Professions Act, 1974 (Act No 56 of 1974)
"Committee" means the Medical Education and Training Committee

Invitation

The Registrar/CEO must invite applications from all stakeholders of internship training. The Registrar/CEO must state, in the invitation, the period within which applications must be made.

Application for Appointment

a. A person wishing to become an Evaluator of Internship Training should indicate his/her commitment to act as an Evaluator of Internship Training as well as to the business of the Medical Education and Training Committee.
b. A person wishing to become an Evaluator of Internship Training should apply to the Medical Education and Training Committee for appointment.
c. Applications should be accompanied by a curriculum vitae as well as proof of registration.

Qualifications

The Medical Education and Training Committee should consider applications received from registered medical practitioners who were suitably qualified, experienced and mature candidates with a minimum of ten (10) years' experience as a medical practitioner and generalist, registered in one of the domains required during internship training.

Appointments

The Medical Education and Training Committee may appoint an applicant who meets the requirements above.

Term of office

a. The term of office of evaluators for internship training would be three (3) years.
b. An Evaluator of Internship Training should not serve the Committee for more than two (2) consecutive terms.
c. The term of office might be revisited from time to time.

Composition of the pool of evaluators

a. A pool of evaluators of internship training, with a minimum of thirty (30), should be appointed.
b. The Medical Education and Training Committee should appoint a new pool of evaluators for internship training after three (3) years of which fifty (50) percent should be retained from the previous pool.
c. Suitable candidates should represent all nine Provinces, where possible.
d. Suitable candidates should represent all eight domains of training, where possible.
e. The list of Evaluators for Internship Training should make provision for institutional memory as well as for capacity building.
f. Working in private practice, should not be a deterrent for being considered as evaluators of internship training.

Schedule of evaluations

A schedule of evaluations of internship training should be kept and a roster be drafted with the allocation of evaluators in accordance with such roster.

Removal from the list of evaluators

The Medical Education and Training Committee may remove from the list of evaluators, in writing:

a. An evaluator who declined three consecutive allocations of evaluations.
b. An evaluator who failed to submit an evaluation report within two (2) weeks of the evaluation taking place without good reason.

The Committee was entitled to appoint a new evaluator in the place of the evaluator which no longer complied with the set requirements.

October 2018

ANNEXURE N

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

MISSION

The Health Professions Council of South Africa and the Professional Boards which function under its auspices, including the Medical and Dental Professions Board, protect the interests of the public through the establishment and maintenance of standards of education, training, practitioner competence and the professional conduct of relevant health professionals.

INFORMATION DOCUMENT

This document is made available to all members of the health professions upon their registration in terms of the *Health Professions Act*, 1974. The Health Professions Council of South Africa, therefore, takes this opportunity to congratulate each and every newly qualified intern and practitioner on the successful completion of his or her studies and entry into the chosen profession.

Council trusts that the information presented in this document will be of assistance and will form the basis for good communication between professionals and the Council/Professional Boards.

1.	Question: I have just paid an amount of money to the Council and am informed that this is a "registration fee". What does this mean?

Answer: The registration fee is a one-time fee only. Payment thereof confers professional status upon the intern or practitioner and, therefore, the right to practise his or her chosen profession by having his or her name entered into the official register of interns or practitioners who are members of the specific profession.

2.	Question: Are there other fees payable?

Answer: Yes, and specifically the annual fee, payment of which ensures that a practitioner remains registered on an annual basis, with the concomitant privilege of being able to pursue his or her profession legally. Other fees that are payable in certain circumstances would, for example, be the fee in respect of the registration of an additional qualification, or registration in an additional professional category, or registration as a specialist, and the like.

3.	Question: When is this annual fee payable?

Answer: Any person having to register with Council for the first time after completing his or her period of education and training and qualifying for registration in any year, will be liable to pay the said registration fee on registration plus the applicable annual fee for the "registration year" which starts on 1 April subsequent to his or her date of registration. On payment of the annual fee, a practising card will be issued which shall be valid until 31 March of the following year as proof of holding registration in the registration and professional category specified on that practicing card.

