HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

HANDBOOK ON ETHICAL RULINGS

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CODIFICATION OF RULINGS ON ETHICAL MATTERS

1. INTRODUCTION

These Rules are made in terms of section 49 of the said Act by the Health Professions Council of South Africa ("Council") in consultation with the twelve (12) Professional Boards for which the Act provides. They will come into effect only when approved by the Minister of Health and when subsequently promulgated in the Government Gazette.

Health Professions Council of South Africa and its predecessors compile this document in an attempt to –

- Consolidate the current Ethical Rulings relating to conduct in respect of which Professional Boards may take disciplinary steps against persons registered in terms of the Health Professions Act, 1974 (Act No. 56 of 1974), for the different professions for which the Act provides.

- Consolidate, update and present the resolutions of Council, its predecessors and Professional Boards relating to matters of professional conduct (the so-called Ethical Rulings) in English. To this end, the rulings from 1928 to 2001 have been scrutinised and the obsolete ones were deleted. Where necessary, rulings have been translated from the Afrikaans to English. This document, therefore, contains only the currently valid rulings. Under each of these rulings the reference is given to the applicable resolution of Council as contained in the detailed Volumes on Ethical Rulings which were compiled over the years. These resolutions may be referred to if more detailed information is required.

- Make the Ethical Rulings useful to all the professions registered with Council. The word "practitioner" is used to refer to a person registered in respect of any of these professions. Where a ruling is only applicable to a specific profession, the designation of that profession is specified. Even so, in principle the rulings may indeed have wider applicability.

- Present the Ethical Rulings in a user-friendly format.

2. HOW TO USE THIS DOCUMENT

The sequence of the Ethical Rules has been followed. The relevant Rule is quoted and thereunder, the rulings follow which relate to that Rule. Where rulings could not be classified under a particular Rule, they are listed under Section 31: Other Matters. It should be remembered that the Ethical Rules are not exhaustive. They have been amplified by rulings which had been made by Council/Professional Boards over many years. However, the rulings themselves also do not cover all aspects of professional conduct.

This document will be updated on a continuous basis in keeping with resolutions of Council and Professional Boards.

ETHICAL RULES AND RULINGS

Ethical rule	Ethical Ruling	Updated Ruling
3. ETHICAL RULE 3: ADVERTISING 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. **CANVASSING AND TOUTING** A practitioner shall not – Canvas for patients in whatever manner from door to door in any particular area to recruit patients either verbally or by handing out promotional material; Tout for patients in whatever manner by improperly drawing attention, either verbally or by means of the printed or electronic media, to the titles or professional attainments, personal qualities, superior	**3.1 RULINGS** **3.1.1 BONA FIDE PATIENTS** a. The Dental Association expressed the view that, in the case of dentistry, the term bona fide patient should be interpreted to mean any patient who was actively receiving treatment in the practice during the immediately preceding period of 12 months. b. Council agreed to this view. Ref: October 1983 Vol 6 p. 5. **3.1.2 CIRCULAR TO COLLEAGUES REGARDING RESTRICTED PRACTICE** a. A practitioner advised that she had been working in a special field of mental health in various hospitals. She then wished to commence private practice as a general practitioner but restricting her activities to marital and family therapy. She wanted to inform her colleagues that she had commenced practice in that field and also to arrange for a similar announcement to be made in the Medical Journal. b. Council noted the contents of the letter and advised the practitioner that the provisions of the Rule relating to advertising had to be complied with. Those provisions prohibited a general practitioner from notifying colleagues that he or she was restricting his or her practice to a specific field of medicine.	

knowledge or quality of service of a particular health care professional or by improperly drawing attention to his or her practice or best prices offered.	Ref: October 1988 Vol 6 p. 15. **3.1.3 VISITS BY SPECIALISTS TO OTHER PRACTITIONERS** Council advised the Medical Association that Council was of the view that introductory visits by practitioners to other practitioners was a traditionally accepted practice and Council, consequently, did not have an objection to a specialist making introductory visits to other practitioners, either specialists or general practitioners, on entering practice: Provided such visits were not abused. Ref: October 1983 Vol 6 p. 16. **3.1.4 NOTIFICATION BY DENTISTS TO ORAL HYGIENISTS** Council informed the Dental Association that Council did not have an objection to a notification by dentists to oral hygienists, stating that a vacancy existed for an oral hygienist at the practice of the practitioner. Ref: April 1983 Vol 6 p.17. **3.1.5 AUDIOVISUAL PRESENTATION AND PATIENT HANDOUTS** a. A practitioner wished to send a circular to his patients who suffered from rheumatological conditions and whom he had seen in the last two years, offering them the opportunity to attend an audiovisual presentation in his rooms. Information handouts would also be provided. The purpose of the presentation was to provide those patients with an update on the nature of their illness. Some spouses expressed the desire to attend the presentation also. A fee equivalent to a scale of benefit consultation fee would be levied. b. Council advised the practitioner that the proposed audio-	

	visual presentation and handouts to patients by the practitioner were not permissible. Ref: April 1986 Vol 6 p.24. **3.1.6 LECTURES TO LAY AUDIENCES** Council agreed with a letter from the Medical Association advising one of its branches that medical practitioners are often requested by lay organisations to lecture on one or other medical subject of importance to members of such an organisation. To promote health education of the public, which is a reasonable function of the medical profession, such requests should be agreed to, provided that arrangements were made to protect the practitioner. The local branch of the Association should also give permission to prevent a practitioner from arranging such events himself or herself in order to build up his or her practice. Ref: October 1986 Vol 6 p. 25. **3.1.7 FREE SEMINARS BY COMMERCIAL ORGANISATIONS** a. The Dental Association requested clarification as to what action should be taken when a practitioner wishes to be associated with a commercial organisation. A brochure was enclosed advising of free seminars to be held at a trade exhibition. Several practitioners were to be keynote speakers. b. Council provided the Dental Association with Council's policy on public appearances by registered persons (see Booklet 1) and advised the Association that Council was of the opinion that, under the circumstances described in the letter and accompanying brochure, each case should be considered on an ad hoc basis. Ref: October 1987 Vol 6 p. 26.	

3.1.8 MAKING AVAILABLE FACILITIES OF MEDICAL RESEARCH COUNCIL TO AUTHORITIES AND PRACTITIONERS

a. The Medical Research Council advised that it had entered into an agreement with a provincial administration to make available to that administration the use of its nuclear magnetic resonance equipment. Private patients would in due course also be admitted for diagnostic services. Approval was asked to use the equipment for diagnostic purposes and to use the existing tariffs for computer tomography as a basis for charging fees to patients.
b. Council advised the Medical Research Council that Council welcomed the use of the equipment concerned and saw no objection to it being made known as set out in the letter. Council did not express an opinion on tariffs as that was a matter which did not fall within the functions of Council. It would, however, appear as if the proposal regarding the charging of fees was reasonable.

Ref: April 1986 Vol 6 p.29..

3.1.9 ADVERTISING OF NON-RELATED PROFESSION

a. A full-time medical officer engaged in the mining industry who also held commercial qualifications, enquired whether he could do business as a part-time consultant in tax and estate planning and to advertise in that regard.

b. Council advised the practitioner that Council could see no objection against the proposed advertising, provided the advertising did not refer to the practitioner's registration with Council and that his two practices would have to be conducted separately.

Ref: October 1983 Vol 6 p. 33.

	3.1.10 ANAESTHESIOLOGISTS' DUTY LISTS Council advised a partnership of anaesthesiologists that it was not permissible for the partnership to put up an afterhours duty list on theatre notice boards, or to circulate the same list to surgeons' consulting rooms. Ref: October 1984 Vol 6 p. 38. **3.1.11 WORKSHOP FOR GENERAL PRACTITIONERS** a. A practitioner enquired whether a workshop could be held for general practitioners after normal practice hours in a large waiting room shared by dentists and an ophthalmologist. The workshop would entail a glaucoma awareness programme for general practitioners and lectures by ophthalmologists on ophthalmoscopy and tonometry. b. The practitioner was advised that Council would have no objection to the holding of a workshop as set out, provided that the Rule relating to advertising was observed and it was not held in a place associated with the consulting room of a particular practitioner. Ref: April 1985 Vol 6 p.39. **3.1.12 ADVERTISING BY PRACTITIONERS NOT IN PRIVATE PRACTICE** Council advised a surgeon that it had noted his letter (in which he stated that doctors in full-time employment had appeared in the media with details of their names and rank, while many of those doctors moved into private practice very shortly after the bout of very useful advertising); and that the surgeon be advised that the policy of Council regarding advertising did not preclude Council from taking action if a complaint was received	

	and Council was of the opinion that a full-time practitioner had abused his or her position for his or her own gain. Ref: April 1988 Vol 6 p.46. **3.1.13 JOINT OWNERSHIP OF ULTRASOUND SCANNING EQUIPMENT** Council advised a group of gynaecologists that it would have no objection to them entering into an arrangement in terms of which they would jointly purchase ultrasound scanning equipment. The equipment would be cited at a nursing home which was in close proximity to the consulting rooms of all the practitioners concerned and offered the advantage of being a neutral site, and was unconnected with any specific practitioner's consulting rooms. The nursing home would be paid a rental for the use of the floor space occupied by the equipment. The nursing home would not receive any other form of remuneration. Council stated that its view was subject to the service not being advertised and the relevant Ethical Rules being adhered to. Ref: October 1986 Vol 6 p. 48. **3.1.14 PRACTITIONERS ACTING AT HORSE RACING MEETINGS** The Jockey Club of South Africa was informed that Council could see no objection to race-course practitioners being registered with the club, but that it was not permissible to publish their names in the racing calendar or in the racing club's race card. Ref: October 1986 Vol 6 p. 49. **3.1.15 ADVERTISING ON ELECTRONIC VIDEO BILLBOARDS**	

	The Executive Committee of the Medical and Dental Professions Board resolved that – advertising on electronic video billboards was not permissible; outside signs and nameplates may only be used in accordance with the guidelines set out in the document entitled Guidelines for making professional service known, all future requests for rulings with regard to the advertising of professional services should be submitted to the HPCSA for consideration and decision on behalf of the Executive Committee with confirmation by the Committee at its next meeting. Ref: MDB Exco Dec 2000, item 42 **3.1.16 ADVERTISING FOR TRIAL SUBJECTS** The Executive Committee of the Medical and Dental Professions Board resolved that – the Medical Association be advised that advertisements for trial subjects should be evaluated and passed by the same Research Ethics Committee that would be responsible for evaluating and approving the proposed clinical trials pertaining to a particular research project; the view of the Association be supported, namely that the name of a medical practitioner or dentist should not appear in the advertisement for trial subjects, but that the particulars of a contact person should rather be given; Ref: MDB Exco Dec 2000, item 41 **3.1.17 E-MAIL RECRUITING OF DOCTORS TO PARTICIPATE IN PHARMACEUTICAL RESEARCH *VIA* INTERNET.**	

	The Executive Committee of the Medical and Dental Professions Board, on the recommendation of the Committee for Human Rights, Ethics and Professional Practice, resolved that – the clinical trials pertaining to the research project to be undertaken had to be passed by an academically recognised Research Ethics Committee; only health care professionals with demonstrable research capabilities should be recruited to conduct the required research; the researchers to be recruited, would be held accountable for anything that could go wrong during the research due to unethical behaviour on their part. Ref: MDB Exco May 2001, item 67	
4. ETHICAL RULE 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;	**4.1 RULINGS** **4.1.1 RENDERING OF ACCOUNTS IN NAME OF PRACTITIONER WHO PROVIDED SERVICE** A ruling was asked for concerning laboratories and clinics which are suppliers of services to medical practitioners and not to medical aid schemes' members. Council decided that accounts for professional services must be rendered in the name of the medical practitioner who rendered the service to the patient. Ref: April 1987 Vol 6 p. 77. **4.1.2 PARTICULARS ON ACCOUNTS** Council informed a dentist that it was not desirable to print on account forms only code numbers with a note that information regarding the codes would be provided if required: Full particulars regarding the services rendered should appear on the account.	

(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.	Ref: April 1982 Vol 6 p. 78. **4.1.3 NAME OF BUILDING ON LETTERHEADS** Council informed a dentist that it was undesirable to print on a letterhead the name of the building in which his practice was situated across the top of the page. Ref: April 1981 Vol 6 p. 80. **4.1.4 USE OF LETTERHEADS OF DECEASED PRACTITIONER** Council ruled that there would be no objection to the executor of the estate of a deceased practitioner employing a registered person to operate the practice of that deceased practitioner until the practice could be sold, provided that all nett income accrued to the registered person operating the practice of the deceased practitioner, that such arrangement was purely temporary, subject to a reasonable time limit and pending disposal of the practice within reasonable time. A period of seven months would appear to exceed a reasonable period Ref: April 1986 Vol 6 p. 81. **4.1.5 USE OF WORDS "MEMBER OF THE MEDICAL ASSOCIATION" ON LETTERHEADS** Council decided that it was not permissible for members of the Medical Association to print the following words on their stationery and letterheads: "Member of the South African Medical Association. Ref: April 1986 Vol 6 p. 82. **4.1.6 PRESCRIPTION FORMS BEARING DRUG BRAND NAME**	

	Council decided that it could see no objection to prescription forms being made available for sample purposes with the drug brand and genetic name of the sample drug on each coupon, but that the identification of a medicinal product on the proposed pharmaceutical sampling coupon was undesirable. Ref: April 1987 Vol 6 p. 83. **4.1.7. PRESCRIPTION FORMS ADVERTISING SPECIFIC PRODUCTS** The quality assurance manager of a company was advised that it was not permissible for practitioners to use prescription forms on which the product of that company was advertised. Ref: October 1981 Vol 6 p. 88.	
5. ETHICAL RULE 5: PRACTICE NAMES A practitioner shall only use a name for a private practice - (a) which shall be his or her own name or the names of the registered persons with whom he or she is in partnership or with whom he or she practises in the manner of a juristic person (as provided for in section 54A), and may retain the name of such a practice even if the original practitioner or practitioners, partner or partners or the members of the juristic person	**5.1. RULINGS** The guidelines referred to under Section 3.2.1 are applicable (see paragraph II. of the guidelines which relates to practice names). **5.1.1 NAME "MEDICAL CENTRE" FOR BUILDING** Council amended its policy regarding the names of buildings by the addition of a further condition that buildings may have a name indicating the profession of the occupants only if a minimum of four medical practices were tenants in such a building. Ref: April 1986 Vol 6 p. 263.	

are no longer part of such a practice; (b) which shall not include the expression "hospital" or "clinic" or "institute" or any other special term which could create the impression that such a practice forms part of, or is in association with a hospital, clinic or similar facility.	**5.1.2. NAMING OF BUILDINGS** Certain practitioners in a small town complained that, by naming a building "medical centre", the impression was being created that all of the doctors in that town practised in that particular building. Council decided that the policy regarding the naming of buildings be amended by the addition of a condition that such buildings may only indicate the name of the profession of the occupiers, if a minimum of four practices were tenants in such a building. Ref: October 1985 Vol 6 p. 264.	
	5.1.3 NAME "ORTHOPAEDIC CENTRE" FOR BUILDING Council decided that it was not permissible to put up a board with the designation "orthopaedic centre" to indicate an orthopaedic practice. **5.1.4 USE OF WORD "CLINIC" TOGETHER WITH NAMES OF PRACTITIONERS** Council decided that the use of the words " anaesthetic clinic" or like words, together with the names of the practitioners concerned on letterheads and account forms was not permissible. Ref: April 1986 Vol 6 p. 267	
6. ETHICAL RULE 6: ITINERANT PRACTICE	**6.1. RULINGS**	**PRACTITIONERS WARNED ABOUT DUBIOUS MOBILE RADIOLOGY SERVICES**
	6.1.1. ANAESTHESIOLOGISTS CHARGING TRAVELLING FEES Council decided that, where an anaesthesiologist carries on a regularly recurring itinerant practice, he or she is not entitled to charge a patient travelling fees. Where he or she is called out to	**5 May 2014** Pretoria – The Professional Board for Radiography and Clinical Technology of the Health Professions Council of South Africa

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.	render a service, he or she is entitled to charge a travelling fee and the patient should be advised thereof prior to the service being rendered, except in the case of an emergency. Ref: April 1981 Vol 6 p. 67. **6.1.2 PATHOLOGY PRACTICE** Arising from the question whether the practice of pathology warranted any exceptions to this Rule, Council decided that this Rule does apply to the practice of pathology and it confirmed a previous decision, namely that it is permissible for pathologists to collect specimens in containers at hospitals; the forms which are made available for this purpose must not amount to advertising and a collection fee must not be charged. It was also permissible for pathologists to collect specimens from the rooms of medical practitioners at the request of such practitioners. Also, if a medical practitioner called out a pathologist for a specific procedure to a place where the pathologist does not practise on a regular basis, the patient must be informed that fees may be charged for transport. Ref: October 1983 Vol 6 p. 68. **6.1.3 CARDIOTHORACIC SURGEONS PRACTISING IN DIFFERENT CITIES** A cardiothoracic surgeon informed Council that he was aware that some surgeons seem to be able to do open heart surgery in at least three different centres. He was of the opinion that this reduced the standard of practice and he enquired whether this was ethical. Council advised the surgeon that the contents of his letter had been noted and that cardiothoracic surgeons had to adhere to the Rule on itinerant practice, the rendering of a satisfactory service as stated in the Rule referred not only to the operation, but was also applicable to the postoperative care.	(HPCSA) has warned practitioners about suspicious mobile radiology practices. It has come to the attention of the Board that some companies have purchased x-ray equipment for mobile radiology services. These companies are apparently struggling to obtain licenses from Radiation Control Directorate of the National Department of Health to use these machines as they are not adequately qualified and trained to operate such machines. They make lucrative offers to practitioners in order to use their HPCSA numbers, thereby securing licenses from Radiation Control. “With a mandate of protecting the public and guiding the professions, the Council is concerned that practitioners and the public might be exposed to suspect operators,” Mable Kekana, Chairperson of the Professional Board for Radiography and Clinical Technology said. “Although the Board is not opposed to practitioners bringing healthcare services closer to communities through various mobile practices, the Board is concerned about the possible unethical and unprofessional relationship that might emanate between the healthcare practitioner and the companies providing the service,” she explained. Practitioners are urged to be conversant with the type of private practice they want to engage in and to ensure that any type of

	Ref: October 1987 Vol 6 p. 70. **6.1.4 MOBILE UNIT** Council ruled that it is not desirable for a medical practitioner to practise from a mobile unit which had been converted into consulting rooms. Ref: October 1981 vol 6 p. 72. **6.1.5 ORTHOPAEDIC SURGEON** a. An orthopaedic surgeon advised that he had commenced practice in the Johannesburg area, but that he would fly to Welkom on a weekly basis. Patients requiring surgery would be operated on in Johannesburg and discharged when they were fit. He planned to do minor operations in Welkom, and these operations would be done in the morning with the assistance of a full-time medical practitioner. The majority of these patients would be discharged in the afternoon. Those patients that he would be unable to discharge, will be looked after and discharged the following day, probably by the full-time medical practitioner. b. Council resolved that the practitioner's attention be directed to the Rule on itinerant practice; this Rule implied that he was responsible to his patients for postoperative care; however, he could consult patients in Welkom, as envisaged. Ref: April 1986 Vol 6 p. 73.	practice adheres to the ethical rules and regulations* of the Council. Practitioners are furthermore advised to desist from giving or selling their HPCSA registration numbers or private practice numbers obtained from the Board of Healthcare Funders (BHF). Practitioners must be cognisant of the fact that they are liable for all professional acts performed or taking place in their presence or absence when their personal registration numbers are used. The Board is also calling on practitioners who are aware of any unethical practices regarding mobile radiology practices to report these to the HPCSA for further investigation.
ETHICAL RULE 7: COMMISSIONS AND FEES A practitioner shall not -	**7.1. RULINGS** **7.1.1 GUIDELINES FOR ACCOUNTS COMPILED BY COMPUTERS**	**GLOBAL FEES** On 13 April 2017 Council issued a media statement urging practitioners not to sign global fees agreements that may violate the

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	Council invited the attention of practitioners to the fact that the Council received various complaints regarding incorrect accounts rendered by computer firms and that it was the policy of Council that a practitioner was personally responsible for his or her practice. Such accounts must be correct. The address and telephone number on such an account must be those of the practitioner and there should not be a reference to the computer firm. This was necessary in order that the patient may approach the practitioner should problems be experienced with the account. If it appeared that the account was incorrect, the practitioner should correct it. The accounts should also comply with the requirements of the Medical Schemes Act 1998, (Act No.131 of 1998). Ref: October 1983 Vol 6 p. 90. **7.1.2 REFUSAL TO TREAT PATIENTS WITH OUTSTANDING ACCOUNTS** a. A practitioner enquired whether he or she could temporarily stop treatment of certain patients until accounts which were grossly overdue, had been brought up to date. Council advised the practitioner that, although a practitioner was at liberty to decide to whom he or she wished to render services or not, a practitioner may be called upon to justify his or her action in the event of unnecessary suffering or death resulting from refusal to render assistance to a patient; and that Council was of the opinion that the orthodontic treatment as referred to, should not be summarily withheld, but that legal steps could be instigated in the meantime to recover outstanding fees. Ref: October 1986 Vol 6 p. 98. b. A practitioner asked whether he could suspend orthopaedic treatment to his patient due to non-payment of accounts and the Executive Committee of the Medical and Dental	HPCSA Ethical Rules. Council further urged health professionals to defer entering into global fee or similar financial- and clinical arrangements or contracts until all aspects relating to the law, ethics, clinical autonomy and funding mechanisms have been properly canvassed with all stakeholders. Council has been engaging with practitioners and different stakeholders since 16 May 2017 through roadshows held in Johannesburg, Durban, Cape Town and Bloemfontein and different meetings held with role players in global fee arrangements. During the consultative process, Council has discovered that the alternative re-imbursement models are not limited to global fees but there are other re-imbursement arrangements entered to between practitioners and medical schemes **Fees and commission** 7. (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.

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. 6) A Practitioner Shall Explain To The Patients The Benefits, Costs And Consequences Associated With Each Service Option Offered.	Professions Board resolved that – i. a medical practitioner or dentist had the right to refuse treatment to a patient, but he or she could be held professionally accountable should that patient unduly suffer or die because of his or her refusal to treat the patient concerned; ii. possible complications or interruption of treatment of a patient, especially of a child, should be fully explained to the patient or parent; iii. a doctor may consider legal remedy to encourage a patient to pay his or her outstanding account, but the consequence of such action should be fully explained to the patient; iv. a medical practitioner or dentist may under no circumstances refuse to treat a patient in the case of an emergency. Ref: MDB Exec Aug 2000, Item 41 **7.1.3 SPECIFYING PROCEDURES FOR OBESITY ON ACCOUNTS** Council expressed the view that where an operation was carried out wholly or partly for obesity, it should be clearly stated as such on the account and then be specified by means of the relevant code. Ref: October 1986 Vol 6 p. 99. **7.1.4 ACCOUNTS GIVING MISLEADING INFORMATION REGARDING PRIMARY PROCEDURE**	(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. (6) A practitioner shall explain to the patients the benefits, costs and consequences associated with each service option offered. **CHARGE UPFRONT FEES FOR RADIATION ONCOLOGY** Medical and Dental Professions Board at its meeting on 22 November 2021 approved the recommendation by the MDB Professional Practice Committee – a. to charge and receive advance payment of fees for radiologist oncology is

	A number of complaints had been received by Council against practitioners who were consulted by patients with primary complaints of obesity and surgical procedures were then, in fact, performed with the object of loss of weight, which procedures were not covered by medical aids. The accounts which were thereafter rendered, indicated an additional procedure which was usually performed and which was covered by medical aids, such as hernia repair, as the main procedure. Council was of the opinion that, to prevent occurrences of this nature when two surgical procedures as above were performed, the account rendered in respect thereof should indicate both surgical procedures and, in terms of the tariff, the fee for the main procedure and relevant units in respect of the second procedure. Ref: April 1986 Vol 6 p. 100. **7.1.5 RECOVERY OF COLLECTION FEES** Council's ruling was that expenses incurred in connection with the collection of an account may not be added to the services rendered and that this ruling should not be interpreted as if such expenses may not be recovered. A practitioner should not hand over an account for collection before all attempts have been made to obtain payment in the usual way. Council was further of the opinion that it was not permissible for a practitioner to recover collection fees other than those of an attorney. Ref: April 1981 Vol 6 p. 102 **7.1.6 ACCOUNTS FOR TREATMENT OF DEPENDANTS** Council stated that it was permissible for a practitioner to treat his own dependants, but that Council had previously ruled that it was of the view that it was not permissible for a practitioner to render accounts for services rendered to such practitioner's own	not approved; b. **Ethical Rule 7(5)** does not preclude practitioners from billing for professional services that had been rendered up to the patients last consultation and for materials procured from a supplier for such services **INTRODUCING INFORMED FINANCIAL CONSENT** *Dr Kwinda 14 July 2015* Patients have a right to information about their condition and the treatment options available to them. The amount of information given to each patient will vary according to factors such as the nature of the condition, the complexity of the treatment, the risk or side effects associated with the treatment or procedure, and the patient's own wishes. This is legislated under the National Health Act & the National Patients' Rights Charter and the Health Professions Act & the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act. These legislations require that practitioners inform patients about the cost of services or treatment provided as part of seeking consent from patients. The majority of complaints against practitioners received by Council are related to the fees and most of these complaints arise because patients are not informed about the costs of treatment or

	dependents; accounts could, however, be rendered in respect of laboratory fees. Ref: October 1986 Vol 6 p. 103 **7.1.7 DUTY OF PRACTITIONER REGARDING MEDICAL COSTS IN PRIVATE HOSPITALS** Council expressed the view that it was desirable for a practitioner in the interest of good patient-practitioner relationships to inform the patient regarding medical costs incurred during the treatment of the patient where such costs were considerable. Ref: April 1985 Vol 6 p. 110 **7.1.8 CHARGING FOR SERVICES RENDERED BY ULTRASONOGRAPHER** A gynaecologist advised that he wished to employ a full-time ultrasonographer to operate a real-time sector scanner. A practitioner would always be available for comment and diagnosis if there was a query regarding the findings. Council informed the gynaecologist that the interpretation of the ultrasound would always be the responsibility of the medical practitioner who should also be the person to charge for the service rendered. Ref: October 1984 Vol 6 p. 112. **7.1.9 CHARGING FOR DELIVERY WHILE NOT PRESENT** A practitioner charged for a full delivery, although he was not present during the full delivery. He operated at the time and on completion of the operation he saw the patient, examined the baby and rendered the normal post delivery care. Council was	services rendered by practitioners. As a result, Council has introduced the following guideline to guide practitioners on obtaining consent related to fees from their patients: **INFORMED FINANCIAL CONSENT**. Informed financial consent (IFC) is a process by which a practitioner informs his or her patients about the costs and out-of pocket expenses associated with the services/treatment/procedure before the services/treatment/procedure commences. Informed financial consent is governed by the National Health Act & National Patients 'Rights Charter; the Health Professions Act & the Ethical Rules of Conduct for practitioners Registered under the Health Professions Act and the ethical and philosophical principles such as the right to individual autonomy and self-determination. It is the view of Council that IFC should not be separated from clinical decisions making processes as it may impact upon decisions made on available treatment options. Informed financial consent should be contextualised within a clinical consultation and become an interactive process between a practitioner and the patient, especially where clinical decisions may impact upon financial decisions and vice versa. From the analysis of complaints received by Council it can be deduced that patients want to receive the details of all procedures associated with their treatment and their costs, including both certain and likely

	of the opinion that the practitioner could charge the full fees for the delivery although he or she was not personally present as he or she was responsible for the patient, but that it was customary in such cases for the practitioner to accommodate the patient. Ref: October 1984 Vol 6 p. 113 **7.1.10 CHARGING FOR SERVICES RETROSPECTIVELY** Council decided that fees for professional services may only be charged if the practitioner rendered such services fully himself or herself or at a reduced rate where the practitioner physically supervised another practitioner who rendered the services. Ref: April 1984 Vol 6 p. 117. **7.1.11 HOSPITAL FEES** Council requested professional associations to bring it to the attention of their members that it appeared that patients were unaware that estimates of fees provided by practitioners for proposed services to be rendered by practitioners, did not include hospital or day clinic fees or were unaware of the extent of such fees. Council regarded it as desirable that practitioners should also inform the patients of these fees. Ref: April 1984 Vol 6 p. 118. **TWO SEPARATE ACCOUNTS BY SAME PRACTITIONER** Council resolved that, in the event of a practitioner performing a number of procedures at the same time and rendering an account in respect of procedures covered by medical aid schemes and a separate account in respect of procedures not so covered, each account must contain a cross reference in	services. These also include costs of other practitioners to be involved in their care, for example, costs of anaesthetists in surgical procedures, paediatricians in deliveries, medical technologists in cardiothoracic procedures, etc. Patients want to know the overall costs and out-of-pocket expenses (co-payments), for example, in relation to private hospital treatment patients want to know both the total cost of the treatment and how much of this would be covered by their medical aid. In order to assist patients with making informed choices about treatment options, patients should also be informed about the costs of alternative treatments or procedures, for example, hospital treatment versus treatment in a day clinic, where applicable. Council has noted that there are categories of practitioners who are not primary caregivers and this will always pose a challenge in these practitioners obtaining informed financial consent. These categories of practitioners which are secondary caregivers include anaesthetists and assistant surgeons working with surgeons, paediatricians working with obstetricians in emergency caesarean sections, pathologists & radiologists providing diagnostic services and other professionals providing therapeutic and rehabilitation services. Although it is not the responsibility of the primary practitioner to provide specific information about the fees for other practitioners who will be involved in the treatment of the patient the primary

	respect of the procedures indicated in the other account. Ref: April 1986 Vol 6 p. 124. **7.1.11 ACCOUNTS FOR ORAL HYGIENE SERVICES** The Dental Association was asked to advise its members to inform patients that oral hygiene services would be rendered before dental services were rendered and that a fee would be charged for such services. Where oral hygienists gave group demonstrations and instructions, it was not permissible to charge the normal fee to a patient. Ref: April 1980 Vol 6 p. 129. **7.1.12 ESTIMATES OF COSTS OF DENTAL SERVICES** Council was of the opinion that dentists should discuss with their patients the costs of the treatment proposed, particularly where such costs were considerable. The Dental Association was requested to bring this to the attention of its members Ref: April 1980 Vol 6 p. 130. **7.1.13 TELEPHONE CONSULTATIONS** a. In 1971 Council decided that it was of the opinion that, in general, consultations by telephone should be discouraged. Council could, however, visualise circumstances under which such consultations would be proper and under which the right of a practitioner to a charge, therefore, could not be disputed. b. In 1974 and again in 1980 Council noted the above resolution and recorded that it was not permissible for medical practitioners to charge fees for telephone consultations.	practitioner should at least inform the patient that besides his or her fees there may be fees associated with other practitioners who will be involved in the treatment and even go further to inform the patient who those practitioners are, where possible. Further than that primary practitioners should provide patients with names and contact details where possible, of other practitioners who will be involved in treatment of the patient and should notify the relevant practitioners of the patient details to facilitate the exchange of relevant information. Council recommends wherever practicable that information about fees and costs for services and treatment should be provided to patients in writing and the patient should acknowledge receipt of that information in writing as acceptance to pay the fees being disclosed. The information about fees should be in Rand value and practitioners should refrain from using the terminology such as, private rates, medical aid rates, contacted in or contracted out as this nomenclature is not recognised by Council. Council further recommends that in addition to providing specific information on fees and charges practitioners should document their fee charging and billing policies which should include the following: • When payment will be required • Any discounts available for early payment (or charges for late payment)

Ref: April 1980 Vol 6 p. 131.

7.1.14 PAYMENT OF SPECIALIST FEES TO NON-SPECIALISTS

A provincial hospital enquired whether the fees at the rate for specialists could be paid to an ophthalmologist who was qualified abroad, but who was not registered as such by Council. Council advised the hospital that the payment of fees did not fall within the purview of Council and Council, therefore, did not express a view on the matter; the hospital's attention was, however, drawn to the fact that, since no speciality was registered against the name of the medical practitioner, the fees paid to him could not be referred to as "specialist fees".

Ref: April 1986 Vol 6 p. 132.

7.1.15 FEES CHARGED BY PLASTIC AND RECONSTRUCTIVE SURGEONS

The Medical Association was advised that -

a. should a practitioner and a patient come to an agreement regarding the quantum of the fees to be charged for services to be rendered, it was unlikely that the Council would take cognisance of the fees, but this would not preclude Council from inquiring into an allegation of excessive fees charged;

b. it was not permissible to render an account for services still to be rendered by a practitioner. However, in the event of services to be rendered by plastic and reconstructive surgeons, Council could see no objection to an arrangement whereby a financial institution, acting on behalf of a patient, guaranteed payment of an account to be rendered;

c. it was not permissible to render different accounts in respect

- Acceptable forms of payment
- Contact for discussion of payment issues and problems.

Council acknowledges that there will be circumstances, for example in emergency cases or admissions where it will not be possible to obtain informed financial consent before the treatment is provided. In these circumstances information about fees and out of pocket costs should be provided to the patient as soon as possible after the treatment is provided. In circumstances where it is not feasible to provide information directly to the patient either before or after treatment (eg. because the patient is not conscious or otherwise incapable of receiving or understanding the information) it may be appropriate to provide the information to a close relative or representative acting in the patient's interests.

In order to assist practitioners to provide adequate information and obtain informed financial consent Council has in addition to this guideline developed a costs estimate forms that practitioners can modify to fit their context.

ADVANCE PAYMENT OF FEES

1. Council at its meeting in October 1980 resolved that it was not permissible for a practitioner to charge fees for services not yet rendered. With regard to costs of prostheses, consideration could be given to

	of cosmetic and non-cosmetic surgical procedures carried out at the same time, unless reference was made on each account to the other service. Ref: April 1986 Vol 6 p. 133. **7.1.16 ANAESTHESIOLOGIST CLAIMING SURGEON'S FEES ON SURGEON'S BEHALF** A medical aid scheme was informed that it was not permissible for a surgeon to render any account on behalf of an anaesthesiologist, nor for an anaesthesiologist to render an account on behalf of a surgeon. Each practitioner should render his or her own account. Ref: April 1980 Vol 6 p. 134 **7.1.17 SHARING OF FEES WITH FULL-TIME PRACTITIONER** a. A specialist enquired whether it would be permissible to form an association with a colleague who held a full-time appointment and whether it would be acceptable if he were to charge a patient for open heart surgery conducted by his colleague at which he personally assisted. The arrangement would be explained to the patient and he and the surgeon would independently come to a financial agreement according to their association. b. Council resolved that the specialist be informed that the charging and sharing of fees as envisaged were not permissible. Ref: April 1981 Vol 6 p. 136. **7.1.18 REFERRAL OF PATIENTS TO PATHOLOGISTS FOR ANTI-COAGULENT THERAPY**	letting the patient purchase some prostheses from a supplier or through the institution where the operation was to be performed prior to the operation itself. 2. The **Executive Committee of the Council** resolved that – i. it be placed on record that the advance payment of fees by patients for services rendered by practitioners would be acceptable to Council, provided that such payment related only to the co-payments at medical aid rates required from patients and that a practitioner would be called upon to justify his or her action in the event of unnecessary complications, suffering, or death resulting from the practitioner's refusal to treat a patient for not paying in advance; ii. should the Medical Association wish to draft a policy statement on the advance payment of fees received by patients, Council would wish to see such statement prior to its dissemination. 3. The **Medical and Dental Professions Boar**d resolved that – i. should a medical practitioner or dentist and a patient come to an agreement regarding the quantum of the fees to be charged for services to be rendered, it was unlikely that the Board would take cognisance of the fees, but this would not preclude the Board from inquiring into an

	In response to an enquiry, Council informed a partnership of pathologists that Council was of the opinion that pathologists should not be involved at a therapeutic level in anti-coagulant dosage control. Ref: April 1987 Vol 6 p. 142. **7.1.19 PAYMENT OF ACCOUNTS THROUGH BUY-AID ASSOCIATIONS** Council decided that the payment of accounts rendered for professional services through buy aid associations be approved, subject to the same conditions as were applicable in the case of credit cards Ref: October 1988 Vol 6 p. 143. **7.1.20 AGREEMENT BETWEEN PRACTITIONER AND PATIENT TO CHARGE HIGHER FEES** Council decided that the existing ruling be retained, namely that if it was brought to the notice of the Council that a practitioner rendered an account which exceeded the fees normally charged considerably, the taking of disciplinary steps would be considered, irrespective of whether the patient agreed with the practitioner prior to the rendering of the service to pay the higher fee or not. Ref: October 1988 Vol 6 p. 144. **7.1.21 FEES CHARGED FOR SERVICES RENDERED BY NURSE EMPLOYED BY PHYSICIAN** a. A physician informed Council that he employed a nurse to assist him with diabetes mellitus. The nurse carried out investigations for control, as well as practical management	allegation of excessive fees charged; ii. it was not permissible to render an account for services still to be rendered by such practitioners. However, in the event of services to be rendered to foreign patients, the Board could see no objection to an arrangement whereby a financial institution, acting on behalf of a patient, guaranteed payment of an account to be rendered. 4. The **Executive Committee of the Medical and Dental Professions Board in October 2000** resolved that it was not permissible to apply the resolution on advance payment of fees as set out in 2.i. above to cardiac rehabilitation programmes Code 14:31 and 14:32. **CHARGING OF FEES FOR SERVICES NOT RENDERED** 1. **In March 2014 the Board –** a. NOTED the following October 2001 ruling of the Executive Committee of the Board: CANCELLATION OF MEDICAL AND DENTAL APPOINTMENTS The Secretariat received regular calls from members of the public and from the medical and dental professions on what the policy of the Board was with regard to the cancellation of medical and dental

	of and instructions to diabetic patients who consulted the physician. This service was rendered free of charge, but the physician requested that a tariff code should be determined for this work. b. Council informed the physician that it noted the contents of his letter, but that what he envisaged was not permissible. Ref: October 1988 Vol 6 p. 145. **7.1.22 SEPARATE ACCOUNTS FOR ONE SERVICE** Council resolved that it was not permissible for a practitioner to send out accounts with a notice stating that the medical aid tariff had been charged by that practice on condition that the account was paid within 60 days, but should the account not be paid within that period of time, the account would then revert to the Medical Association tariff Ref: April 1988 Vol 6 p. 148. **7.1.23 DEPOSIT REQUIRED FOR MEDICO-LEGAL REPORTS** A neurosurgeon required a deposit before he would examine a patient for the purposes of medico-legal reports. Council did not have any objection to the request by the practitioner for the payment of a deposit for a service of a non-personal nature such as the service outlined where the attorney did not accept personal responsibility for payment of the practitioner. Ref: October 1986 Vol 6 p. 149. **7.1.24 FINAL NOTICE RE COLLECTION OF FEES** In reply to a patient who advised that he had been threatened	appointments. *In this regard the policy guidelines of the Medical Association were brought to the attention of the Secretariat. The policy stipulated that, unless timely steps were taken to cancel an appointment, the relevant consultation fee might be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist, twenty-four (24) hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warranted, no fee shall be charged. If a patient had not turned up for a procedure, each member of the surgical team would be entitled to charge for a consultation at or away from the rooms of the doctor concerned.* *The Executive Committee of the Medical and Dental Professions Board resolved in the above regard that –* a. the above policy of the Medical Association be noted; b. it be recorded that the Board would have no objection if the above policy guidelines would be applied in practice by medical practitioners and dentists. Ref: MDB Exco: Oct 2001: Item 41 b. RESOLVED that practitioners be not allowed to charge for services not rendered based on rule 7. 5. of the Ethical and Professional Rules of the Health

	with court action if he did not bring his account up to date, Council advised the patient that Council did not see any objection to a practitioner sending a final notice if the payment for an account remained outstanding for a considerable period. Ref: October 1986 Vol 6 p. 150. **7.1.25 LISTING OF "BAD DEBT" PATIENTS** a. A partnership of practitioners enquired whether medical aid schemes could be sent a letter pointing out that patients' accounts would be computerised so that, at the end of each month, statements would be forwarded direct to the medical aid scheme and identical copies to the patients. Council resolved that the partnership be informed that a practitioner was personally responsible for his or her practice, including matters relating to the accounts of the practice. Ref: October 1981 Vol 6 p. 152. b. The Medical and Dental Professions Board confirmed its previous resolutions regarding the listing of "bad debt" patients, namely – i. there was no objection to a practitioner subscribing (i.e. receiving on a regular basis upon payment or otherwise) to lists, published by any agency, of persons who represented a bad risk financially, in view thereof that a practitioner was free to decide to whom he or she wanted to render services; ii. a practitioner could, however, be called upon to justify his or her action in the event of unnecessary suffering or death resulting from his or her refusal to render help to a patient; iii. a practitioner was also obliged to render assistance	Professions Council of South Africa: (*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.* 2. In her email latter dated 15 May 2014 Dr M Khan, Manager Coding and Nomenclature, SADA, refered to the item of April 2014 eBulletin in particular the item dealing with "Charging for no-shows" which states, **"**The common practice of charging patients who do not honour appointments is in breach of the Council's ethical rules that states: *"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.* Practitioners are urged to uphold the ethical rules and regulations" 3. According to Dr Khan SADA would like to point out that this ethical rule is for services being provided by persons other than the practitioner and the practitioner charging for such services. This rule does not apply for an appointment not kept. 4. **In September 2014 the Board** RESOLVED that the matter be deferred to

	under all circumstances in emergencies. However, it was only permissible for practitioners to furnish information on their own "bad debt" patients to agencies for inclusion in a list if such a list was intended solely for circulation amongst practitioners registered with the Council, since this could be regarded as being of inter-collegial interest and assistance; iv. patients could, therefore, only be listed on a "closed user group" database at the request of a particular practitioner if such a list was intended solely for circulation amongst practitioners registered with Council; v. should a practitioner decide to list a "bad debt" patient on a "closed user group" database, such patient should be informed in writing of such action by the "listing agency" concerned; vi. should there be a dispute between the practitioner and the patient concerned regarding an outstanding debt, such patient should not be listed until the dispute had first been settled; vii. practitioners and not the "listing agency" should decide whose name should be listed; viii. a patient should be properly informed by the practitioner concerned about the implications should his or her name be listed before such action was taken. Prior to treatment, a practitioner should make full details available to the patient regarding the cost of treatment; ix. a practitioner should not refuse treatment to a patient at the request of another practitioner to whom that patient was indebted. Ref: MDB Exec Feb 2002: Item 50	the next meeting of the Executive Committee. 5. **In October 2014 the Executive Committee -** a. NOTED that the Committee had no objection with practitioners charging fees for the cancellation of appointments on short notice, but that no fees could be charged for services not rendered. b. RESOLVED that – i. Adv P Khumalo be requested to provide guidance on how the ethical rules could be amended to provide for the charging of fees for the cancellation on short notice of appointments; ii. it be recommended to the Board that – aa. the previous resolution be rescinded to make provision for the amendments to the Generic Ethical Rules incorporating the guidance provided by Adv P Khumalo on the matter; bb. the press release made on the charging of fees be withdrawn and be replaced by a new press release which will incorporate the guidance provided by Adv P Khumalo; iii. feedback be provided to Dr Khan of the Dental Association of South Africa.