Bear in mind that the registration fee and the annual fee are two entirely unrelated and separate entities.

NB: The due date for the payment of the annual fee is 31 March.

4.	Question: How do I pay the annual fee?

Answer: The annual fees may be paid at the counter per cheque, credit card or cash. However, practitioners are strongly encouraged to arrange to have their annual fees paid by debit order or electronic means. Cheques can also be posted if so preferred. For this purpose, practitioners are provided with preprinted deposit slips with their annual fee reminder. Direct payment through the Internet may be done. Credit card payments are also acceptable, but written authorization must be given with the following details: credit card number, expiry date and CVV number (last three numbers at the back of the card). In all cases, practitioners must use their registration number as a deposit identification.

5.	Question: Once I am registered with Council and I continue payment of the annual fee, do I have any further legal obligation to Council?

Answer: Yes. The *Health Professions Act*, 1974, stipulates that every health professional who is registered in terms of the Act, has the obligation to advise Council of any change of his or her address as entered into the register. Failure to do so may lead to the removal of a practitioner's name from the register and subsequent legal and professional complications.

Please do not neglect to notify Council in writing of any change of address as registered with the Council. A physical and postal address must be registered.

It is of vital importance to have a reliable database of available human resources in the health professions. Such statistics are indispensable for strategic planning of health care at the national, provincial and local levels. For these reasons there rests a legal obligation upon practitioners to furnish information in this regard to Council upon request. The information asked for is very basic and relates to the practitioner's work environment and the type of practising engaged in.

Your co-operation in furnishing information for statistical purposes when requested annually by Council is essential.

As of 1 January 1999, the Medical and Dental Professions Board introduced a system of Continuing Professional Development (CPD) for medical practitioners and dentists. Similar systems are being introduced for each of the other professions for which Council and the Professional Boards provide.

In terms of section 26 of the *Health Professions Act*, 1974, and the *Rules relating to continuing education and training* in the different professions, compliance with the requirements of CPD will be a condition for recertification of practitioners and for their continued registration/practicing. Documentation pertaining to CPD and to a practitioner's standing in terms of the CPD requirements, will be submitted to him or her on an annual basis.

Equally, every practitioner will be required to provide the Board with details and proof of his or her participation in approved CPD activities and compliance with the prescribed requirements.

Interns in medicine are not required to participate in CPD as they are still in training. For them CPD commences after registration as medical practitioners to perform community service.

6.	Question: I now know that, as a registered professional person, I have to pay certain fees, keep the Council informed of changes of addresses and to participation in CPD, where applicable. But what is the Council?