	7.1.26 FRAUDULENT USE OF MEDICAL AID SCHEME MEMBERSHIP CARDS Council informed the Medical Association that Council could see no objection to a practitioner resubmitting an account for a higher fee (private fee) in a case where a patient was not a member of a medical aid scheme and fraudulently presented a medical scheme membership card. Ref: October 1983 Vol 6 p. 153. **7.1.27 COMPUTER LINK BETWEEN PRACTITIONERS AND MEDICAL AID SCHEMES** Council rescinded its resolution of November 1980 and resolved that – a. an account must in the first instance be rendered to the patient (as was required by section 53 of the Act); b. the practitioner could simultaneously, with the patient's consent and with the concurrence of the medical aid scheme and, provided the account was based on the scale of benefits, submit to the medical aid scheme concerned, a copy of the account on which was indicated that it had also been submitted to the patient; c. the rendering of accounts to a medical aid scheme through a computer link would be permissible, subject to compliance with a. and b. above. Ref: April 1988 Vol 6 p. 154. **7.1.28 CHARGING OF FEES BY HOSPITAL FOR PSYCHIATRIC**	6. **In December 2014 the Board -** i. NOTED that – a. the Board accepted its responsibility to provide guidance to practitioners registered with the Board; b. charging of fees was an important matter in relation to informed consent by the patient. ii. RESOLVED that – a. the October 2001 ruling was still applicable; b. the Practice Committee be requested to provide guidance on how the matter of no-shows could be managed, as well as the development of a new billing code for "no shows". 7. **In January 2015 the Practice Committee -** i. NOTED that – a. Rulings are only binding to a specific case in hand and cannot be applied unilaterally to other case whereas Ethical Rules of Conduct for Practitioners are applicable and binding to all matters; therefore the Rulings need to be reviewed and if found to be

	REPORTS The Director-General of Health advised that psychiatric hospitals of the Department were asked from time to time by insurance companies to provide medical reports on discharged patients and, because such reports were required for commercial purposes, the question arose whether a fee could be charged for such a service. Council informed the Director-General that it did not have any objection to the charging of fees for psychiatric reports, provided that the consent of the patient was obtained in terms of Ethical Rule 12 (professional confidentiality). Ref: April 1984 Vol 6 p. 156. **7.1.29 CHARGING LOWER TARIFFS** A dentist wrote that he did not agree with the schedule of fees which had then been published by the Dental Association as he felt that the increases were inflationary and unnecessary. He indicated that he intended sending a communication to this effect to his bona fide patients. Council advised the dentist that he was at liberty to charge a fee lower than the tariff recommended in the schedule of fees published by the Dental Association. However, the proposed communication to patients as contained in his letter was not permissible. Ref: October 1986 Vol 6 p. 160. **7.1.30 FEES FOR ASSISTANTS AT OPERATIONS** Regarding going into private practice, a practitioner had been informed that it was customary to send an assistant's fee to the referring practitioner, even when that practitioner was not present at the operation. It had been suggested that failure to do so, could result in unpopularity and the withdrawal of support from referring practitioners. Council advised the practitioner	relevant should be recommended for inclusion onto Ethical Rules of Conduct for Practitioners Registered under the HPCSA Act,1974 ; b. Concern of interference with the contract between the patient and the practitioner was raised. ii. RESOLVED that – a. process of changing the Ruling into an Ethical Rules of Conduct for Practitioners for it to be enforceable should be initiated; b. recommend to MDB and Council to develop a Rule on no-show and an amendment to Ethical Rules of Conduct for Practitioners Registered under the HPCSA Annexure 6 for MDB; c. Benchmark with other regulatory and professional bodies on how they handle such practices; and d. Secretariat be delegated the responsibility to research and prepare a document to be presented on the 23 March 2015 meeting. 8. **In March 2015 the Board** resolved that the Practice Committee of the Board be tasked to draw up guidelines pertaining to services not rendered. 9. **In March 2015 the Practice Committee** RESOLVED that –

	that it was not permissible to send an assistant's fee to a referring practitioner if such practitioner did not assist at the operation. Ref: October 1980 Vol 6 p. 161. **7.1.31 ADVANCE PAYMENT OF FEES** a. Council resolved that it was not permissible for a practitioner to charge fees for services not yet rendered. With regard to costs of prostheses, consideration could be given to letting the patient purchase some prostheses from a supplier or through the institution where the operation was to be performed prior to the operation itself. Ref: October 1980 Vol 6 p. 162. b. The Executive Committee of the Council resolved that – i. it be placed on record that the advance payment of fees by patients for services rendered by practitioners would be acceptable to Council, provided that such payment related only to the co-payments at medical aid rates required from patients and that a practitioner would be called upon to justify his or her action in the event of unnecessary complications, suffering, or death resulting from the practitioner's refusal to treat a patient for not paying in advance; ii. should the Medical Association wish to draft a policy statement on the advance payment of fees received by patients, Council would wish to see such statement prior to its dissemination. c. The Medical and Dental Professions Board resolved that – i. should a medical practitioner or dentist and a patient	a. This matter is a work in progress; b. This committee develops that which should be the Rule on "Charging fees for No Show"; c. Delegated Adv Mathibeli and Dr Kwinda to start the process of crafting the Ethical Rule for Charging fees for No-Show (services not rendered) with reference to the National Consumer Act (note S17) and other relevant literature. Due by 29 July 2015. 10. In **December 2015 the Board –** i. noted that the Board and Council was requested to develop a Rule on no-show and an amendment to Generic Ethical Rules of Conduct for Practitioners Registered with HPCSA (Annexure 6) ii. RESOLVED that further consideration of the matter be deferred to the next meeting of the Executive Committee. 11. **In February 2016 the Practice Committee –** i. NOTED that Dr Kwinda had submitted a proposed Ethical Ruling: Cancellation of medical or dental appointments.

	come to an agreement regarding the quantum of the fees to be charged for services to be rendered, it was unlikely that the Board would take cognisance of the fees, but this would not preclude the Board from inquiring into an allegation of excessive fees charged; ii. it was not permissible to render an account for services still to be rendered by such practitioners. However, in the event of services to be rendered to foreign patients, the Board could see no objection to an arrangement whereby a financial institution, acting on behalf of a patient, guaranteed payment of an account to be rendered. d. The Executive Committee of the Board resolved that it was not permissible to apply the resolution on advance payment of fees as set out in b.i. above to cardiac rehabilitation programmes Code 14:31 and 14:32. Ref: MDB Exec Oct 2000, Item 34 **7.1.32 PAYMENT OF ACCOUNT BY CREDIT CARD** Council advised the Medical Association that it did not have any objection to practitioners making provision for a tear off slip on account forms on which the patient could enter his or her credit card number, signature and the amount owing, and returning such a slip as payment of the account in a similar fashion as payment by cheque. Ref: April 1986 Vol 6 p. 164. **7.1.33 ASSIST PLAN INTERNATIONAL** Council did not have an objection to a practitioner entering into a contract with a company, Assist Card International, which assisted visitors from abroad who had purchased an assist	**Ethical Ruling: Cancellation of medical or dental appointments** A patient reserves the right to cancel a medical and dental appointment and a medical and dental practitioner may not charge a consultation fee or a procedure fee for such a cancelled appointment unless: 1. A cancellation was made less than 24 hours for a specialist appointment and less 2 hours for a general practitioner appointment, before the appointment time. 2. A practitioner can provide evidence of failure to find an alternative patient between the time of receiving the cancellation notice and the time of the cancelled appointment. 3. The practitioner can provide sufficient proof that the patient was informed about the cancellation of appointments policy. 4. The practitioner has first established the reasons of the patient's failure to cancel or honour the appointment. ii. RESOLVED to adopt the Ethical Ruling and recommend to Board for adoption 12. **In May 2016 the Board -** i. NOTED that the Office of the Ombudsman proposed an Ethical Ruling

	card, with medical services without accruing any further charges. The cost of medical services would be carried by the international company and the attending practitioner would be paid directly. Ref: April 1980 Vol 6 p. 165. **7.1.34 SIGN IN WAITING ROOM REGARDING PAYMENT BY CREDIT CARD** Council advised the Medical Association that it could see no objection to the display of a plain sign in practitioners' waiting rooms bearing the words: "Accounts may be paid by cash, cheque or credit card", provided the other rulings of Council concerning payment by means of a credit card were complied with. Ref: October 1985 Vol 6 p. 167. **7.1.35 FINANCING AND PROCESSING OF ACCOUNTS BY COMPANIES** Council informed a general practitioner that it was not permissible for a company to buy the accounts of practitioners, subject to conditions, and to process such accounts. Ref: April 1981 Vol 6 p. 168. **7.1.36 SESSION OF BOOK DEBTS** The Executive Committee of the Medical and Dental Professions Board resolved that – "A practitioner would remain responsible for his or her own accounts in respect of professional services rendered by him or her, including the collection of monies from patients in settlement of such accounts, whether or not a cession of the	regarding the cancellation of medical and dental appointments. ii. FURTHER NOTED that in February 2016 the Practice Committee NOTED that Dr M A Kwinda had submitted a proposed Ethical Ruling: Cancellation of medical or dental appointments. **Ethical Ruling: Cancellation of medical or dental appointments** A patient reserves the right to cancel an appointment and a practitioner may not charge a consultation fee or a procedure fee for such a cancelled appointment unless: 1. A cancellation was made less than 24 hours for a specialist appointment and less than 2 hours for a general practitioner appointment, before the appointment time. 2. A practitioner can provide evidence of failure to find an alternative patient between the time of receiving the cancellation notice and the time of the cancelled appointment. 3. The practitioner can provide sufficient proof that the patient was informed about the cancellation of appointments policy. 4. The practitioner has first established the reasons of the patient's failure to cancel or honour the appointment.

	whole or a portion of such practitioner's book debts had been affected. The Board does not express a view on financial arrangements which practitioners make with financial institutions in respect of such accounts, saving to record that the practitioner would remain personally and professionally responsible and accountable to the Board and to his or her patients in respect of these accounts". Ref: MDB Exec June 2001, Item 43 **7.1.37 FINANCE SCHEME FOR PATIENTS** a. A company offering special financial arrangements to those patients who could not afford to pay cash for their medical requirements, proposed the following procedure. The practice would offer the company's finance arrangements to patients as an alternative means of settling the account. On receipt of the completed agreement, the company would pay the practice, the capital amount less its commission, within the specified time period. The company would then send out monthly statements and undertake the necessary follow-up to the point of handing the patient over for collection. If, after a period of two months, the patient failed to meet his or her monthly repayments, the company would warn the practice concerned of a possible bad debt. If mutual efforts to collect were to be unsuccessful, the company would hand the debt back to the practice. The commission would then proportionately be based on the percentage of the capital amount collected. b. Council resolved that the finance firm be informed that what was envisaged, was not permissible. Ref: April 1987 Vol 6 p. 170. **7.1.38 TREATMENT OF DEPENDANTS AND RENDERING OF**	5. The patient must be informed about these conditions when making the appointment. The Practice Committee recommended the adoption of the Ethical Ruling submitted. ii. RESOLVED that - a. the Ethical Ruling on cancellation of medical and dental appointments be ratified and adopted; b. the Medical and Dental Board Rules be amended to reflect the adopted Ethical Ruling; c. the Ethical Ruling be communicated to the Medical and Dental professionals. **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

	ACCOUNTS IN RESPECT THEREOF The Medical and Dental Professions Board – a. resolved that the previous resolution by the Interim Council be confirmed, namely that it was permissible for a practitioner to treat his or her immediate dependants, but that it was not permissible for a practitioner to render accounts for services rendered to such dependants, except in the case of laboratory fees and material for which it would be permissible to render an account b. Having considered a request by Discovery Health for clarification as to whether "material", as referred to in the above resolution by the Board, also included "dispensary pharmaceuticals", the Executive Committee resolved that the expression "material", could include "dispensary pharmaceuticals" Ref: MDB Exe: Febr 2001: Item 30 **7.1.39 SPLIT VS BALANCED BILLING FOR PROFESSIONAL SERVICES** The Chief Executive Officer, Gynaecology Management Group Ltd, stated that, in the light thereof that the medical aid reimbursement rate lagged far behind the recommended rate of fees of the Medical Association, doctors were requiring patients to collect the balance. This required doctors to balance the bill which meant to specify the medical aid and patient's portions, and the total. When the medical aid schemes received such a bill, the money was usually paid to the patient and in many cases the doctor would never be paid. Bad debt further aggravated the situation as the doctor might build this into the price or charge 'at scale' tariffs and make up the difference by over-servicing.	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. (6) A practitioner shall explain to the patients the benefits, costs and consequences associated with each service option offered. **PRACTICE GUIDELINES: PROPOSED ETHICAL RULING ON BILLING PRACTICES** In July 2016 the Board, after a motivation received from the Office of the HPCSA Ombudsman, had resolved to task the Practice Committee with development of practice guidelines in relation to, but not

	The Executive Committee of the Medical and Dental Professions Board resolved that the previous resolutions by the South African Medical and Dental Council be confirmed, as follows: a. Resulting from a case where practitioners either required advance payment or submitted more than one account for the same service – one account to the medical aid scheme according to the Scale of Benefits and a second account for the balance to the patient, Council ruled that practitioners were not permitted to use such billing methods. b. Complaints had also been investigated where one part of the account was rendered according to the Scale of Benefits and the other according to the Private Tariff while it had been stated on the account that it was rendered in accordance with the Scale of Benefits. Council directed practitioners' attention to the fact that such method was inadmissible. c. Although a practitioner would at all times be free to use whichever scale he or she wished, the items according to the particular scale should appear on a separate statement and rendered according to either the relevant regulations in terms of the Medical Schemes Act (Scale of Benefits) or according to the Medical Association's guidelines (Private Tariff). It was suggested that where the Private Tariff was used, the statement should contain an indication to that effect explaining to the patient how to set about paying the account. Ref: MDB Exco: May 2001: Item 85 **7.1.40 CANCELLATION OF MEDICAL AND DENTAL APPOINTMENTS** The Secretariat received regular calls from members of the	limited to billing practices for different categories of practitioners registered with the Medical and Dental Board (MDB). The Practice Committee on 11 November 2016 and explored the following issues: Proposed Ethical Ruling: Rendering of separate accounts for services rendered by same health practitioner / Split-billing. In May 2016 the Human Rights, Ethics and Professional Practice Committee tasked the Ombudsman to put together a guideline that will provide guidance regarding two separate accounts rendered by same practitioner for the same professional service. In April 1986 the South African Medical and Dental Council (SAMDC) had resolved that, in the event of a practitioner performing a number of procedures at the same time and rendering an account in respect of procedures covered by medical aid schemes and a separate account in respect of procedures not so covered, each account must contain a cross reference in respect of the procedures indicated in the other account. The Executive Committee of the MDB further resolved that the previous resolutions by the SAMDC be confirmed, as follows: a. Resulting from a case where practitioners either required advance payment or submitted more than one

	public and from the medical and dental professions on what the policy of the Board was with regard to the cancellation of medical and dental appointments. In this regard the policy guidelines of the Medical Association were brought to the attention of the Secretariat. The policy stipulated that, unless timely steps were taken to cancel an appointment, the relevant consultation fee might be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist, twenty-four (24) hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warranted, no fee shall be charged. If a patient had not turned up for a procedure, each member of the surgical team would be entitled to charge for a consultation at or away from the rooms of the doctor concerned. The Executive Committee of the Medical and Dental Professions Board resolved in the above regard that – a. the above policy of the Medical Association be noted; b. it be recorded that the Board would have no objection if the above policy guidelines would be applied in practice by medical practitioners and dentists. Ref: MDB Exco: Oct 2001: Item 41 **7.1.41 SERVICE CHARGE PAYABLE BY PRACTITIONERS** According to documents submitted by a member of the Professional Board for Physiotherapy and Biokinetics and also Chairperson of the PhysioFocus Tariff Committee, Promedis (Pty) Ltd, an agency that assisted patients who had claims in terms of injuries on duty, especially from abroad, required of practitioners to levy an additional 30% on top of the agreed professional fee for a specific service which then was deducted from the payment to the practitioner as a service levy. The	account for the same service – one account to the medical aid scheme according to the Scale of Benefits and a second account for the balance to the patient, Council ruled that practitioners were not permitted to use such billing methods. b. Complaints had also been investigated where one part of the account was rendered according to the Scale of Benefits and the other according to the Private Tariff while it had been stated on the account that it was rendered in accordance with the Scale of Benefits. Council directed practitioners' attention to the fact that such method was inadmissible. c. Although a practitioner would at all times be free to use whichever scale he or she wished, the items according to the particular scale should appear on a separate statement and rendered according to either the relevant regulations in terms of the Medical Schemes Act (Scale of Benefits) or according to the Medical Association's guidelines (Private Tariff). It was suggested that where the Private Tariff was used, the statement should contain an indication to that effect explaining to the patient how to set about paying the account. **LEGISLATIVE FRAMEWORK UNDERPINNING BILLING PRACTICES** i. **The National Health Act:** • **Section 6(1)(b) & (c)** of the National Health Act states that. "Every health care provider must inform a user of the range of diagnostic procedures and

	Board was asked for a ruling regarding such a practice. It was resolved by the Executive Committee of the Medical and Dental Professions Board that it be recorded that the above practice was considered by the Committee to be not permissible. Ref: MDB Exco: Aug 2001: Item 80 **7.1.42 PROPOSED PAYMENT OF ADMINISTRATION FEES BY PATIENTS IN RESPECT OF MEDICAL AID SCHEME CLAIMS** a. The Dental Association recommended as follows in the above regard: i. A dentist be permitted to charge an administration fee (for non-clinical services) in respect of the submission of a patient's claim to his or her medical aid scheme: Provided that the patient be informed by the dentist from the outset that, should fees not be paid in cash on completion of treatment and the patient required the dentist to submit the account to the medical aid scheme, an administration fee of RX would be charged. The patient shall be separately invoiced for that service. ii. The administration fee to be reasonable and to bear some relationship to the services provided and the practitioner may be called upon to justify the fees charged. iii. The proposed ruling also to be extended to those dentists who, though charging private fees, nevertheless were requested by the patient to submit an account for procedures covered by the medical aid schemes. b. The Executive Committee of the Medical and Dental	treatment options generally available to the user; the benefits, risks, **costs** and consequences associated with each option". • **Section 90 (u) (v)** of the National Health Act: ***'90.*** *(1) The Minister, after consultation with the National Health Council, may make regulations regarding- the processes and procedures to be implemented by the Director-General in order to obtain prescribed information from stakeholders relating to health financing,* *(u) the pricing of health services, business practices within or involving health establishments, health agencies, health workers and health are providers, and the formats and extent of publication of various types of information in the public interest and for the purpose of improving access to and the effective and efficient utilization of health services;* *(v) the processes of determination and publication by the Director-General of one or more reference price lists for services rendered, procedures performed and consumable and disposable items utilised by categories of health establishments, health care providers or health workers in the private health sector which may be used (i) by a medical scheme as a reference to determine its own benefits; and (ii) by health establishments, health care providers or health workers in the private health sector as a reference to determine their own fees, but which are not mandatory; '*

	Professions Board resolved that the Association be informed that – i. the payment of administration fees by patients in respect of medical aid claims did not fall within the ambit of the Board; ii. the Association be advised to take the matter up with the relevant medical aid authorities such as the Board of Healthcare Funders of South Africa or the Council of Medical Aid Schemes. Ref: MDB Exco: Dec 2001: Item 47 **7.1.43 APPOINTMENT OF PREFERRED MEDICAL SERVICE PROVIDERS BY MEDICAL AID SCHEMES** a. In principle Council had no objection to a medical aid scheme notifying its members of preferred provider agreements entered into with specific doctors, provided that – i. all doctors in the area(s) concerned were informed that they could apply to be preferred providers for the scheme. Furthermore, that no practitioner was unreasonably excluded from being a preferred provider for that scheme; ii. the patient was not deprived of his or her right of freedom of choice of a medical practitioner, albeit that it might cost the patients more; iii. in so notifying its members, exact details of the agreement with preferred providers (e.g. the extent of discounts or comparative details of costs) need not be furnished. However, members might be informed in general terms that the use of preferred providers would result in greater benefits to them;	i. **The Patient's Rights Charter:** According to the National Patients' Rights Charter (2.8), "Everyone has a right to be given full information about the nature of one's illness, diagnostic procedures, the proposed treatment and risks associated therewith and the **costs** involved". i. **The Health Professions Act:** • **Section 53(1**) of the Health Professions Act states that "every person registered under this Act shall, unless circumstances render it impossible for him or her to do so, before rendering any professional services inform the person whom the services are to be rendered or any person responsible for the maintenance of such person, of the **fee** which he or she intends to charge for such services: (a) when so requested by the person concerned; or (b) when such fee exceeds that usually charged for such services, and shall in a case to which paragraph (b) relates, also inform the person concerned of the usual fee" • **Section 53(2)** of the Health Professions Act States that: "Any practitioner who in respect of any professional services rendered by him or her claims payment from any person (in this section referred to as the patient) shall, subject to the provisions of the Medical Schemes Act, furnish the patient with a detailed account within a reasonable period".

	iv. practitioners who were approached to enter into preferred provider agreements with any organisation were obliged to ascertain that the provision of paragraph i. had been complied with. b. Having considered the concerns by the Medical Association, Goldfields Branch, regarding a certain medical aid scheme's policy that patients could only be referred to certain general practitioners and specialists, the Executive Committee of the Medical and Dental Professions Board resolved that – i. it was the free choice of a patient to decide which medical practitioner or dentist to consult, bearing in mind that it costs the patient more in medical expenses; ii. medical practitioners or dentists in the area should be informed that they could apply to be preferred providers for a particular medical aid scheme and no practitioner may unreasonably be excluded from being a preferred provider for such a medical aid scheme; iii. the Board could not prescribe ethical rules of conduct to organisations, but could do so for medical practitioners or dentists in the employ of such organisations; iv. this matter was also being regarded to be an employment issue and should be sorted out between the management of the relevant company and its employees. Ref: MDB Exec: Aug 2000: Item 37	iv. **HPCSA Ethical Rules**: Ethical Rule 27(A)(d) of the Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act, 1974 states that, " A practitioner shall at all times 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". v. **The Medical Schemes Act:** • **Section 59(1) of the Medical Schemes Act** states as follows: "A supplier of a service who has rendered any service to a member or to a dependant of such a member in terms of which an account has been rendered shall, notwithstanding the provisions of any other law, furnish to the member concerned an account or statement reflecting such particulars as may be prescribed". • **Section 59(2) of the Medical Schemes Act** states that, "a medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service

		within 30 days after the day on which the claim in respect of such benefit. vi. **Regulation 5 of the Medical Schemes Act**: Regulations states as follows: The account or statement contemplated in section 59 (1) of the Act must contain the following— (a) The surname and initials of the member; (b) the surname, first name and other initials, if any, of the patient; (c) the name of the medical scheme concerned; (d) the membership number of the member; (e) the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; (f) the relevant diagnostic and such other item code numbers that relate to such relevant health service; (g) the date on which each relevant health service was rendered; (h) the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine; (i) where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a

		medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it; <u>In terms of the legislative framework, the following obligations were noted:</u> a. A health practitioner has an obligation to inform the patient about the cost of services before rendering the services. It should be noted that this has nothing to do with the benefit option that the patient has purchased with his or her medical aid or the scale of benefits of the medical aid in relation to the service to be provided. b. A health practitioner has an obligation to Furnish the patient with a detailed account for the services rendered as prescribed in terms of regulation 5 of the Medical Schemes Act Regulations. The detailed account should include the nature and cost of each relevant health service rendered. Should there be an amount paid by the patient, the same amount should reflect as details in the detailed account. The same account should be sent to both the patient and the medical scheme for the purpose of re-imbursement. It should be noted that the submission of the account to the medical scheme is the primary responsibility of the member of the scheme (patient) and not the health Practitioner. Where health practitioners submit the account to the scheme for the purpose of re-imbursement it should

		be taken as a courtesy to the patient or member of the scheme. c. The patient has an obligation to pay for the services rendered to him or her by a health practitioner irrespective of the method of payment; whether through his or her medical scheme or out of pocket payment. d. Where a medical aid is a method of payment the medical schemes act places an obligation to the medical scheme to do so within 30 days of receiving the claims **BILLING PRACTICES** The differences between split billing and balanced billing for the purpose of this ethical ruling or guideline: i. **Two separate accounts means –** A situation where a practitioner renders a service/s to a member of a medical scheme, and in view of the scale of benefits purchased by the member of the scheme that cannot cover the cost for the services rendered, a practitioner requires the member to pay a portion of the cost of his or services, but the amount paid is not included in the account submitted to the medical scheme for re-imbursement purpose and only appear in the statement issued to the patient or member of the scheme.

		ii. **Split-billing means –** A situation where a patient is billed separately for the amount paid by the patient or member of the scheme which the scheme does not cover and the medical scheme is billed separately in line with the medical scheme tariff amount. In other words the account to the patient only reflects the amount that the patient is responsible for, while the claim/account to the medical scheme only reflects the amount equal to the benefits the medical scheme is prepared to pay for the service rendered and does not reflect the out of pocket payment by the member iii. **Balance-billing means –** A situation where the health practitioner bill the patient for the amount not covered by the scheme and sends two identical accounts to both the patient and the scheme indicating the full amount for the service rendered, but specifying the portion owed/paid by the patient towards the practitioner in view of the scale of benefits purchased by the member of the scheme. The committee deliberated and noted that: a. The primary common denominator underpinning the legal frameworks was the principle of Informed Consent and its application or lack application;

		b. Informed Consent was thereof identified as a common problem on the nature of billing practices that practitioners registered under the MDB were exposed to and consequently as the root cause for the complaints/challenges brought to the attention of Council; c. The committee RESOLVED to recommend to Board adoption of the proposed Ethical Ruling: **Rendering of separate accounts for services rendered by same health practitioner/Split-billing**: *i. In line with the mandate of the HPCSA of protecting the public and Rule 27A (d), and in compliance with the National Health Act and the Patients' Rights Charter (2.8) a practitioner is required to comply with principles and requirements of Informed Consent. From time to time, practitioner may require patients who are members of medical schemes to settle a portion or portion of their fees out of pocket. This is usually common when the scale of benefits that the member of the scheme has purchased with their scheme does not cover all the cost of the services rendered. A practitioner who has complied with requirements for Informed Consent in full and who is satisfied that the medical scheme will not cover all his/her costs is allowed to require an out of pocket payment from the member of the scheme.*

		ii. It is not permissible for health practitioners to do split-billing: the account to the patient only reflects the amount that the patient is responsible for, while the claim to the medical scheme only reflects the amount equal to the benefits the medical scheme is prepared to pay for the service rendered. However, the amount so required or paid should be reflected in the detailed account submitted to both the medical scheme and the member of the scheme (patient)
ETHICAL RULE 8: PARTNERSHIPS AND JURISTIC PERSONS **RULE 8** A practitioner shall only - (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	8. **RULINGS** **8.1. PROPOSED CONDITIONS UNDER WHICH CLOSE CORPORATIONS MAY BE ESTABLISHED BY MEDICAL PRACTITIONERS AND DENTISTS** The Executive Committee of the Medical and Dental Professions Board resolved as follows: a. Practitioners may conduct their practices in the following manners: I. In solus practice II. In partnership/Group/Organisation iii. Personal liability companies (incorporated company exempted in terms of section 54A of the Act) iv. In association v. In a trust under the same conditions as in the case of an incorporated practice. Iv Franchises (subject to compliance with the ethical rules) Any of the above who outsourced their administration or established a company to manage the administration provided that such arrangement is not in violation of the established	

professional category as the employing practitioner. (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.	ethical rules of Council. Any other business model/formation or structure outside of these models must come to HPCSA for consideration or approval by the HPCSA b. It followed that a practice may not be conducted in any other form such as in a close corporation with lay persons. Practitioners may not form any of the above entities with persons not registered under the Health Professions Act, 1974. c. However, a practitioner might form an entity to manage and administer his or her practice and/or to own assets used by the practice. In that sense the practice was renting services, such as the administration of property of that entity. Such an entity may be a close corporation which must be administered separately from the practice established to render patient related services. d. Close corporations can, therefore, be utilised by practitioners registered under the Act to render non-patient related services. Non-patient related services include, amongst others, the renting of rooms, leasing of vehicles and office equipment, payment of staff salaries and maintenance of buildings. e. It would be possible for practitioners to form a close corporation (or any other entity) with a clinic for purposes of owning the equipment in question. The close corporation was not to operate the unit as that was being regarded as conducting a practice. It could operate the unit in an ownership and administrative sense and rent the unit to a practitioner who wished to utilise it. f. Provision had been made for an entity, other than a hospital, to collect fees from patients for the use of	

equipment such as X-ray units owned by the hospital (the one third principle). Therefore, the close corporation could not bill patients and would have to collect rent from practitioners utilising the unit. The practitioner had to bill the patient for the full amount to which he or she was entitled.

ref: MDB exec: Aug 2001: item 79

8.2. DESCRIPTIVE TRADE NAMES FOR PRACTICES OF MEDICAL PRACTITIONERS AND DENTISTS IN SOLUS PRACTICES, PARTNERSHIPS, ASSOCIATIONS AND INCORPORATED PRACTICES

The Medical and Dental Professions Board resolved in the above regard –

a. that descriptive trade names are not used by medical practitioners and dentists in solus practices, partnerships, associations and incorporated practices;

b. medical practitioners and dentists in any of the types of practices referred to would, however, be permitted to name such practices after their own name or the names of their associates or partners, without limitation on the duration thereof, for example, the name or names of a partner or associate could be retained by the practice even after the death of such a partner or associate.

Ref: MDB Exco: June 2001, Item 44

8.3 IDENTIFICATION OF HEALTH CARE PROFESSIONALS IN PARTNERSHIPS, ASSOCIATIONS OR INCORPORATED PRACTICES

Having noted that it was not always possible for patients to identify a particular health care professional practising in

	partnerships, associations or incorporated practices, the Executive Committee of the Medical and Dental Professions Board resolved that health care professionals should be identified by means of a notice in his or her rooms which should specify the profession of each of the health care professionals concerned, e.g. Dr XXX Wilson, Physician; Dr YYY de Klerk, Obstetrician and Gynaecologist; Mr ZZZ du Toit, Psychologist, etc Ref: MDB Exco: May 2001, Item 90 **8.4 FORMATION OF TRUSTS BY MEDICAL PRACTITIONERS AND DENTISTS, AND WHETHER RULES FOR INCORPORATED PRACTICES APPLY** Having considered a request for a ruling on the formation of trusts by medical practitioners and dentists and whether the same rules as for incorporated practices would apply, the Executive Committee of the Medical and Dental Professions Board resolved that, although trusts were normally reserved for the protection of assets, the formation thereof for running a medical or dental practice would be permissible, subject to the same rules that applied in the case of incorporated practices. Ref: MDB Exco: Dec 2000, Item 50 **8.5 PARTNERSHIPS OF MEDICAL PRACTITIONERS AND DENTISTS IN MORE THAN ONE INCORPORATED PRACTICE ("PAPER PARTNERS")** Having considered a request for a ruling by the Medial Association with regard to the matter of "paper partners", the Executive Committee of the Medical and Dental Professions Board resolved that the Association be advised that paper partnerships by medical practitioners or dentists were not permissible.	

Ref: MDB Exco: Dec 2000, Item 49

8.6 HEALTH FARMS

Council resolved that practitioners were allowed to have consulting and waiting rooms in health resorts (or health farms), on condition that such practitioners did not have any financial interest in the particular health resort and that they generate their own accounts for services rendered by them. Practitioners were also informed that the Rule relating to advertising (see Rule 1) should be adhered to.

Ref: October 1993 Vol 6 p. 250.

8.7 PRIVATE CLINIC

a. A practitioner informed Council that he wished to open a clinic that would be able to admit a maximum of eight patients. He intended charging normal hospital fees. The idea was to admit his own patients for their convenience if such a patient required one to two days hospitalisation for close observation.

b. Council advised the practitioner that what he proposed to do was not permissible as part of his practice.

Ref: April 1987 Vol 6 p. 251.

8.8 ENTRANCE THROUGH MEDICINE SHOP

Practitioners were advised by Council that in erecting consulting rooms, provision had to be made for an entrance which would not be through a medicine shop.

Ref: April 1987 Vol 6 p. 252.

RECEPTION AREA VISIBLE TO PUBLIC

	a. A practitioner advised that he was planning to open a collection depot. The premises to be rented had stipulated that no curtains could be placed on the windows. He could design the depot layout such that the area where patients actually gave blood or other specimens was screened from public view. The waiting or reception area would, however, face a pedestrian mall and the main street, and would be visible from those points. b. Council advised the practitioner that it was not permissible for the reception area, to be visible to the public. Ref: October 1984 Vol 6 p. 255. **8.10 HEALTH SPA** Council informed a practitioner that the establishment of a health spa and an aesthetic spa on the same premises as his consulting rooms, necessitating the employment of beauticians to perform certain non-medical procedures, was not permissible. Ref: October 1981 Vol 6 p. 258. **8.11 MANICURING SERVICE AT CONSULTING ROOMS** A member of the public was informed that the rendering of manicuring services to patients in the waiting rooms of practitioners was not permissible. Ref: April 1981 Vol 6 p. 259.	
ETHICAL RULE 9: COVERING	**RULINGS** No rulings recorded	

A practitioner shall only - (a) employ as professional assistant or locum tenens or in any other professional capacity a person who holds registration under the Act, whose name currently appears on any register kept by the registrar under section 18 of the Act, or the Allied Health Professions Act, 1982, and who is not suspended from the practising of his or her profession; (b) in any way help or support a person registered under the Act, the Pharmacy Act, 1974, the Nursing Act, 1978, the Social Work Act, 1978, or the Dental Technicians Act, 1979, if the professional practice or conduct of such a person is legal and within the scope of his or her profession.		
ETHICAL RULE 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	**RULINGS** **10.1 MEDICAL DEPUTISING SERVICES** Council resolved that the following guidelines be agreed to: a. All applications for the rendering of deputising services should first be submitted to the local branch of the Medical Association for a recommendation, whereafter the application would be considered on an ad hoc basis and initially, if approved, be limited to a period of two years.	

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.	b. Applications for the rendering of deputising services should conform to the following principles: i. The organisation must be managed by medical practitioners. ii. The service should be for medical practitioners only. iii. The service should only be provided on the patient's own medical practitioner's request or authority. iv. The Rule relating to supersession should be strictly observed. v. Patients should be sent back to their own medical practitioners, as would usually be the case with patients seen by any medical practitioner in an emergency situation, and a report is to be sent to their own practitioners. vi. Fees were to be charged in the same manner as was usually done when attending to an emergency call on patients. vii. Although the patient was only seen once as an emergency, total care, as usual practice, must be completed by the patient's own practitioner since it would be impossible for any practitioner to complete the patient's emergency care without transgressing the Rule relating to supersession. Ref: October 1985 Vol 6 p. 197. **10.2 MEDICAL SERVICES TO STUDENTS ON TECHNICON CAMPUS** Council informed a technikon, that enquiries could be made	

	from already existing health services at university campuses regarding the rendering of medical services to students. Attention was invited to the fact that, if medical practitioners were to be appointed, such appointments should be advertised and that the medical practitioners responsible for the rendering of medical services to students, should also uphold the Rule regarding supersession with regard to the personal medical practitioner of the student. Ref: October 1986 Vol 6 p. 204. **10.3 SUPERSESSION BY OPHTHALMOLOGIST AND OPTOMETRIST** Council expressed the view that supersession, i.e. the taking over of a patient who was under actual treatment for the same condition, could take place between ophthalmologists and optometrists. Ref: April 1981 Vol 6 p. 209.	

ETHICAL RULE 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.	**NO RULINGS**	
ETHICAL RULE 12: PROFESSIONAL REPUTAION OF COLLEAQUES A practitioner shall not cast reflection on the probity or professional reputation or skill of another person registered under the Act or any other Health Act.	**NO RULINGS**	
ETHICAL RULE 13: 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	**13 ETHICAL RULING** **13.1 PHARMACY PERSONNEL ATTENDING CLINICALDISCUSSIONS** Council informed the director of hospital services of a province that Council could not see any objection to the personnel of the pharmacy department of a university attending clinical discussions regarding patients and their treatment at a provincial hospital, provided that the permission of the patients were obtained, the Rule regarding professional confidentiality was complied with and that non-medical practitioners did not attend the physical examination of a patient. Ref: October 1980 Vol 6 p. 211.	

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 (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.	**13.2 TRAINING OF THEOLOGY STUDENTS IN PSYCHIATRIC HOSPITALS** Council informed a university that it could not see any objection to the training of theology students in psychiatric hospitals, provided the consent of the patients concerned, their medical practitioners and the superintendents of the hospitals concerned were obtained and the students did not get involved in the clinical management of patients. Ref: October 1985 Vol 6 p. 212. **13.3 REPORTING OF CASES OF GUNSHOT WOUNDS** c. A director of hospital services of a province informed Council that an increasing number of patients were admitted to hospitals with gunshot wounds which, in many instances, were contracted while committing or attempting to commit a criminal act. He asked for a ruling on the question of whether medical practitioners were required to report such cases to the authorities. d. Council advised the director that Council did not wish to express an opinion on the matter of reporting of cases of gunshot wounds to the police. Council was of the view that if the authorities considered it necessary in the interest of the country, they might consider introducing legislation regarding such reporting. Ref: April 1981 Vol 6 p. 216. **13.4 CLINICAL INFORMATION TO PHARMACISTS IN HOSPITALS** d. The Superintendent of a hospital asked for a ruling from Council on the question of whether a departmental	

instruction to the effect that all clinical information (including a diagnosis) had to be supplied to the hospital pharmacist together with the prescription whenever medicines were prescribed for patients or staff, complied with the Ethical Rules.

e. Council directed the attention of the Superintendent to the provisions of the Ethical Rule relating to professional confidentiality and advised him that, making available clinical information could be construed as a contravention of that Rule.

Ref: April 1980 Vol 6 p. 217.

13.5 COMPUTER SERVICES FOR PRACTICES

a. A practitioner indicated that the following computer services were being made available to practices: Recording of patient appointments; patient accounting records; patient history recording; recourse to the following support information, namely ethical drug characterisation, WHO ailments details, printing of prescriptions and immediate printing of patient statements and medical aid claims. The computer service would maintain patient confidentiality and the cost of the system would be dependent on whether the doctor allowed advertising by means of his personal computer.

b. Council did not express itself on the legal aspects of the agreement. However, Council informed the practitioner that a practitioner was personally responsible to a patient in respect of matters relating to confidentiality and that the matter would be further considered on receipt of information regarding the advertising aspect.

Ref: April 1986 Vol 6 p. 218.