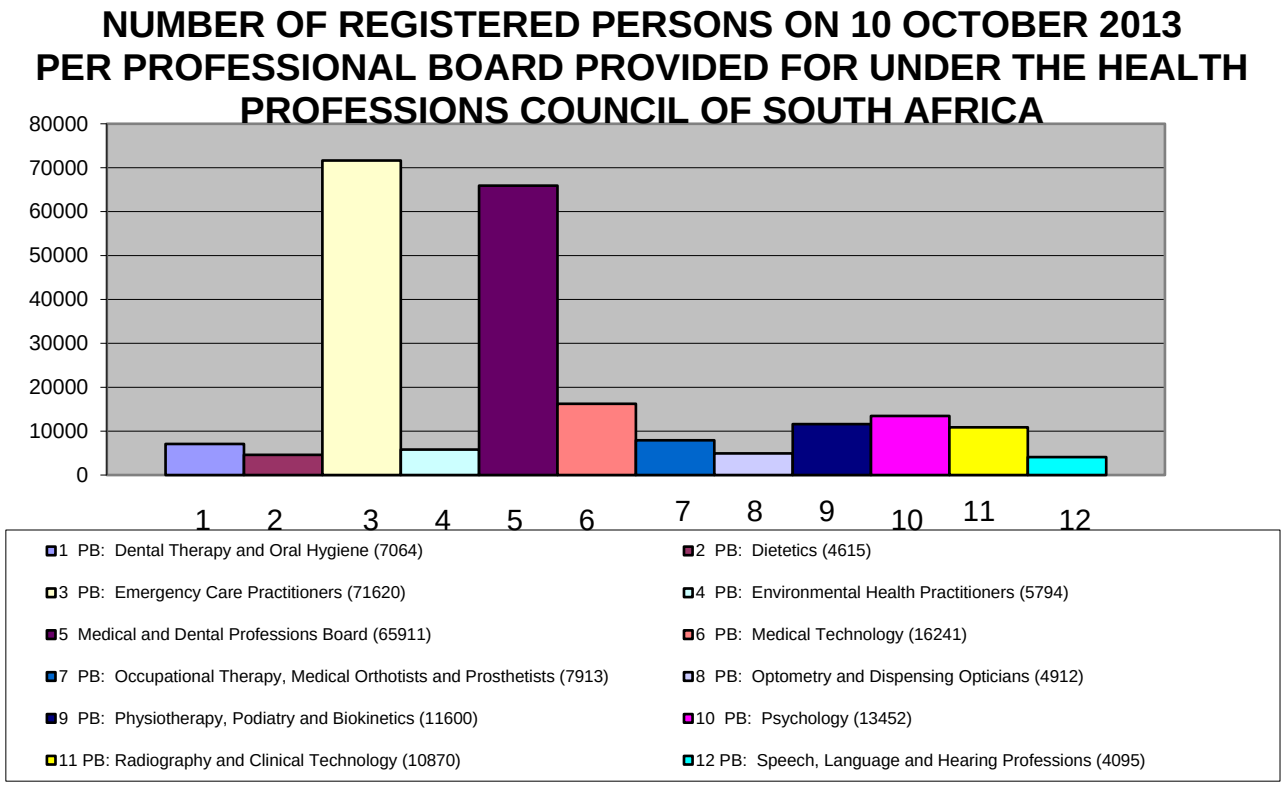
Answer: The Council was originally established in 1928. It later became the South African Medical and Dental Council. The name was subsequently changed to the Interim National Medical and Dental Council of South Africa in 1995 and is now known as the Health Professions Council of

South Africa (HPCSA) since its establishment and that of the twelve Professional Boards in 1999. As such, the Council and Professional Boards provide for a wide spectrum of health professions such as Dentistry, Medicine, Occupational Therapy, Physiotherapy, Psychology and some twenty others.

7.	Question: How do the "health professions" interrelate with the Council?

Answer: The Health Professions Council of South Africa is an umbrella body for all of the professions registering in terms of the Act. Individual or groups of professions, however, have their own regulatory bodies in the form of specific Professional Boards.

As from 1999, the following Professional Boards are functioning under provisions of the Act and in terms of Government Notice No 75 of 16 January 1998. The total number of persons registered per Professional Board, as at 1 October 2009, was as follows:



It should be noted that pharmacists, nurses, chiropractors, homeopaths and dental technicians have their own regulatory bodies and do not register with the HPCSA in terms of the *Health Professions Act*, 1974.

8.	Question: What do the Council and the Professional Boards do?

Answer: The primary object of Council and the Professional Boards is to assist in the promotion of the health of the population of South Africa. This, broadly speaking, is achieved mainly in the fields of education and training, and in terms of the regulation of professional conduct:

Recognition of Professional Education, Training and Qualifications

In terms of education and training, the work of Professional Boards entails the recognition of qualifications for registration purposes; laying down the requirements and standards for the

education and training leading to such qualifications; the accreditation of teaching institutions and training facilities for all levels, i.e. diploma, undergraduate, internship and postgraduate (including specialist); and the conducting of certain examinations.

Regulation of Professional Conduct

Professional conduct issues are fully vested in Professional Boards. These duties include dealing with complaints of alleged unprofessional conduct which are discharged in accordance with legal principles as set out in relevant Regulations which are implemented during professional conduct inquiries against registered persons. The need for impartiality is self-evident and clearly implies the observance of every nuance and fact of legislation, as well as of the basic human rights of the public - but, at the same time, also those of practitioners.