	13.6 DIVULGING INFORMATION TO HOSPITAL SOCIAL WORKERS a. Council considered the establishing of a register for hospital (medical) social workers in order to facilitate teamwork between social workers and clinical psychologists. Information was obtained from the Council for Social Work regarding professional confidentiality as applicable to persons registered with that Council. b. Council noted the Rules relating to the professional conduct of social workers and, in the light thereof, permitted persons registered with Council to divulge such information regarding a patient to social workers registered in terms of the Social Work Act, 1978, which the social worker required in the course of his or her professional activities and which was in the interest of the patient. Ref: April 1986 Vol 6 p.219. **13.7 GUIDELINES FOR ETHICAL BEHAVIOUR DURING CIVIL UNREST** a. Guidelines for ethical behaviour in situations following civil unrest issued by the Medical and Dental Associations were brought to the attention of Council. The guidelines inter alia stated that gunshot wounds did not have to be reported and that the divulging of the names or particulars of an unrest victim to law enforcement officers, was a breach of patient confidentiality and it was, therefore, unethical behaviour for which action could be taken by the relevant professional Council.	

	b. Council then resolved that – as far as the ethical aspects were concerned – aa. Council had resolved previously that it did not wish to express and opinion on the matter of reporting of cases of gunshot wounds to the police; Council was of the view that, if the authorities considered it necessary in the interest of the country, they might consider introducing legislation regarding such reporting; bb. Council had resolved also that it adopted the view that the rendering of medical assistance, in cases where a patient required such assistance urgently, remained compulsory - also where a terrorist was concerned, but in such cases, the authorities had to be advised of the circumstances without delay; cc. Council was of the view that a practitioner treating prisoners and detainees, should render the appropriate generally accepted medical assistance and, if he or she was not able to do this - for instance because the patient was removed from his or her care, or if his or her prescribed treatment was not adhered to - he or she should protest, indicate the condition of the patient and the probable consequences of such action and bring the matter to the attention of the district surgeon, or regional director of health or direct to the hospital services; dd. attention was directed to the Rule relating to professional confidentiality of the Ethical Rules and advised that, in a court of law, professional confidentiality may be contravened only under protest after direction from the presiding judicial officer; ee. Council referred also to its decision under the item "Responsibilities of medical practitioners regarding statutory	

	authority of police, (see item 31.69). ii Council did not express a view on the legal aspects of the matter. Ref: April 1986 Vol 6 p. 220 **13.8 PRACTICE PROFILE INFORMATION TO MEDICAL AID SCHEME** a. A medical practitioner informed Council that a medical scheme had requested him to provide information confidentially and without the consent of the patient in order to determine a patient practice profile for general practitioners, as well as for specialists in the same discipline in that area. The practitioner was dissatisfied because the provision of this information would be time-consuming and no remuneration was offered. The medical scheme would use this patient practice profile in order to identify possible over usage, misuse or exploitation of medical services. b. Council noted that the term practice profile was being used. Council did not have an objection to this and would like to receive further information regarding the functioning of this system after two years. Ref: April 1986 Vol 6 p. 222. **13.9 SENDING BROCHURES TO ATTORNEYS** The head of the department of forensic medicine of a university enquired whether a pathologist in the speciality Pathology (Forensic) may send brochures to attorneys and advocates. The head of the department was of the opinion that lack of expert evidence in a case may lead to an incorrect court verdict. The legal persons allegedly did not	

	always know to whom they should turn for help. Council decided that what was proposed, was not permissible. Ref: April 1986 Vol 6 p. 223 **13.10 REPORTING BY HEALTH CARE PROFESSIONALS TO POLICE ON ASSAULT OR OTHER CRIMINAL CASES** Having considered an enquiry in this regard, the Executive Committee of the Medical and Dental Professions Board resolved that – a. medical practitioner or dentist could only report cases of assault or other criminal conduct to the police if the patient who was the victim of such assault or other criminal activity agreed to such report, in view of the fact that the rights of the patient had to be respected; b it would nevertheless be expected of medical practitioners and dentists to also be guided by the stipulations of the Child Care Act, 1983 (Act No. 74 of 1983), and the Prevention of Domestic Violence Act, 1998 (Act No. 116 of 1998). Ref: MDB Exec: April 2000: Item 31 **13.4 REQUEST THAT PRESCRIBERS SPECIFY DIAGNOSES/CONDITIONS ON PRESCRIPTIONS** Having considered a request by the South African Pharmacy Council, the Executive Committee of the Medical and Dental Professions Board resolved that the February 2000 resolution by that Committee be re-confirmed, namely that the specification of diagnoses/conditions on prescriptions would be unethical and could, therefore, not be agreed to. Ref: MDB Exec: Dec 2000: Item 40	

	13.5 MAKING PUBLIC CONFIDENTIAL INFORMATION ABOUT PATIENT IN COURT OF LAW A medical practitioner was asked by a Court of Law to do a mental evaluation of a detainee in his capacity as a District Surgeon. During the evaluation of the detainee, that person divulged confidential and personal information to the said practitioner about the financial and mental state of her father. The said information was heard in open court and not in camera and was later published verbatim in the news paper Beeld of 14 July 2000. The Committee was asked to provide guidelines with regard to the confidentiality of doctor-patient information in a Court of Law. The Executive Committee of the Medical and Dental Professions Board, resolved in the above regard that – a) the medical practitioner concerned be advised that he should not have made confidential and privileged information about a patient known to a third party, in view thereof that the Board held the view that confidential information about a patient could only be released with the informed consent of that patient and that in a Court of Law, confidential information with regard to a patient's ailments should only be made available by a practitioner under protest and after direction by the presiding judicial officer; b). it was further the view of the Committee that, where confidential and privileged information about a patient was to be presented in Court by order of the Court, such information should be heard in camera and not in open Court; Ref: MDB Exec: Dec 2000: Item 65 **13.6 CONFIDENTIALITY IN RESPECT OF NATURE OF**	

	ILLNESS, AILMENT OR INJURY OF PATIENT The Executive Committee of the Medical and Dental Professions Board resolved that – a. the fundamental principle of confidentiality between doctor/dentist and patient should be maintained; ii. it should not be obligatory for a medical practitioner or dentist to specify the nature of an illness, ailment or injury and only to do so with the consent of a patient; iii. if a patient consulted another medical practitioner or dentist, full information on the condition of the patient should be made known to that medical practitioner or dentist on request; Ref: MDB Exco: Aug 2000: Item 33b. The Executive Committee of the Medical and Dental Professions Board resolved that a description of the illness, disorder or malady in layman's language could be provided by a medical practitioner or dentist on a medical certificate, but only with the informed consent of the patient; where a patient was not prepared to give consent, the medical practitioner or dentist should merely specify that, in his or her opinion, based on an examination, the patient was unfit for work. Ref: MDB Exco: May 2001, Item 60	
ETHICAL RULE 14: RETENTION OF HUMAN ORGANS (1) A practitioner shall only for research, educational, training or	**NO RULINGS**	

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 14 14 (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.		
ETHICAL RULE 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.	**15. RULINGS** **15.1 SIGNING MEDICAL CERTIFICATES ON F OF PRACTITIONERS** Council advised the medical officer of a factory that it was not permissible for nurses to sign medical certificates on behalf of medical practitioners. However, he was at liberty to accept or refuse medical certificates with illegible signatures presumably by locums or new partners. (Note the rule on the signing of official documents, see Rule 14). Ref: October 1984 Vol 6 p. 224. **15.2 DEATH AND CREMATION CERTIFICATES SIGNED BY PRACTITIONER FOR OWN FAMILY** Council noted a letter from the Medical Association regarding the signing of the death certificate and cremation form by a medical practitioner for his mother. Attention was directed to the relevant regulations relating to crematoria and the cremation of human remains as promulgated by the then	

	Administrator of Natal in terms of Ordinance 39 of 1969. Ordinance 70 provided that the confirmatory medical certificate required in terms of ordinance 65(c), if not given by the medical referee, shall be given by a medical practitioner of not less than five years' standing who is neither a relative of the deceased, nor a relative, partner or assistant of the medical practitioner furnishing the medical certificate required in terms of ordinance 65(b). Ref: October 1988 Vol 6 p. 225	
ETHICAL RULE 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	**16 ETHICAL RULING** **16.1 CERTIFICATE OF MEDICAL ATTENDANCE** a. A factory manager advised that he had received a certificate of medical attendance and not a medical certificate and enquired whether he would be justified in not paying the person concerned and not taking it off his sick leave. He felt that this type of certificate transferred the responsibility of deciding on the validity of illness from the doctor to the employer. b. Council informed the factory manager that Council was of the opinion that a practitioner was obliged to issue a factual certificate of illness if so requested by a patient; and that his attention be directed to the Rule relating to certificates (see Rule 16), as well as Council's previous ruling on the acceptance of certificates of illness. c. Council had previously made the following ruling on the acceptance of certificates of illness: i. An employer does have the right to refuse to accept a medical certificate where circumstances exist	

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	(whether of a medical or another nature) which justified such refusal. Naturally such refusal, involving as it does the exercise of a discretion, must be judicially exercised; and ii. in evaluating a certificate of illness, regard must also be had to the exact wording of the certificate. Ref: April 1988 Vol 6 p. 226. **16.2 CERTIFICATES OF ILLNESS ISSUED BY PRIMARY HEALTH NURSES** a. A provincial secretary stated that, in terms of section 38A of the Nursing Act, 1978, certain nurses were qualified and authorised to carry out any activity relating to physical examinations, the diagnosing of all physical ailments, the keeping and providing of prescribed medicines and the promoting of family planning. These personnel were mainly employed at remote clinics where medical practitioners were not readily available because of logistical problems. The question had thus arisen whether such nurses ought to be allowed to issue medical certificates in support of applications for sick leave. b. Council advised the provincial secretary that Council was of the opinion that the envisaged practice, as set out by him, was not permissible. Ref: October 1987 Vol 6 p. **16.3 ACCEPTANCE OF CERTIFICATES OF ILLNESS BY EMPLOYERS** Having considered its ruling on an employer's right to accept or refuse medical certificates, Council resolved that –	

	a. it was at no stage the intention of Council to suggest that an employer had the right to refuse to accept a medical certificate without contrary medical or other evidence; b. the decision of Council was not in the any manner intended to undermine the value of medical certificates, nor did it have the effect of doing so; c. it had, however, to be placed on record that, in the opinion of Council, an employer did have the right to refuse to accept a medical certificate where circumstances exist (whether of a medical or another nature) which justified such refusal. Naturally such refusal, involving as it did, the exercise of discretion, must be judicially exercised; d. in evaluating a certificate of illness, regard must also be had to the exact wording of the certificate. Ref: April 1986 Vol 6 p. 232. **16.4 ANAESTHESIOLOGIST ISSUING FICATES OF ILLNESS** Council did not see any objection to the issuing of a certificate of illness by an anaesthesiologist to his or her own patient, subject to the provisions of the Rule relating to professional acts (see Rule 21). Ref: April 1986 Vol 6 p. 233. **16.5 PERIOD FOR WHICH MEDICAL PRACTITIONERSAND DENTISTS MAY BOOK OFF PATIENTS ON SICK LEAVE**	

	The Executive Committee of the Medical and Dental Professions Board resolved that it was within the discretion of a medical practitioner or dentist in terms of his or her education and training and clinical experience to determine the period that a patient under his or her care and treatment was to be booked off from work. Ref: MDB Exco: Aug 2000, Item 33 16.6 STATUS OF MEDICAL CERTIFICATES ISSUED BY HEALTH CARE PROFESSIONALS REGISTERED WITH OTHER STATUTORY COUNCILS OR BOARDS SUCH AS PHARMACISTS The Executive Committee of the Medical and Dental Professions Board – b. in April 2000, resolved that – i. Medical certificates by other professions: Section 23 (2) of the BCEA: "the medical certificate must be issued and signed by a medical practitioner or any other person who is certified to diagnose and treat patients and who is registered with a professional council established by an act of Parliament" ii. it was the prerogative of the recipient of a certificate of illness to accept or not to accept such certificate; iii. the Committee could not express a view on the legality or validity of certificates of illness issued by health care professionals registered with other councils or boards. b. in August 2000, resolved that –	

	i. pharmacists were not considered by the Committee to be adequately qualified to issue certificates of illness in the case of many of the conditions identified in a document before it; ii. such certificates should be issued on the basis of a proper medical examination and diagnosis of a patient and not on the mere observation of a patient. Ref: MDB Exco: Aug 2000, Item 32 **16.7 AVAILABILITY TO PATIENTS OF CORNEAL TOPOGRAPHY PICTURES** The Executive Committee of the Medical and Dental Professions Board resolved that corneal topography pictures or copies thereof, together with a factual report on the treatment that the patient had thus far received, should on request be made available to the referring practitioner or to another ophthalmologist if the patient decided to consult such other ophthalmologist for a second opinion. Ref: MDB Exco: Aug 1999, Item 44	
ETHICAL RULE 17: PRESCRIPTIONS A practitioner - (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 I, 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	**17 RULINGS** 17. **COMPUTER DIAGNOSING PATIENTS AND RIBING MEDICINES** Having considered an enquiry from the Pharmaceutical Manufactures Association of South Africa with regard to medial consultation and prescription on line, the Executive Committee of the Medical and Dental Professions Board resolved that – c. with regard to the diagnosing of patients generated by computer, the previous resolution by the Executive Committee of the Interim Council be confirmed, namely that a medical practitioner or a dentist was personally	

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.	responsible for his or her diagnoses, irrespective of what facilities he or she used to aid him or her in that regard; d. medicine could only be prescribed on the basis of a physical examination which had been done of a patient. Ref: MDB Exco: April 2000, Item 36 **17.2 INTERNET AND E-MAIL PRESCRIPTIONS** With regard to concerns expressed by the Executive Committee of the Medical and Dental Professions Board with regard to the emerging international practice of internet and e-mail prescriptions, the Committee resolved that - a. no medical practitioner or dentist may issue a prescription unless he or she had ascertained through a personal examination of the patient, or by virtue of a report by another practitioner under whose treatment the specific patient was or had been, that such prescription or supply was necessary for the treatment of the patient, except in the case of a repeat prescription for, or the supply of a substance in respect of a patient with a chronic illness; b. only prescriptions issued by a medical practitioner or dentist registered in terms of the Health Professions Act, 1974, may be recognised as valid for dispensing purposes; Ref: MDB Exco: Dec 2000, Item 39 **17.3 PRESCRIBING AND DISPENSING BY RAL MEDICAL PRACTITIONERS** The Executive Committee of the Medical and Dental	

	Professions Board – a. in August 2000 resolved that – i. dispensing of medicine should occur in terms of the official guidelines as see out in HPCSA Form 119 which, amongst others, states that medicines may be dispensed by a medical practitioner or dentist provided – aa. it is done on such conditions as the Board may determine in general or in a particular case; bb. the medicine must be prescribed by himself or herself or his or her partner; cc. the medicine must be for the use of his or her own (or his partner's) patients; dd. the medicine must be personally compounded; ee. the dispensing must be incidental to his or her practice. ii. a medical practitioner or dentist may only prescribe and dispense medicine under his or her own name (signature) (see also Rule 17); Ref: MDB Exco: Aug 2000, Item 42 b. in August 2001 resolved that a general medical practitioner may dispense medicine on the script of a specialist only when he or she is in partnership, association or in an incorporated practice with that specialist and not when he is in solus practice. Ref: MDB Exco: Aug 2001, Item 57	

ETHICAL RULE 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.	**18 RULINGS** Employment of practitioners by private hospitals Council adopted the recommendations of a working committee of Council and decided that individual applications for the employment of practitioners by private hospitals would be considered by Council on an ad hoc basis, taking the following guidelines and factors into account: a. The following basic guidelines would apply: i. As a basis for considering such applications, the proposed employment should have as its object benefits to patients and not benefits to the private organisation, nor should it primarily be aimed at the financial stability of the practitioner. ii Relaxation of the specific Ethical Rule would only be considered in selected and well-motivated cases. b. The following factors would be taken into account: i. The motivated need for a specific service and the accompanying employment of full-time practitioners to render the service. ii. The capacity of the private hospital to render the service successfully for which full-time practitioners would have to be employed (see facilities and general infrastructure). iii. The capacity of the private hospital to render the more comprehensive service on a continuous basis with the aid of full-time practitioners, supported by a panel of practitioners who declared themselves prepared to render that service. iv. Whether the service would be rendered by practitioners	

	with the necessary and appropriate qualifications and experience that would be required to render the service for which the hospital wished to appoint full-time practitioners. v. Whether the full-time practitioner appointed as such by the private hospital would be limited to service rendering to the organisation or was intending to conduct a private practice from the private hospital. vi. Whether the private hospital would submit itself to the Ethical Rule and Guidelines relating to advertising and whether the available full-time posts at the hospital would be advertised in the general media (see Rule 1). Ref: April 1986 Vol 6 p. 234. **18.2 PRIVATE PRACTICE FROM PRIVATE HOSPITAL** Council advised the Medical Association that Council was of the opinion that it was not permissible for a practitioner holding a full-time post in a private hospital to conduct a private practice from that private hospital. Ref: October 1987 Vol 6 p. 236. **18.3 DENTIST EMPLOYED AGAINST POST OF MEDICAL OFFICER** Council advised the Superintendent of a hospital that Council did not have any objection to the appointment of a dentist by the hospital against a post of senior medical officer in the toxicology unit of the department of pharmacology to render a non-medical service in the toxicology unit, provided the dentist did not hold himself or herself out to be a medical practitioner. (The dentist also held the degree PhD in biochemistry).	

Ref: April 1993 Vol 6 p. 237.

18.4 EQUAL EMPLOYMENT OPPORTUNITIES FOR PRACTITIONERS

Council resolved that the Doctor's Guild be informed that Council was of the opinion that equal opportunities to practise their profession should exist for all persons registered with Council.

Ref: April 1986 Vol 6 p. 238.

18.5 DIAGNOSTIC RADIOLOGIST IN FULL-TIMEEMPLOYMENT ALSO CONDUCTING PRIVATE PRACTICE

Council informed the Medical Association that Council could not see any objection to a practitioner in full-time practice also conducting a private practice provided –

a. the Ethical Rules were complied with;

b. the contract of employment in terms of which the practitioner was appointed made provision for private practice;

c. the relevant full-time post was advertised and was re-advertised if the contents of the contract of employment were amended.

Ref: October 1986 Vol 6 p. 239.

Agreement between orthopaedic surgeon and private company

orthopaedic surgeon submitted a memorandum on his terms

	employment for consideration by Council. The memorandum agreement stated that - "the doctor undertakes during the currency hereof to continue to utilise the facilities including beds, theatre and other medical facilities available from time to time at the hospital to no lesser extent than at the date of signature hereof. the consultancy fee aforesaid shall be payable for a period of …..years from the inception date of the policy or until such time as the doctor fails to utilise the hospital facilities as contemplated in 2.2 above." uncil informed the orthopaedic surgeon that Council noted the ntents of his letter and that he could act as set out therein, vided the Ethical Rules were complied with, and the post as nsultant was advertised in terms of the Rule relating to fessional appointments of the Ethical Rules. However, ctions 2.2 and 4.1.2 of the proposed agreement were not rmissible. Ref: October 1988 Vol 6 p. 240. **18.6 ADVERTISING OF SERVICES OF UROLOGIST EMPLOYED BY NURSING HOME** a. The hospital manager of a nursing home advised that the nursing home had employed an urologist and enquired whether a letter which was submitted, would be acceptable to be circularised to medical practitioners. The letter mentioned the name of the urologist. b. Council informed the hospital manager that Council noted the contents of his letter. However, his attention was directed to the fact that the name of a practitioner should not be referred to and that, in terms of the Ethical	

	Rule relating to professional appointments, the post concerned had to be advertised; and Council might ask to be provided with a copy of the contract of employment. Ref: October 1988 Vol 6 p. 241. **18.7 COMPLIANCE WITH RULE RELATING TOPROFESSIONAL APPOINTMENTS BY PHARMACEUTICAL FIRM** a. A pharmaceutical company advised that it had recently appointed a medical adviser to its company without the post being formerly advertised in the open press. Notwithstanding, several candidates were interviewed and the appointment was made on merit. The successful applicant had now been refused membership to a branch of the Medical Association on the grounds that his post had not been advertised in terms of the Rules. b. Council advised to the pharmaceutical company that Council would not take action on the non-compliance with the Rule relating to professional appointments under the circumstances stated in the letter. However, the post should now be advertised. Ref: April 1988 Vol 6 p. 242. **18.8 PAYMENT OF PART OF SALARY OF PRACTITIONER TO HOSPITAL** a. A practitioner employed by the State advised Council that he would be seconded to Malawi on behalf of a church society. This would entail that he would receive a lower salary equal to that of other practitioners employed by the church society. The difference between his civil service salary and his salary in the employ of the church society	

would be paid into the account of the church society.

b. Council advised the practitioner that what was proposed with regard to the payment of part of his salary, was not permissible. Council did not foresee any problems if he would receive his full salary and would voluntarily donate a part of his salary to the relevant society.

Ref: April 1980 Vol 6 p. 246

18.9 SPECIALIST POSTS IN NON-CLINICAL DEPARTMENTS

Council informed the dean of medicine of a university that Council could see no objection to the appointment of persons who were medically qualified and who possessed special education and training in anatomy, physiology, biochemistry and pharmacology, but who were not registered with Council as specialists, to posts of specialists created on the joint staff establishment of a teaching institution and teaching hospital if such posts were allocated to non-clinical departments.

Ref: October 1981 Vol 6 p. 247.

18.10 MEDICAL OFFICER OF HEALTH POST AND PART-TIME PHYSICIAN

Council informed a practising specialist physician who also held a part-time appointment at a hospital that his acceptance of a post of part-time medical officer of health of a town was not permissible.

Ref: October 1980 Vol 6 p. 248.

18.11 ADVERTISING FOR INDUSTRIAL APPOINTMENTS

Council advised the Medical Association that it was not

	permissible to advertise for industrial appointments on the following industrial advertisement: "Factory doctors - Cape Town Doctor wishing to restrict his practice to industrial work, wishes to buy one or more factory appointments. Please reply" Ref: April 1986 Vol 6 p. 249.	
ETHICAL RULE 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.	**NO RULINGS**	
ETHICAL RULE 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	**20 RULINGS** **20.1 LEGAL ACTION AGAINST COMPLAINANT** a. Legal opinion was obtained regarding Council's ruling on legal action against a complainant by a practitioner against whom a complaint had been lodged. The legal opinion was as follows: i. In the normal course of events, a complaint lodged with Council against the conduct of a practitioner was privileged, and the complainant did not expose himself or herself to a possible civil action by a practitioner. ii. The abovementioned general rule was, however, not	

board, a committee of such board or an official of council.	applicable where the complainant had lodged the complaint with Council in bad faith or where the complainant was aware of the fact that the complaint was false in one or more respects. In such a case it was possible that the practitioner could hold the complainant liable in civil law on the ground of defamatory statements. b. Council confirmed its ruling on legal action against a complainant by a practitioner against whom a complaint had been lodged, namely that all complaints lodged with Council were privileged unless it could be proven that the complainant had acted in bad faith or fraudulently. Ref: October 1980 Vol 6 p. 210.7 **20.2 STATUTORY DUTIES TO COUNCIL OR BOARDS** During 2001, the Professional Conduct Review Committee of the Medical and Dental Professions Board expanded on this Rule as follows: a. A practitioner shall not refrain from furnishing the Processional Board with a response to the allegations of unprofessional conduct lodged against him or her, within the time frames as set out in the Regulations relating to Conduct of Inquiries into Alleged Unprofessional Conduct or such extended period as the Board may allow. b. A practitioner shall not refrain from attending a consultation or from furnishing the Board with information in terms of section 41(2) of the Act if requested to do so by the Board or a Committee of the Board in order to be able to proceed with a matter: Provided that, where a practitioner has submitted	

	written proof that he or she does not wish to file an explanation or to attend the consultation, this will be sufficient for purposes of paragraphs a. and b. c. If it appears to a Committee of Preliminary Inquiry that a practitioner has failed to furnish a response within the stipulated time frame or such extended period as may be allowed, or to attend a consultation when so required without just cause, the Chairperson or any member of such Committee may lodge an additional complaint of unprofessional conduct against such practitioner with the Registrar.	
ETHICAL RULE 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.	**21** **RULINGS** **21.1PATHOLOGY INVESTIGATIONS BY PERSONS NOT REGISTERED AS PATHOLOGISTS** Council resolved that - a. a general practitioner is limited to the conduct of normal side room pathology tests and, should he or she wish to do more than that, he or she must comply in all respects with the requirements of the Rule relating to the conduct of professional acts, and must be sufficiently qualified and adequately experience to conduct and control all the relevant tests; a. a hospital may conduct a pathology laboratory, provided there was sufficient supervision by a medical practitioner who was competent to carry out and to control all the tests; b. a medical technologist may only perform work in his or her profession under supervision of a medical practitioner; c. only a pathologist (clinical) may carry out acts pertaining to the other specialities of pathology, while a pathologist who was registered in another (related) speciality in pathology,	**GUIDELINES FOR PROFESSIONALS PERFORMING ACTS IN EMERGENCY SITUATIONS - GUIDELINES FOR SURGICAL ASSISTANCE** **Definition:** An assistant surgeon is someone who is able to participate in and actively assists a surgeon (from any clinical discipline including general practitioners and medical officers who are skilled at performing operations) in completing an operation safely and expeditiously by helping provide exposure, maintain haemostasis, and perform any other technical function required under the guidance of the surgeon. **Types of surgical assistants:** • Assistant surgeon: A practitioner who actively assists the operating surgeon. An assistant may be

	has to limit himself or herself to that speciality. Ref: October 1983 Vol 6 p. 276. 21.2 **GENERAL PRACTITIONERS DOING WORK OF SPECIALISTS IN SA INSTITUTE FOR MEDICAL RESEARCH** Council resolved that - a. it was of the opinion that, in the light of the historical set up and in view of its teaching, research and service delivery functions, the status quo relating to the activities of the SA Institute for Medical Research be maintained; b. it be recorded that, in the opinion of Council, general practitioners in the service of the SA Institute for Medical Research may conduct acts which normally were performed by specialist pathologists, provided such general practitioners had the necessary training and/or experience to perform such acts in terms of the Rule relating to the conduct of professional acts (see Rule 21); c. the Director, SA Institute for Medical Research be asked to ensure that the activities of the Institute were made known in such a way that it could not be regarded as advertising. Ref: October 1980 Vol 6 p. 279. **21.3 PATHOLOGY TESTS PERFORMED BY PHYSICIANS** Council resolved that - a. it was of the opinion that, in addition to the accepted	necessary because of the complexity of the procedure or because of the patient's condition. An assistant surgeon is usually trained (or is being trained) in the same clinical discipline. • Co-surgeons: Two or more surgeons, usually of the same clinical discipline, where the skill of these surgeons are necessary to perform distinct parts of a specific procedure. • Team of surgeons: Two or more surgeons, usually of different specialities, where the skill of these surgeons is necessary to perform distinct parts of a specific procedure. **Principles:** 1. The decision to use an assistant surgeon (or more than one assistant) is made by the surgeon performing that procedure, as it is that surgeon's responsibility to ensure that the operation is performed effectively, safely and expeditiously. Generally this means that a surgeon will seek assistance (looking at both the level of expertise and number of assistants required) in accordance with the complexity of the proposed procedure, and the

side room tests normally performed by physicians, physicians could, subject to the Rule relating to the performance of professional acts (see Rule 21), perform such other pathology tests as were acceptable in terms of the Regulations relating to the Specialisties and Subspecialities in Medicine and Dentistry and that only general practitioner fees may be charged for such tests performed by physicians;

b. should the Association of Physicians so wish, it could, through the Medical Association, submit a list of tests regarded as acceptable in terms of paragraph a. for consideration by Council.

Ref: April 1980 Vol 6 p. 280.

21.4 VIROLOGICAL TESTS PERFORMED BY PERSONS NOT REGISTERED AS VIROLOGISTS

a. The Director: National Institute for Virology expressed concern regarding so-called "groof-proof" kits to carry out a wide variety of vital tests. Many of these tests were of a high quality, but the easy performance and accessibility to tests for a number of viruses by way of these kits had brought with them the potential for widespread abuse which was apparently occurring with increasing frequency by individuals and laboratories with little virological expertise. The Director expressed the view that indiscriminate testing, inability to carry out adequate performance testing and, especially, the inability to evaluate test results and to carry out an informed back-up consultative service, were becoming more and more worrying. As a consequence numerous problems were being brought to the attention of the Institute.

b. Council informed the Director that Council noted the

urgency and setting under which it needs to be undertaken.

2. It is the general practice in South Africa that the first assistant at the operating table in highly complex procedures should be a qualified surgeon or a senior registrar in an approved training program in the same clinical discipline as the surgeon. Experienced, non-surgical medical/dental practitioners can also take on this role in operations of modest complexity or as a second assistant in highly complex operations.

3. If such an assistant/s as defined above is/are unavailable, other medical/dental practitioners who are experienced in assisting may participate. A medical/dental practitioner who assists with an operation should be sufficiently

4. Trained to participate in and actively assist the surgeon in safely completing the operation. When a medical/dental practitioner is unavailable to serve as an assistant in a life or limb saving emergency (or at times in remote or resource constrained settings), any other suitably qualified (licenced) health care professional can be called upon to assist.

	contents of his letter and that medical practitioners in terms of the Rule relating to performance of professional acts by practitioners, could perform any professional acts, provided they were adequately qualified and/or sufficiently experienced for the performance thereof. Ref: October 1988 Vol 6 p. 282. **21.5 WIRING OF TEETH FOR WEIGHT LOSS PURPOSES** Council resolved that the wiring of teeth for weight loss purposes was permissible, provided that the patient was referred to the dentist by a medical practitioner and that the dentist and medical practitioner were working in close collaboration with each other. Ref: October 1980 Vol 6 p. 283. **21.6 DIAGNOSTIC RADIOLOGICAL REPORTS BY GENERAL PRACTITIONERS** a. A Director of Hospital Services informed Council that he had been advised of a general practitioner who wrote radiological reports on official X-ray forms which the Director believed was contrary to the Rules of the Council. According to the information, the general practitioner recorded a diagnosis on the X-ray forms which could possibly be considered to be a report. b. Council advised the Director that, subject to the Rule relating to the performance of professional acts by practitioners, a general practitioner may carry out the acts as referred to in his letter, provided the practitioner did not hold himself out to be a specialist.	Ideally, such a practitioner should have sufficient training to conduct a delegated portion of a procedure without the need for direct supervision. 5. Deviation from standard practice, as described above, is justifiable in extreme life-saving circumstances but must be clearly recorded and is open to peer review. 6. The practice of inviting medical/dental practitioners in training or medical/dental students to be second assistants in an operation for training purposes is well established. 7. What is in the best interest of the patient must guide decisions made regarding assistants at surgery. It is therefore also good practice, to inform patients about who will be assisting/participating in their operations. ***Board 21 June 2021: Surgical Assistance*** **PRACTICE GUIDELINES UNDER EMERGENCY SITUATIONS: DOCTORS PERFORMING MAJOR SURGERY WITHOUT ASSISTANTS (DURING COVID-19)**

	Ref: April 1980 Vol 6 p. 284. **21.7 BIOCHEMICAL TESTS PERFORMED BY AUTOMATED METHODS** a. The College of Medicine asked for clarification with regard to which laboratory tests could be performed and what apparatus could be used by practitioners who were not pathologists or registered as medical technologists. Clarification was also asked as to whether a medical technologist could practise only under supervision of a pathologist or whether he or she could do so under the supervision of any medical practitioner. In cases where such tests were performed, should costs be separately charged or should the cost thereof be regarded as part of a consultation fee? b. Council informed the College of Medicine that – i. in addition to the normal side room tests performed by medical practitioners, they could perform any procedure subject to the Rule relating to the performance of professional acts by practitioners (see Rule 21) and, in the case of specialists, subject also to the regulation that specialists had to limit themselves to their speciality; i. if such procedures were carried out, they should be specified in accounts; i. the Ethical Rules specifically applying to medical technologists provided that medical technologists may undertake work under supervision of a medical practitioner. Such practitioner should, however, in terms of the Rule relating to the performance of professional acts, have the necessary qualification and/or experience to carry out such procedures.	The Medical and Dental Professions Board at its meeting on 21 June 2021 approved the Guidelines for professionals performing acts in emergency situations and the guidelines **Guidance regarding Surgical Assistants** **Definition:** - An assistant surgeon is someone who is able to participate in and actively assists a surgeon (from any clinical discipline including general practitioners and medical officers who are skilled at performing operations) in completing an operation safely and expeditiously by helping provide exposure, maintain haemostasis, and perform any other technical function required under the guidance of the surgeon. **Types of surgical assistants:** - Assistant surgeon: A practitioner who actively assists the operating surgeon. An assistant may be necessary because of the complexity of the procedure or because of the patient's condition. An assistant surgeon is usually trained (or is being trained) in the same clinical discipline.

Ref: April 1980 Vol 6 p. 285.

21.8 OESOPHAGOSCOPY PERFORMED BY MEDICAL PRACTITIONER

a. A medical practitioner advised that he was involved in an oesophageal carcinoma study, and enquired whether he was permitted to perform an oesophagoscopy.

b. Council advised the practitioner that, subject to the Rule relating to the performance of professional acts by practitioners (see Rule 21), Council could see no objection to what was envisaged.

Ref: April 1986 Vol 6 p. 286.

21.9 TEMPORARY PROHIBITION ON CERTAIN PROFESSIONAL ACTIVITIES OF MEDICAL PRACTITIONER

a. A Director of Hospital Services advised Council that an operation had been attempted at a provincial hospital by a practitioner who was apparently not competent to carry out that operation. He suggested as a possible solution that, where a complaint of incompetence had been received by Council, Council should, on the strength of confidential reports by three medical practitioners, order the practitioner concerned to desist from carrying out specified professional activities until Council had finalised the inquiry.

b. Council advised the Director that Council did not have the statutory authority to prohibit medical practitioners from carrying out professional activities on the basis

- Co-surgeons: Two or more surgeons, usually of the same clinical discipline, where the skill of these surgeons are necessary to perform distinct parts of a specific procedure.

- Team of surgeons: Two or more surgeons, usually of different specialities, where the skill of these surgeons are necessary to perform distinct parts of a specific procedure.

Principles:

1. The decision to use an assistant surgeon (or more than one assistant) is made by the surgeon performing that procedure, as it is that surgeon's responsibility to ensure that the operation is performed effectively, safely and expeditiously. Generally this means that a surgeon will seek assistance (looking at both the level of expertise and number of assistants required) in accordance with the complexity of the proposed procedure, and the urgency and setting under which it needs to be undertaken.

2. It is the general practice in South Africa that the first assistant at the

	as suggested by him. Should the Council, however, receive a complaint concerning the professional competence of a practitioner, Council would expedite the holding of an inquiry as much as possible. (See the subsequent amendment to the Act - section 15B(1)). Ref: October 1980 Vol 6 p. 287. **21.10 TRAINING OF MEDICAL PRACTITIONERS IN DIAGNOSTIC ULTRASOUND AND FEES FOR ULTRASOUND INVESTIGATIONS** a. The Medical Association expressed concern about the use of ultrasound machines by practitioners who did not have the necessary training to carry out the procedures. b. The Medical and Dental Education Committee expressed the view that, although practitioners may, in terms of the Rule relating to the performance of professional acts (Rule 21), carry out any professional act, the use of diagnostic ultrasound apparatus required training which should form part of the clinical training of medical practitioners in the relevant discipline of medicine. c. Council subsequently confirmed the opinion of the Education Committee. Ref: October 1983 Vol 6 p. 291. **21.11 ESTABLISHMENT OF AN ELECTRO-ENCEPHALOGRAM FACILITY BY MEDICAL PRACTITIONER** Council informed a medical practitioner that it could see no	operating table in highly complex procedures should be a qualified surgeon or a senior registrar in an approved training program in the same clinical discipline as the surgeon. Experienced, non-surgical medical/dental practitioners can also take on this role in operations of modest complexity or as a second assistant in highly complex operations. 3. If such an assistant/s as defined above is/are unavailable, other medical/dental practitioners who are experienced in assisting may participate. A medical/dental practitioner who assists with an operation should be sufficiently 4. trained to participate in and actively assist the surgeon in safely completing the operation. When a medical/dental practitioner is unavailable to serve as an assistant in a life or limb saving emergency (or at times in remote or resource constrained settings), any other suitably qualified (licenced) health care professional can be called upon to assist. Ideally, such a practitioner should have sufficient training to conduct a delegated portion of a procedure without the need for direct supervision. 5. Deviation from standard practice, as

objection to the establishment of an electro-encephalogram facility, provided that the Rule relating to advertising (Rule 1) and the Rule relating to the performance of professional acts by practitioners (Rule 21) were observed and only his own patients were tested.

Ref: April 1985 Vol 6 p. 292.

21.12 SPECIALISTS IN COMMUNITY HEALTH

a. A department of community health of a university enquired whether specialists in community health were able and free to practise clinical medicine in cases where services were offered voluntarily, where there was no gain and in instances where emergencies arose. What would the position be if a community health specialist was employed by a local authority and were to be allocated clinical duties in a local health authority's clinics?

b. Council advised the department of a previous ruling, namely that the speciality community health (previously referred to as preventative medicine) did have a right to exist on condition that –

i. education and training in the speciality must comply with the same requirements as in the case of other specialities;

ii. taking into account the existing policy relating to the Rules of conduct, a specialist in this speciality, shall limit himself or herself to his or her speciality and its functions which were primarily administrative. He or she could not handle clinical matters as they would then act within the field of a general practitioner.

described above, is justifiable in extreme life-saving circumstances but must be clearly recorded and is open to peer review.

6. The practice of inviting medical/dental practitioners in training or medical/dental students to be second assistants in an operation for training purposes is well established.

7. What is in the best interest of the patient must guide decisions made regarding assistants at surgery. It is therefore also good practice, to inform patients about who will be assisting/participating in their operations.

COSMETIC OPERATIONS BY GENERAL PRACTITIONERS

In October 2010 **the Medical and Dental Professions Board --**

a. NOTED that Dr A A Visser, Chief Executive Officer, Alliance of South African Independent Practitioners, in his letter dated 6 November 2009, requests information regarding general practitioners previously performed cosmetic surgery, since the ruling of the HPCSA on the performance of cosmetic surgery indicated that only registered plastic surgeons

Ref: October 1986 Vol 6 p. 293.

21.13 REFERRAL OF PATIENTS BY PHYSICIANS TO SURGEONS IN OTHER CENTRES

a. A physician stated that he was charged by a local general surgeon to the effect that he was not competent to refer a patient in his care to other surgeons in another centre. He apparently referred patients for elective cardiothoracic or neurosurgical procedures to another centre where, unlike the hospital concerned, there were cardiothoracic and neurosurgeons and full radiological facilities for preoperative evaluation.

b. Council informed the physician that it was of the opinion that, subject to the rights of a patient, it was in the discretion of a medical practitioner to refer patients to colleagues of his or her own choice and, in exercising such a discretion, the referring doctor had to accept responsibility for his or her decision.

Ref: April 1987 Vol 6 p. 294.

21.14
GIVING ANAESTHETIC AND PERFORMING SURGERY

a. A medical practitioner wished to know what procedures he was permitted to perform on his own patients under an anaesthetic and which procedures had to be performed by other medical practitioners when he gave the anaesthetic.

b. Council informed the practitioner that, subject to the Rule relating to the performance of professional acts by practitioners (Rule 21), he could perform any professional act for the performance of which he had can perform cosmetic operations.

b. RESOLVED that the item be referred to the SGB Steering Committee to define formal structured Training, i.e. "adequate training" required for Medical Practitioners performing cosmetic surgery as reflected in the ruling of the Board.

NATIONAL HEALTH LABORATORY SERVICE (NHLS) REQUEST FOR EXTENSION OF SCOPE OF DISASTER TO ALLOW SARS-C0V2 TESTING

The Medical and Dental Professions Board at its meeting on 21 June 2021 RESOLVED to approve the recommendation by the Professional Practice Committee for the Board to allow continuation by Medical Scientists and Pathologists to provide SARS-CoV2 diagnostic services outside their scope of registration, on condition that they were appropriately trained, competent and supervised during the state of the pandemic.

the necessary qualification and/or adequate experience. Subject to the above, he could carry out procedures as set out in the conditions under which the particular theatre unit was registered by the Department of Health. His attention was, however, invited to Council's policy regarding the administration of anaesthesiology, as well as to the fact that he was not permitted to perform procedures and simultaneously administer the anaesthetic.

Ref: April 1987 Vol 6 p. 295.

21.15 VASECTOMIES PERFORMED BY GYNAECOLOGIST

Council informed a regional Medical Superintendent that it had noted his letter in which it was stated that a gynaecologist performed vasectomies on adults. Council was of the opinion that the carrying out of a vasectomy did not normally pertain to the speciality gynaecology. However, if he submitted a motivated request in this regard, Council would consider a special concession.

Ref: October 1987 Vol 6 p. 296.

21.16 CONSENT TO PERFORM PROCEDURES OBTAINED BY ANOTHER PRACTITIONER THAN THE ONE CARRYING THEM OUT

a. The head of a cardiology unit asked for clarification about obtaining consent for procedures such as brain scanning with contrast, gastroscopy, heart catheterisation or broncoscopy by a medical practitioner in charge of a patient, whilst the procedure would be performed by a medical practitioner in another department, although in the same hospital. This second practitioner would, therefore, not see the

	patient beforehand, would not explain the procedure and complications personally to the patient, while his or her name would not appear on the consent form. b. Council advised the head of the unit that, if consent for the carrying out of procedures as set out was obtained by another medical practitioner, it still remained the responsibility of the practitioner who carried out the procedure to ensure that all requirements had been complied with. Ref: April 1988 Vol 6 p. 297. **21.17 HYSTERECTOMIES AND POSSIBLE PREGNANCIES** a. A obstetrician and gynaecologist enquired whether he would be contravening any rule if he were to remove a uterus which contained an early pregnancy without the patient informing him preoperatively of the possibility of a pregnancy or whether he would contravene such rule if, during an operation, he did not remove the uterus because he was under the impression that there was an early pregnancy present which later on would prove not to have been the case. b. Council informed the obstetrician and gynaecologist that the acts performed by a medical practitioner in situations as set out in his letter, were at his own responsibility and provided that he should, therefore, take all possible precautions in respect of the diagnosis of his patients. Ref: October 1986 Vol 6 p. 300. **21.18 HYPNOSIS BY DENTISTS**	

After considering the matter on several occasions and obtaining of the views of the Dental Association and the Professional Board for Psychology, Council resolved that dentists be permitted to apply hypnosis in respect of pain control only in the course of their professional activities.

Ref: October 1986 Vol 6 p. 302.

21.19 SYSTOSTATIC CHEMOTHERAPY

a. A medical aid scheme asked Council to express an opinion on the awarding of benefits for systostatic chemotherapy and whether this was a generally recognised medical treatment.

b. Council advised the medical aid scheme that systostatic chemotherapy was a generally accepted medical treatment which may be carried out by practitioners, provided that the medical practitioner was responsible for the safety of the treatment and that he or she may only charge fees for the service rendered by himself or herself.

Ref: April 1983 Vol 6 p. 303.

21.20 PATHOLOGY TESTS CARRIED OUT BY PHYSICIANS

Council recorded that subject to the Rule relating to the performance of professional acts by practitioners (Rule 21), a specialist physician could carry out pathology tests on his or her own patients, but could not render an account for such tests at specialist rates.

Ref: April 1986 Vol 6 p. 305.