In addition, Council and Professional Boards advise the Minister of Health on matters within their competence and also communicate to the Minister information on matters of public importance which comes to the attention of Council and the Boards.

Council and Professional Boards should not be confused with professional associations, such as, for example the South African Medical Association. Council and Professional Boards are statutory bodies and the country's official "keepers of registers". In order to safeguard the public, registration in terms of the Act is a legal prerequisite for practising any of the health professions for which the Act provides. The professional associations, on the other hand, are voluntary bodies, established mainly to serve the interests of the relevant professions and their members.

9.	Question: Why do professional registering and regulatory bodies exist?

Answer: The reason for the existence of Council and Professional Boards stems mainly from the very nature of the professions.

The essential character of a profession is that its members have specialised knowledge and skills which the public wishes to use. To enable the public to have access to practitioners who are competent to practise, a list or "register" of such practitioners is a prerequisite, since only those practitioners whose names are entered into the register may legally make this fact known to the public. The body responsible for maintaining the register, therefore, has two duties to discharge: To assure itself that practitioners admitted to the register are competent; and to remove those practitioners who are found unfit to practise.

The maintenance of a register is, conversely, also to the advantage of those whose names appear in it, since this confers public recognition on the competent practitioner who will thus

be able to command a reward for his or her services.

A further characteristic of a profession is that it is self-regulatory and that non-professional authorities (such as governments or governmental agencies) do not dictate to a profession on matters of professional responsibility, education and training. It is, therefore, to be noted that

Council and Professional Boards are autonomous statutory bodies. They receive no grants or subsidies from Government or any other source. They are totally funded by the professionals who register with them. The main consumer of their services - the public - does not and is not expected to contribute financially to the functioning of Council or the Boards.

10.	Question: It is stated above that the Professional Boards have the power "to remove the name of those practitioners from the register who are found to be unfit to practise". This is surely a draconian provision?

Answer: Not at all. Practitioners who remain within the bounds of professional propriety (as indeed dictated by the professions themselves), and who do not act outside the norms of serving the best interests of the public, have no concern with Professional Boards' disciplinary powers. Reference was made in paragraph 8 to the Council and Professional Boards' legal and moral obligations to both practitioners and the public. This is best summed up in the legal maxim "*audi alteram partem*", dating back to Roman times which state the principle that "the other side must be heard". Any practitioner against whom a complaint is lodged with a Professional Board, may rest assured that this basic principle in law is adhered to in all cases.

11.	Question: I have heard of certain "ethical rules". What are they?

Answer: The "ethical rules" are contained in Regulations prescribed in terms of the Act and published in the *Government Gazette*, setting out those acts or omissions in respect of which the Professional Boards may take disciplinary steps. These are generally known as the "ethical rules", a copy of which is made available with this document.

It must be borne in mind that these Rules do not and cannot enumerate all the possible acts or omissions on the part of a professional person which may become the subject of scrutiny by a Professional Board following a complaint, charge or allegation lodged with that Board.

12.	Question: What other guidelines are there as to what is regarded as "ethical" or "unethical" conduct?

Answer: The Council and Professional Boards make rulings from time to time on various aspects of professional conduct in the light of the needs of society and changing professional norms, for example, on the question of so-called "advertising" by the health professions.

The professions are kept abreast of these developments by way of Council's publication, *Bulletin,* which is sent to all registered persons. In addition, a number of Professional Boards have recently introduced their own "newsletters" which are being distributed to the relevant professionals such as *MedicDent News*, the newsletter of the Medical and Dental Professions Board which is distributed twice per annum. Other matters of sufficient import are made known to the professions by way of circular notices as the need arises.

Under the guidance of the Committee for Human Rights, Ethics and Professional Practice, a series of Booklets on Good Practice is being developed to deal with a variety of practice related issues. The first of these Booklets will be available in print in due course and will be on sale at a minimal cost of R10,00 per booklet.