21.21 SCOPE OF SPECIALITY DIAGNOSTIC RADIOLOGY

a. Council advised the Medical Association that it was of the view that the performance of oesophago-gastro-duodenoscopy examinations did not fall within the scope of the speciality diagnostic radiology, and adhered to the resolution adopted in October 1977.

b. In October 1977 Council resolved that the abovementioned examinations fell within the scope of the specialities Medicine and Surgery and that the procedure could be carried out by a diagnostic radiologist, subject to the proviso contained in the Regulations relating to the Specialities and Subspecialities in Medicine and Dentistry.

Ref: April 1983 Vol 6 p. 306.

21.22 SKIN TREATMENT BY OBSTETRICIANS AND GYNAECOLOGISTS

a. A medical aid scheme informed Council that most medical aid schemes did not provide benefits for contraceptives. The prescription of a contraceptive (Diane) for the treatment of acne, however, increased rapidly. The question arose whether obstetricians and gynaecologists could treat acne and, if so, whether the cost of treatment could be reduced because they would be operating in the field of dermatologists.

b. Council advised the medical aid scheme that treatment of the skin as set out fell within the scope of the speciality Obstetrics and Gynaecology.

Ref: April 1983 Vol 6 p. 307.

21.23 SURGEON PERFORMING ORTHOPAEDIC AND

	GYNAECOLOGICAL SURGERY a. A general surgeon in private practice was requested by a mine hospital to do some orthopaedic and gynaecological surgery for the hospital. b. Council advised the surgeon that, subject to the Rule relating to the conduct of professional acts by practitioners (Rule 21), a surgeon could carry out any surgical procedure, but that on the information available, it appeared to Council that he should not perform orthopaedic and gynaecological surgery. Ref: October 1983 Vol 6 p. 308. **21.24 CIRCUMCISION BY OBSTETRICIANS AND GYNAECOLOGISTS** Council advised the Medical Association that it was of the opinion that the circumcision of new-born babies fell within the scope of the speciality Obstetrics and Gynaecology, subject to the Rule relating to be performance of professional acts by practitioners (Rule 21). Ref: April 1985 Vol 6 p. 309. **21.25 SCOPE OF CARDIOTHORACIC SURGERY AND OTORHINOLARYNGOLOGY** a. An obstetrician and gynaecologist asked whether the following was acceptable: i. For a cardiothoracic surgeon to carry out female breast biopsies and amputations for malignancy. ii. For an otorhinolaringolgist to carry out thyroid treatment and/or co-operative treatment, for	

example removal.

b. Council was of the view that the acts specified did not fall within the specialities Cardiothoracic Surgery and Otorhinolaryngology; if they were performed incidental to another operation which was performed by the specialists concerned, no fees may be charged for such procedures.

Ref: April 1984 Vol 6 p. 310.

21.26 NOSE SURGERY PERFORMED BY PLASTIC AND RECONSTRUCTIVE SURGEONS

Council informed a medical aid scheme that the performance of functional nose surgery (especially turbinectomies and septoplasties) did not fall within the scope of Plastic and Reconstructive Surgery.

Ref: October 1988 Vol 6 p. 311.

21.27 PULMONARY FUNCTION TESTS PERFORMED BY CARDIOTHORACIC SURGEONS

Council informed a cardiothoracic surgeon that he could use a vitallograph spirometer for doing pulmonary function tests and reporting thereon only in respect of his own patients and provided general practitioners' fees were charged for such tests.

Ref: April 1980 Vol 6 p. 312.

21.28 PATHOLOGIST (HAEMATOLOGICAL) PERFORMING OTHER PATHOLOGY TESTS

A pathologist was advised that it was not permissible in terms of the Regulations relating to the Specialities and

	Subspecialities in Medicine and Dentistry for him, as a specialist registered in the speciality Pathology (Haematological) to perform other pathology tests besides haematological tests, even though he was of the opinion that he was sufficiently qualified to do such tests, and that he should confine his practice to the speciality for which he was registered. Ref: April 1980 to Vol 6 p. 313. **21.29 DIAGNOSTIC RADIOLOGISTS PERFORMING CARDIAC CATHETERISATION** Council was of the opinion that cardiac catheterisation and other angiographic procedures could be performed by either a clinician or a diagnostic radiologist subject to be Rule relating to the performance of professional acts by practitioners (Rule 21), and that specialist fees may be charged by specialists for such procedures. However, a diagnostic radiologist had to be responsible only for the radiological aspects of these procedures. Ref: October 1980 Vol 6 p. 314. **21.30 DIAGNOSTIC RADIOLOGISTS PERFORMING DUODENOSCOPIES** Council expressed the opinion that the carrying out of esofargo-gastro-duodenoscopies fell within the scope of the specialities Medicine, Surgery and Paediatrics and that these procedures could be carried out by a diagnostic radiologist subject to the proviso in the Regulations relating to Specialities and Subspecialities in Medicine and Dentistry. Ref: October 1980 Vol 6 p. 315. **21.31 MEDICAL PRACTITIONER PERFORMING SLEEP**	

THERAPY

At the request by the Department of Health to prepare and release guidelines on the performance of sleep therapy by practitioners, the Executive Committee of the Medical and Dental Professions Board resolved that –

a. the letter by the Society of Psychiatrists of South Africa as published in the South African Medical Journal (Vol 87, No. 12, December 1997) be endorsed;

b. the following statement by Council regarding sleep therapy be confirmed:

i. "Intravenous antidepressants were viewed as high-risk treatment. It belonged in the domain of psychiatrists and then only in specific circumstances. Recommendations for the use thereof were to be clearly circumscribed.

ii. "There was no place for the routine use of intravenous antidepressants.

iii. "A place for the use of parenteral antidepressants was seen in rare, specific and exceptional cases.

iv. "In situations where that form of treatment was exercised by a practitioner, it must be accompanied by adequate motivation;"

c. the above statement was to serve as a guideline.

Ref: MDB Exco: April 1999: Item 11

21.32 PREVENTION AND TREATMENT OF OSTEOPOROSIS BY DIAGNOSTIC RADIOLOGIST

	The Executive Committee of the Medical and Dental Professions Board resolved that the prevention and treatment of osteoporosis fell outside the scope of practice of a diagnostic radiologist who may not be involved in clinical practice. Ref: MDB Exco: April 1999: Item 12 **21.33 PROPOSED TREATMENT OF CERTAIN DISEASES BY MEANS OF THE RIFE BIO-ACTIVE FREQUENCY INSTRUMENT** The Executive Committee of the Medical and Dental Professions Board resolved that it had no evidence of the effectiveness of the said instrument as a method of treating diseases or other ailments, and the use thereof in the treatment of certain diseases could, therefore, not be supported. Ref: MDB Exco: Dec 1999: Item 66 **21.34 MINILAPAROTOMY UNDER LOCAL ANAESTHESTIC** At the request of the Reproductive Health Research Unit, the Executive Committee of the Medical and Dental Professions Board resolved that the Board would have no objection to the use of minilaparotomy under local anaesthetic, provided that such procedure only be conducted by well qualified and competent practitioners. Ref: MDB Exco: Dec 1999: Item 69 **21.35 TREATMENT BY PRACTITIONERS OF CHRONIC RICKETTSIAL INFECTION**	

	With regard to an enquiry, the Executive Committee of the Medical and Dental Professions Board resolved that treatment prescribed by a certain practitioner could not be supported as no scientific evidence had been presented to convince the Committee that it was effective. Ref: MDB Exco: Apri 2000: Item 33 **21.36 SURE-SLIM BLOOD TESTS** a. Members of the Society for the Study of Obesity, raised the following concerns, namely – i. the demand for compulsory blood tests before a prospective client could join Sure-Slim; ii. that these blood tests were requested by "lay people"; iii. that their modus operandi were contradictory to the proven, cost effective and traditional medical consultation model to determine a diagnosis, treatment and prognosis. b. Concerning the blood test itself, they felt that, a number of specific blood tests were needed to exclude co-morbidities (syndrome X) in obese patients. c. The clinical examination would determine whether other tests were indicated. The Executive Committee of the Board advised that – a. the above procedure was not permissible in that a patient should first be examined by a medical	

practitioner before relevant tests could be ordered;

b. a medical practitioner was not permitted to work in association with a non-medically qualified person or body as was the case in this instance.

Ref: MDB Exco: June 2001: Item 32

21.37 RESPONSIBILITY OF SURGEONS REGARDING CONTROL OF SPONGES, NEEDLES AND INSTRUMENTS DURING OPERATIONS

The Association of Surgeons advised that the responsibility for counting and checking all instruments, needles and swabs at the start of a surgical procedure was that of the scrub sister who was taking the case. At the completion of the operation, the correctness or otherwise of the instruments, needles and swab count was to be reported to the surgeon in charge. The surgeon had to acknowledge the report and, if the count was reported to be incorrect, he or she was to take all necessary measures to rectify the count. The surgeon did not bear responsibility for an incorrect count.

The Executive Committee of the Medical and Dental Professions Board, resolved that the above guidelines on the responsibility of a surgeon be agreed to with the proviso that it be added that it was the responsibility of the surgeon to ensure that the counting and checking of all instruments, needles and swabs had been undertaken by the scrub sister at the start and conclusion of a surgical procedure.

Ref: MDB Exco: May 2001: Item 46

21.38 PROFESSIONAL RESPONSIBILITY OF MEDICAL PRACTITIONERS AND DENTISTS REGARDING ADMISSION OF PATIENTS FOR MAJOR SURGERY

	a. The Executive Committee of the Medical and Dental Professions Board resolved that – i. the onus was on the practitioner concerned to decide whether or not or when a patient should be admitted for surgery, whether minor or major; ii. the practitioner concerned would, therefore, be held accountable should the patient unduly suffer or die because of non-compliance with regard to the above. Ref: MDB Exco: Aug 1999: Item 40 b. The Medical and Dental Professions Board subsequently resolved that – i. the decision as to when a patient should be admitted for elective surgery, should be left to the discretion of the doctor concerned, subject to peer review norms; ii. if a health care funder decided to act contrary to paragraph b.i, such health care funder had to be prepared to take full responsibility for that decision. Ref: MDB Exco: Dec 2000: Item 37 c. The Executive Committee of the Medical and Dental Professions Board then – i. noted a request by the Alliance of Consulting Clinical Specialists for a ruling as to whether the resolutions in paragraph b. would also apply to the following scenarious, namely –	

	aa. a diagnostic procedure which a medical specialist deemed necessary and essential to establish a diagnosis so that appropriate therapy may be instituted; bb. refusal of treatment by the health care funder; ii. resolved that the Alliance be advised that, should a health care funder act contrary to the scenario's set out herein, such health care funder had to be prepared to take full responsibility for that decision. Ref: MDB Exco: Dec 2000: Item 37 **21.39 PROFESSIONAL RESPONSIBILITY OF MEDICAL PRACTITIONERS OR DENTISTS IN CASE OF TREATMENT OF CRITICALLY ILL PATIENT** a. The Executive Committee of the Interim Council expressed grave concern regarding a report that critically ill patients could be refused essential treatment and eventually die as a result of a policy by Health Authorities that patients could not be admitted to and treated by a hospital, if they were not coming from the referral area of that particular hospital. Ref: MDB Exco: Feb 2000: Item 39 a. The Executive Committee of the Medical and Dental Professions Board advised that – b. a medical practitioner or casualty officer who received a patient, would remain responsible for the safety and wellbeing of that patient until such time as the patient had been handed over into the care of another medical practitioner who had accepted responsibility for that patient;	

c. a medical practitioner remained personally responsible for the care and treatment of his or her patients for as long as they required such care and treatment;

d. it was 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 would be held professionally accountable for his or her actions;

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

Ref: MDB Exco: May 2001: Item 53

21.40 MEDICAL EMERGENCY ROOM ACCESSIBLE BY TELEPHONE

In view of a request regarding a scheme to operate a medical emergency room which would be accessible by telephone, the Executive Committee of the Medical and Dental Professions Board advised that –

a. the proposal be approved;

b. in-calling patients would only be provided without any fee, with services relating to an

initial diagnosis, referral to practitioners and/or medically related advice;

c. those services may only be provided by registered practitioners;

d. the practitioner who would be providing the service, would be held accountable for any complications that might arise as a result thereof;

e. the employment contract of the medical practitioners concerned should be made available to the Board, if required.

Ref: MDB Exco: April 1999: Item 10

21.41 REFUSAL BY PATHOLOGISTS TO HAND OVER TEST RESULTS TO PATIENTS

The Executive Committee of the Medical and Dental Professions Board advised that –

a. pathologists should exercise discretion in deciding whether test results or reports should be made available to any person other than the referring doctor and that the Ethical Rule on confidentiality (Rule 12) should serve as the guiding principle;

b. the Ethical Rules state that, such a medical practitioner or dentist divulge information regarding a patient which ought not to be divulged (see Rule 12), such conduct would constitute an act in respect of which the Board may take disciplinary steps,

	Ref: MDB : Sept 2000: Item 62 **21.42 DENTAL EXTRACTIONS PERFORMED BY NURSING STAFF** The Executive Committee of the Medical and Dental Professions Board resolved that – a. the Board considered dental extractions performed by nursing staff to be an unacceptable dental practice; b. posts should be created for dental therapists to render the services in question. Ref: MDB Exco: April 1999: Item 15	
ETHICAL RULE 22: EXPLOITATION A practitioner shall not permit himself or herself to be exploited in any manner.	**NO RULING**	
ETHICAL RULE 23: MEDICINE AND MEDICAL DEVICES Medicine and medical devices 23. (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, (2) a practitioner shall not engage in or advocate the preferential use or prescription of any medicine or medical device which, save for the	**23. ETHICAL RULING** **23.1 EMERGENCY EQUIPMENT RENDERED BY COMPANY TO PRACTITIONERS** a. A person advised Council that she intended to set up a company to provide the material needed by general practitioners in assisting at an emergency after hours. The company intended to provide cars with drivers and each vehicle would provide a full set of medical equipment and a full spectrum of drugs, particularly for emergency situations. The company would only function after hours and on public holidays. b. Council informed the person concerned that it could	

valuable consideration he or she may derive from such preferential use or prescription, would not be clinically appropriate or the most cost-effective option. (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, 17 17 and shall, subject to subrule (5), obtain the patient's informed written consent prior to prescribing such medicine or medical device for that patient."; and (5) a practitioner may prescribe or supply medicine or a medical device to	see no objection against what she proposed to do, but as far as the provision of medicines was concerned, she was referred to the Medicines Control Council. Ref: April 1988 Vol 6 p. 316. **23.2 REFERRAL OF PATHOLOGY WORK TO SOUTH AFRICAN INSTITUTE FOR MEDICAL RESEARCH** a. The South African Institute for Medical Research (SAIMR) advised that it regularly ordered specimens from private pathology practices where the private pathologist for one reason or another did not perform the investigation ordered. The Institute enquired about the ethical implications of a situation in which a specimen was sent to one pathologist, but was reported on by another. It also wished to establish by what mechanism fees should be levied by the referring laboratory. Should the patient be invoiced directly or should the referring 22.2 pathology practice be invoiced, leaving that firm to recover the costs from the patient. The question was also asked to whom copies of the reports had to be sent. b. Council advised the Institute that it was of the opinion that, under the circumstances as set out, the Institute should render the account directly to the patient, while the report should be submitted to the referring general practitioner. Ref: April 1988 Vol 6 p. 317. **23.3 SELLING OF PRACTICE TO PRIVATE TRUST** Council informed a practitioner that it was not permissible 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, (6) in the case of a patient with a chronic disease the provision of subrule (5) shall not apply.

RULE 23A
Financial interests in hospitals 23a. 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

sell his practice to his private family trust. (It was stated by that practitioner that this would be an internal arrangement with no change in the conduct of the practice, but that it would be only for financial and estate purposes. The practice would still be conducted by himself as the responsible person).

Ref: April 1988 Vol 6 p. 318.

23.4 LUNG FUNCTION LABORATORY

a. A group of physicians and cardiothoracic surgeons asked for approval to establish a lung function laboratory to determine blood gases at the cardiothoracic unit of a hospital.

b. Council resolved that the practitioners be informed that Council did not see any objection to what they proposed, provided the Rule relating to the conduct of professional acts by practitioners (Rule 21) was complied with, the apparatus was correctly calibrated and only general practitioners' fees were being charged for the services rendered.

Ref: April 1988 Vol 6 p. 319.

23.5 SHARES IN PRIVATE HOSPITAL

a. The Department of Health submitted a letter from a hospital group which stated that every specialist who bought shares in a certain day clinic, had to guarantee that he or she would carry out at least 200 operations per month in that clinic. Should any of the participating specialists not carry out the required operations, he or she would have to sell his or her shares. There was also a provision that, if more than a certain number of operations was performed over a

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 18 18 (h) such practitioner annually submit 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. referral of patients to hospitals	specified period in the clinic, the specialist would have his or her consulting rooms free of charge. b. Council advised the Department that participation in such a scheme could be interpreted as exploitation of patients and practitioners. See also Rule 24 (financial interest in hospitals). Ref: April 1987 Vol 6 p. 321. **23.6 GENERIC EQUIVALENTS** Council declared itself in favour of pharmacists being given the authority to substitute a particular medicine prescribed by medical practitioners or dentists by another medicine which was declared by the Medicines Control Council as the generic equivalent of the particular medicine. Such authority should be subject thereto that the practitioner may write on the prescription that substitution may not take place. Ref: April 1984 Vol 6 p. 323. **23.7 ETHICAL MEDICINES ADVERTISED IN LAY MEDIA** Council informed a pharmaceutical company that Council was of the opinion that the advertising of certain ethical medicine through a pamphlet which was distributed amongst lay people by the Rheumatoid Disease Foundation was undesirable. (The company was of the view that this was causing unethical pressure on practitioners to prescribe that medicine.) Ref: October 1986 Vol 6 p. 324. **23.8 DISPENSING OF MEDICINES AFTER EXPIRY DATE** a. The Registrar of Medicines alleged that it had come to	

the attention of the Inspectorate of Medicines that certain pharmaceutical manufacturers were selling medicines which had already expired to practitioners at discount prices.

b. Council advised the Registrar that such a practice was not permissible.

Ref: October 1987 Vol 6 p.326.

23.9 PRACTITIONER'S OBLIGATION IN RESPECT OF SUBSTANCES PURCHASED UNDER PROVINCIAL TENDER

a. A practitioner at a provincial hospital advised that he was forced to use an intravenous fluid which had proven suspect in its sterility and vacuum sealing. The tender was to run for another ten months and he was concerned about possible litigation in the event of complications and also the fact that the Council might question an apparent lack of professional responsibility in such a situation.

b. Council was of the opinion that the practitioner should take all reasonable steps, including the lodging of a protest to the relevant authorities. As to possible action by Council, Council could not advise him thereon as this would amount to prejudging the issue.

Ref: October 1985 Vol 6 p. 327.

23.30 ELECTRONIC INSTRUMENT TO DETERMINE TIME OF OVULATION

Council advised a company that it was not permissible to market an electronic instrument which could be used to

accurately determine the time of ovulation and hence the optimum period of conception. (The company planned to market the instrument through medical practitioners and not pharmacies.)

Ref: April 1984 Vol 6 p. 328.

23.31 DISPENSING OF MEDICINES WITHOUT SUPERVISION OF PRACTITIONER

a. The Secretary for Health brought it to the attention of Council that a person employed by two medical practitioners was found packing pills and schedule VI substances, while the two partners of the practice were not available.

b. Council advised the Secretary that he could lodge a complaint against the medical practitioners concerned in which event it would be dealt with in terms of the Regulations relating to disciplinary steps by Council.

Ref: October 1980 Vol 6 p. 329.

23.32 IMPLANTS FOR ORTHOPAEDIC SURGERY

a. An orthopaedic surgeon enquired whether it would be in order for him to distribute implants for orthopaedic surgery. He would be acting as a director for the company distributing the implants.

b. Council directed the attention of the orthopaedic surgeon to ethical Rule 28 (now Rule 23) and advised him that Council was of the view that the provisions of that Rule applied to the matter concerned.

Ref: April 1980 Vol 6 p. 330.

23.33 DISPENSING OF MEDICINES TO MEMBERS OF MEDICAL AID SCHEMES

a. A practitioner informed Council that a certain medical aid scheme had decided that it would discriminate against its members if they obtained medicines from that practitioner. She enquired whether she could refuse to do the normal consultations of patients belonging to that medical aid scheme, except in emergencies.

b. Council advised that -

i. the attention of the practitioner be invited to Council's policy on refusal to treat patients;

ii. Council was of the opinion that refusal to treat a patient should not be used as a lever against a medical aid scheme;

iii. a patient could decide from whom to purchase medicines.

Ref: October 1986 Vol 6 p. 331.

23.34 REGISTRATION TO DISPENSE IN PART-TIME APPOINTMENTS

Council resolved that the exemption from registration as dispensing practitioners, which was granted to practitioners in full-time appointments, also be granted to practitioners in part-time appointments in the public sector in respect of their dispensing in the normal course of their duties.

Ref: October 1985 Vol 6 p. 332.