Council also has various pamphlets and brochures available on issues such as the following:

The establishment of managed health care delivery systems.
Preferred-provider agreements.

Charging of fees for telephone consultations.
Information to be included in sick-leave certificates.
Incorporated practices by practitioners registered in terms of the Act.

13.	Question: If I need information about any aspect of my professional relationship with Council or the relevant Professional Board, who do I approach?

Answer: Please feel free to get in touch with the Council by telephone or in writing at any time. Council's personnel will be pleased to assist you.

When writing, please write to:

The Registrar
HPCSA
P O Box 205
Pretoria
0001

E-mail: hpcsa@hpcsa.co.za
Website: http://www.hpcsa.org.za

Please quote your reference number which, in the case of individual interns and practitioners, is your registration number with Council.

Health Professions Council of South Africa

MEDICAL AND DENTAL PROFESSIONS BOARD GUIDELINES ADDRESSING ISSUES AND CONCERNS OF MEDICAL INTERNSHIP DURING COVID-19 PANDEMIC

In 2020 South African public health system is hosting interns in their second year in the old programme and first year in the new programme in HPCSA accredited facilities.

The rotations were designed in such a way that the majority of second year interns should complete their rotations by the end of December 2020 and qualify for community service in January 2021

Similarly interns in first year should complete their 24-month programme at the end of December 2021 and proceed to community service in January 2022.

The COVID19 pandemic has posed specific challenges to the training programmes that will result in compromised training to individuals or groups of interns across our accredited facilities.

This may be due to scaling down of elective services in many hospitals in an effort to create designated beds and specific services for COVID care, as well as to reduce contact time with patients with a view to protect the health care professionals without compromising clinical care; reduced duration of shifts; and time off given to interns, trainers and supervisors to allow for recuperation.

In addition, interns being in the front line may lose valuable training time because of quarantine/isolation, should they come into contact with patients diagnosed with COVID19 without the appropriate PPE or because some of the interns may unfortunately become infected with COVID19. Interns must be supervised and supported by supervisors while on the frontline of covid related clinical activity.

It is also difficult to predict the full course of this pandemic and its full impact on the health system.

The Medical and Dental Professions Board thus proposes the following in this context

1. Rotation of interns in different domains must continue as planned. Allocation for COVID related activities must not compromise their primary training needs in the domains
2. The HPCSA expects that appropriate PPE will be provided to front line health professionals including interns by the health authorities and interns must adhere to PPE requirements to protect themselves.

3. The HPCSA expects that quarantine and isolation protocols should be in place in facilities for interns as for any other health care professional.
4. The normal procedures for the assessment of competency requirements in each of the domains will be maintained.
5. With regard to the assessment of competency requirements supervisors should use their discretion to decide as to whether an individual intern has been able to master a competency without necessarily having been able to abide by the number of procedures prescribed in the logbook. This relates to the educational concept of "entrustable professional activities" (EPA) and as to whether a trainee can provide evidence of mastery of such an activity.
6. To allow for possible absence from duty due to COVID19 related sickness, the principle of a minimum attendance of 80% in a domain will be acceptable for both first- and second-year interns provided that the required competencies for each domain are acquired in that time.
7. In case of prolonged absence from duty for first year interns in their three month domains, operational flexibility may be required for the completion of all required competencies; for example, it may be possible to use the six month family medicine domain in second year for this purpose thus allowing interns to move on to the ensuing domain in first year according to the rotation plan. However, if all the required competencies cannot be achieved within the 24 months, extension of internship will be required and the HPCSA must be notified. Please note that internship can be completed within a continuous period of 36 months from the date of commencement.

An Entrustable Professional Activity is a key task of a discipline (i.e. specialty or subspecialty) that an individual can be trusted to perform in a given health care context, once sufficient competence has been demonstrated. EPAs are a common approach to Competency Based Medical Education (CBME) around the world. (see attached document: ***ENTRUSTABLE PROFESSIONAL ACTIVITY (EPA) FAST FACTS***

-o0o-