23.35 DELIVERY SERVICE BY DISPENSING PRACTITIONER

Council informed a group of practitioners that it was not permissible for them to introduce a delivery service to deliver medicine dispensed by them to patients who were unable to attend the surgery. This would largely have been for the benefit of elderly patients who had no transport

Ref: April 1987 Vol 6 p. 333.

23.36 FEES FOR DISPENSING OF MEDICINES

Council resolved that -

a. the Minister of Health be advised that Council recommended that a professional fee per prescription for the dispensing of medicine by medical practitioners may be charged;

b. it be confirmed that, in addition to the account for professional services, practitioners had to render a separate account for medicines dispensed on which the cost of the medicine dispensed and the dispensing fee be specified.

Ref: October 1987 Vol 6 p. 334.

23.37 COMPANY TO DISPENSE MEDICINES

a. A physician enquired whether he could dispense medicine to his patients by forming a company to obtain the drugs from the suppliers and supply them to his practice.

b. Council informed the physician that a practitioner who

was registered as specialist in medicine, should not dispense medicine and that what was envisaged was not permissible.

Ref: October 1982 Vol 6 p. 335.

23.38 PACKING OF MEDICINES IN ROOMS OF PRACTITIONERS

Council directed the attention of a practitioner to section 52 of Act No. 56 of 1974 and pointed out that a practitioner was personally responsible for the acts set out in his letter (i.e. a nursing sister assisting with an electronic pill packing machine to pack of medicine under the supervision of the practitioner).

Ref: April 1981 Vol 6 p. 336.

23.39 MEDICAL AID SCHEMES DIRECTING MEMBERS TO SPECIFIC PROVIDERS OF SERVICES

a. The Medical Association advised Council that a circular letter had been issued by a medical scheme in which the impression was created that the scheme wished to direct its members to specific providers of services in cases of prolonged treatment.

b. Council advised the Medical Association that guiding or directing members of medical aid schemes was not permissible, and that participation in such practices by a medical practitioner may lead to charges against such practitioner which would be dealt with in terms of the relevant Regulations relating to disciplinary matters.

Ref: April 1987 Vol 6 p. 338.

23.40 REGISTRATION AS APPROVED DISPENSING PRACTITIONER BY MEDICAL AID SCHEMES

Council decided that it was not permissible for a practitioner to be registered as an approved dispensing practitioner by certain administrators of medical aid schemes.

Ref: April 1987 Vol 6 p. 339.

23.41 PRESCRIPTION OF SCHEDULE VI AND VII MEDICINES

a. The Director General of Health brought it to Council's attention that the chief district surgeon of a city had recommended, in the light of the ease with which a patient managed to obtain palfiun tablets in large quantities from various medical practitioners, that a regulation be made to limit the dispensing of such prescriptions to pharmacists within five kilometres of the person's residential address in urban areas.

b. Council advised that it was of the view that an ethical rule as envisaged would be difficult to implement and that Council, therefore, did not recommend the making of such a rule; Council did, however, believe that this matter was to be dealt with during medical education and training.

Ref: October 1980 Vol 6 p. 340.

23.42 SAMPLE SUBSTITUTE SYSTEM

a. A marketing firm advised that a system was being developed to substitute physical samples. It was often found that samples were never issued to patients and eventually expired and had to be

discarded. The new system would be in the form of a certificate that would be issued by the doctor to the patient. The patient would present the prescription together with the certificate to the pharmacist who would give the patient either a discount or a free supply of medication specified on the certificate. The pharmacist would then be reimbursed by the relevant pharmaceutical company. The doctor would be the sole decision maker as to when to use such certificates. The intent was not to advertise and, therefore, the certificates would not bear any advertising slogans. No incentive would be received by either the doctor or the pharmacist for the use of the certificates.

b. Council informed the marketing firm that Council could see no objection against what was proposed.

Ref: October 1988 Vol 6 p. 342.

23.43 TRANSMISSION OF PRESCRIPTIONS BY FAX

Council informed the director of a company that Council could see no objection against medical practitioners sending prescriptions through a fax machine, provided the fax had the medical practitioner's signature on it.

Ref: October 1988 Vol 6 p. 344.

23.44 KEEPING RECORDS OF MEDICINES

a. A practitioner enquired about what records of scheduled medicines had to be kept.

b. Council resolved that the practitioner be provided with a copy of the Rule relating to the prescription or supply of specific medicines and with Council's ruling

	on the keeping of records; further, that he be referred to the Medicines Control Council for additional information on the matter. Ref: October 1988 Vol 6 p. 345. **23.45 USE OF VETERINARY MEDICINES ON HUMANS** a. The Registrar of Medicines informed Council that it had come to his attention that medical practitioners were using veterinary medicine on human patients and that a practitioner using such medicine apparently only had to inform the patient of that fact as part of the practitioner's ethical duties towards the patient. b. Council advised that it was of the opinion that practitioners may only use medicine on humans which was intended for that purpose. The use of veterinary medicines on humans was, therefore, not permissible. Ref: April 1984 Vol 6 p. 346. **23.46 PURCHASING OF MEDICINES BY COMPANY** Council advised a practitioner that it was not permissible for him to establish a company with the objective of purchasing drugs and materials used in his dispensing practice from the relevant pharmaceutical companies. Ref: October 1985 Vol 6 p. 347.	
ETHICAL RULE 24: REFERRAL TO HOSPITALS (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	**NO ETHICAL RULINGS**	

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. (2) deleted (3) deleted (4) deleted (5) deleted (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; (a) has informed such patient that such admission in such private clinic or hospital was necessary for his or her treatment; and (b) has obtained such patient's consent for admission to such private clinic or hospital.		
ETHICAL RULE 25: EPORTING 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	**NO RULINGS**	

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.		
ETHICAL RULE 26: RESEARCH, DEVELOPMENT AND USE OF CHEMICAL, BIOLOGICAL AND NUCLEAR CAPABILITIES 26. (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	**NO RULING**	

applicable international treaties or conventions to which south africa is a signatory.		
ETHICAL RULE 27: MULTIPLE REGISTRATION A health practitioner who holds registration with more than one statutory council or professional board or in one or more categories within the same professional board shall at all times ensure that - (a) no conflict of interest arises from such multiple 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 more than one capacity or charged fees based on more than one such consultation; and 20 20 (e) no patients may be serviced by the same health practitioner in more than one capacity (f) the ethical rules applicable at a given moment to the profession in which the practitioner is acting, are strictly adhered to.	**NO RULINGS**	

28 OTHER RELEVANT ETHICAL MATTERS	RULINGS
28.1 ANAESTHESIOLOGISTS AND GAS SUPPLY LINKS a. An Attorney General Informed Council that he was of the opinion that one of the primary duties of an anaesthesiologist was to ensure that the correct gas was administered to his or her patients. He alleged that it would appear to be accepted that the connecting points were manufactured in such a way that pipes cannot or ought is not exchanged when linked. Should a nurse experience problem in linking pipes it would ostensibly be his or her problem and not that of the anaesthesiologist. Allegations were made in a court case that, in various hospitals in Pretoria, it was not the responsibility of the anaesthesiologist to do and/or check the gas supply linkage, but the duty of the hospital personnel. The Attorney General did not agree with this view. b. Council recorded that, in its opinion, medical practitioners who administer anaesthetics were responsible that the gas supply from the linkage point in the hospital was correct, but that the gas supply to the linkage point was the responsibility of the hospital authority. Ref: April 1986 Vol 6 p. 349. **28.2 ANAESTHESIOLOGISTS SUPERVISING ADMINISTRATION OF ANAESTHETICS BY JUNIOR PRACTITIONERS AND INTERNS** a. The Head: Department of Anaesthesiology of a hospital enquired whether interns may carry out anaesthetics lists on their own and whether the controlling specialists may carry out three routine lists in adjacent theatres. b. Council informed the Head that it was the responsibility of the supervising anaesthesiologist to make effective arrangements regarding the administration of anaesthetics, and that he or she may delegate the administration of anaesthetics, but that his or her responsibility could not be delegated. Ref: April 1987 Vol 6 p. 350.	The Health Professions Council of South Africa is a statutory body established under the Health Professions Act No. 56 of 1974 (as amended) Its mandate is to regulate the Health Professions registered with it in the country in aspects pertaining to: • Education, Training and Registration • Professional conduct and ethical behavior • Ensuring Continuing Professional Development of practitioners (CPD) • Fostering compliance with the health care standards • Investigate complaints lodged against practitioners registered under the Act The nurses are only allowed to practice according to their scope of practice as prescribed by their regulatory body (SANC). Please find the information from SAMA below that could be useful in defining the assistant surgeon. **Extract from the 2018 Medical Doctors' Coding Manual (MDCM)** **Modifier 0008:** Specialist surgeon assistant: The units of the procedure(s) for a specialist surgeon acting as assistant

28.3 RELATIONSHIP BETWEEN OPERATING DOCTOR AND ANAESTHESIOLOGIST

Council resolved that a gynaecologist be advised that a sound relationship and effective communication between the operating doctor and anaesthesiologist should be ensured at all times. It was not permissible for an anaesthesiologist to carry out two general anaesthetics simultaneously; Council did not comment on the legal aspects, but insofar as the ethical aspects in the matter were concerned, Council was of the opinion that it would be acceptable for an anaesthesiologist to supervise more than one continuous epidural anaesthetic, provided that he or she remained readily available.

Ref: October 1988 Vol 6 p. 351

28.4 PERSONALISED SERVICE TO ANAESTHESIOLOGISTS

a. A medical personnel employment agency enquired whether it would be acceptable to offer a personalised service to anaesthesiologists. The service would offer a diary of events and appointments, telephone messages and limited secretarial services. Locum relief could be arranged by the service by means of identified lists of anaesthesiologists/surgeons who had previously been authorised by the anaesthesiologists to whom the service would be rendered.

b. Council advised the employment agency that its proposal was not permissible.

Ref: April 1984 Vol 6 p. 352.

28.5 RESPONSIBILITIES OF SURGEONS AND ANAESTHESIOLOGISTS AFTER OPERATIONS

Council confirmed a resolution by the Executive Committee advising that, depending on the prevailing circumstances, both surgeon and anaesthesiologist, each in his or her own area, but also as a team, had responsibilities in respect of the patients' care in the immediate postoperative period and that it was consequently not possible to lay down specific guidelines in this regard.

Ref: October 1987 Vol 6 p. 353

28.6 ANAESTHETIC SERVICES TO SURGEONS

surgeon in procedures of a specialised nature, is 40% of the units for the procedure(s) performed by the specialist surgeon. Modifier 0008 may only be used if the assistance of a specialist assistant is imperative to be able to perform the procedure. If not, this assistant must refer to modifier 0009

M0008

• Definition of an assistant: if, on request of the primary surgeon, a doctor is present in theatre for the duration of the procedure, such a doctor is regarded as an assistant and should be remunerated accordingly by the primary surgeon.
•the need for an assistant at a procedure is determined by the primary surgeon and not by the type of procedure performed.
•an assistant may render his/her own account.
•the primary surgeon may render an account on behalf of the assistant.
•if the assistant renders his/her own account, the primary surgeon should reflect the name and practice number/mp number of the assistant on his/her account with an indication that the assistant will render his/her own account.
•the assistant should then also reflect the name and practice number/mp number of the primary surgeon on his/her account together with the item(s) of the procedures performed and date of service.
•when calculating the assistant remuneration, all the procedures and appropriate modifiers (except modifier

a. Anaesthesiologists proposed forming an Association (not a partnership, agency or profit-making organisation) to improve the availability of anaesthetic services to surgeons and to assist anaesthesiologists in obtaining locums for themselves. Each anaesthesiologist would maintain his or her independent practice, each and every anaesthesiologist in the Johannesburg area was welcome to join, a receptionist would be employed, rooms would be rented and telephones would be installed. The receptionist would be informed of the availability of each anaesthesiologist throughout the week and surgeons requiring the services of an anaesthesiologist would, on contacting the receptionist, be given a list of anaesthesiologists who would be available at that time. The surgeon would make his or her own choice of anaesthesiologist and would personally contact the anaesthesiologist concerned. The receptionist would not be allowed to make the choice. The administration of the Association would be supervised by an elected committee. It was not envisaged that an after hour roster be provided, as each surgeon would contact his or her own regular anaesthesiologist during that period.

b. Council advised the anaesthesiologists that Council had no objection against the arrangement of anaesthetic services as proposed, provided that -

i. fees for the administration of anaesthetics would not be collected from patients;

ii. participation in the arrangement was open to all anaesthesiologists who were interested;

iii. another name for the arrangement of the service should be selected;

iv. the local branch of the Society of Anaesthesiologists monitored the arrangement of services and submitted a report to Council after one year.

October 1987 Vol 6 p. 354.

28.7 DATA PROCESSING OF INFORMATION CONCERNING PATIENTS

a. The Director General of Health advised that one of its hospitals wished to data process information that normally appeared on a patient's bed chart or out-patient's card. The problems for which solutions were sought were the following:

0011) should be taken into account.
•for procedures requiring a registered specialist surgeon assistant, the specialist assistant remuneration is 40% of the remuneration of the primary surgeon.
•for procedures requiring more than one assistant, the first specialist assistant remuneration will be calculated using modifier 0008 and the subsequent assistants, whether a specialist or a general practitioner, according to modifier 0009.
•assistant remuneration where an orthopaedic surgeon and a neurosurgeon operate under the same anaesthetic: each surgeon remunerates an assistant for the procedures performed by the other surgeon, as calculated according to modifier 0009. If the procedure necessitates a second assistant, this assistant will be remunerated by both of the surgeons as calculated according to modifier 0009.

Modifier 0009:
Assistant: the fee for an assistant is 20% of the fee of that of a specialist surgeon, with a minimum of 36.00 clinical procedure units. The minimum fee payable may not be less than 36.00 clinical procedures units.

•Definition of an assistant: if, on request of the primary surgeon, a medical doctor is present in theatre for the duration of the procedure, such a doctor is regarded as an assistant and should be remunerated

i. Is a complete handwritten bed chart required as a legal document or is a print out with all the relevant information acceptable?

This would be acceptable with a few exceptions as specified below.

ii. How should prescriptions containing habit forming and scheduled drugs be processed where the doctor's signature and specification of degrees was a legal requirement?

iii Surgical procedures, with or without a local or general anaesthetic require a patient's signature or thumb print to signify his or her consent. A similar register as for ii above was suggested.

iv. A record of medicine administered to patients legally requiring the signature and qualification of the nurse on the medicine chart, could similarly be entered and kept on file for this purpose.

v. Facsimiles of temperature charts seemed unnecessary. When abnormal temperatures had specific indications this could easily be codified.

vi. Monitoring of shock conditions could similarly be reflected by preplanned characters.

b. Council advised the Director General that it did not express an opinion on the legal questions as contained in his letter. With regard to the ethical aspects, Council had no objections to the computerising of information in respect of patients, but Council wished to specifically indicate that such computerising in no way changed the medical practitioner's ethical responsibility.

Ref: October 1985 Vol 6 p. 358.

28.8 ASSISTANCE AT OPERATIONS

a. The Interim Council resolved as follows with regard to assistance at operations:

i. Although in many instances, surgeons had developed techniques whereby assistants at operations appeared to be unnecessary, Council was informed

accordingly by the primary surgeon.
•the need for an assistant at a procedure is determined by the primary surgeon and not by the type of procedure performed.
•an assistant may render his/her own account.
•the primary surgeon may render an account on behalf of the assistant.
•the assistant remuneration, under modifier 0009, is calculated at 20% of a specialist surgeon's remuneration for the procedure, regardless whether the primary surgeon was a general practitioner or a specialist.
•please note that the minimum remuneration of an assistant may not be less than 36.00 clinical procedure units.
•when calculating the assistant remuneration, all the procedures and appropriate modifiers (except modifier 0011) should be taken into account.
•if the assistant renders his/her own account, the primary surgeon should reflect the name and practice number/mp number of the assistant on his/her account with an indication that the assistant will render his/her own account.
•the assistant should then also reflect the name and practice number/mp number of the primary surgeon on his/her account together with the item(s) of the procedures performed and date of service.
•for procedures requiring more than one assistant, the first specialist assistant remuneration will be calculated using modifier 0008 and the subsequent assistants, whether a specialist or a general practitioner, according to modifier

that the general opinion in Surgery was that an assistant should be present at operations of a certain magnitude, e.g. an appendectomy or where difficulties or complications might occur, or were anticipated. Council found itself in agreement with that view. Such an assistant must be a medical practitioner, an intern or a student intern. In addition, it was necessary that a medical practitioner should be present to administer the anaesthetic. In elective surgery where general, spinal or caudal anaesthesia was to be used, except in caudal anaesthesia in uncomplicated obstetrics and/or where its effect was limited to the pelvic region, an additional medical practitioner must be present to attend to the patient in order to safeguard the patient against possible complications. ii. A registered nurse may not act in place of an assistant surgeon at an operation. In the case of emergencies, i.e. life-threatening situations, a registered nurse with appropriate training and experience may assist a surgeon, or even administer the anaesthetic. iii. If an assistant as envisaged above was not available and, in the opinion of the surgeon and on his or her responsibility, circumstances warranted it, a registered nurse with appropriate training and experience may act as assistant, but may not accept responsibility for the operating table as well as the responsibilities involved with assisting the surgeon. iv. In the case of emergencies, a registered nurse with appropriate training and experience may assist the surgeon or even administer the anaesthetic. Ref: MDB Exec Oct 2000: Item 54 b. The Executive Committee of the Medical and Dental Professions Board resolved that – i. it was the responsibility of the operating surgeon to judge which procedure was of a "certain magnitude" and therefore required an assistant; ii. the designation "intern" referred to a medical graduate who was doing a programme of training in an accredited facility i.e. a hospital, clinic or a health centre, mainly in the public service; iii. the designation "student intern" referred to a student in medicine who was doing his or her final	*0009.* *•assistant remuneration where an orthopaedic surgeon and a neurosurgeon operate under the same anaesthetic: each surgeon remunerates an assistant for the procedures performed by the other surgeon, as calculated according to modifier 0009. If the procedure necessitates a second assistant, this assistant will be remunerated by both of the surgeons as calculated according to modifier 0009.* *Correspondence dated 5 Feb 2018 from Dr M A Kwinda* **CLEAR DISTINCTION BETWEEN ELECTIVE PLASTIC SURGICAL PROCEDURES AND NON-INVASIVE TECHNIQUES:** **In October 2007 the Medical and Dental Professions Board** noted the report from the SGB Technical Committee that it was scheduled to conduct a workshop with the relevant stakeholders in order to develop some recommendations on the matter. 2. **In January 2008 the MDB SGB**

year of study towards the basic degree in medicine;

iv. the designation "medical student" referred to a student in medicine who had not yet reached the final year of study towards the basic degree in medicine;

v. student interns, interns and medical practitioners performing community service were permitted only to work in the public service in accredited facilities or hospitals approved by the Minister of Health for community service purposes;

vi. it was, therefore, not permissible for student interns, interns and medical practitioners performing community service to assist at operations in any hospital or other health sector facility not so accredited or approved. Subject to the provisions of the Health Professions Act, 1974, and the ruling of Council they may do so in accredited public facilities and hospitals approved by the Minister of Health for community service purposes;

vii. the term "assistant" means a practitioner who had "scrubbed-up" and was present in theatre during the operation.

Ref: MDB Exec Oct 2000: Item 54

28.9 ASSISTANCE AT OPERATIONS IN RURAL CIRCUMSTANCES

a. A Regional Medical Superintendent asked for a ruling on the situation where, in rural circumstances, the services of a third medical practitioner to serve as an assistant in a non-emergency operation could not be obtained.

b. Council referred the Regional Medical Superintendent to the policy of Council on assistance at operations which applied also in the circumstances which he described (see item 31.8)

Ref: October 1982 Vol 6 p. 362.

28.10 ASSISTANCE IN ARTHROSCOPIC SURGERY

Council advised an orthopaedic surgeon that Council was of the opinion that in arthroscopic procedures, a medical assistant was not required.

Committee RESOLVED that it be recommended to the Education and Registration Committee that -

aa. "Surgery" be defined as an operative procedure in which the principal purpose is to improve the appearance, usually with the connation that the improvement sought is beyond the normal appearance, and its acceptable variations, for the age and the ethnic origin of the patient – *Steadman's Dictionary for Health Professions and Nursing File, 2004;*

bb. cosmetic surgery was always an elective procedure;

cc. cosmetic surgery was performed in the main by specialists in plastic and reconstructive surgery, but may also be performed by other specialists which have formal structured training, assessment and ongoing professional development in certain aspects of cosmetic surgery relevant to those particular specialties;

dd. assessment of competence of any such registered specialist in any particular cosmetic surgical procedure which has not formed part of specialist training shall be by a training/examination body

Ref: April 1988 Vol 6 p. 363.

28.11 DEFINITION OF ASSISTANTS

a. The Representative Association of Medical Schemes advised that the Association had been faced with the problem of defining "assistants" during surgical procedures, and was of the opinion that an assistant should be a practitioner who had "scrubbed-up" and was present in the theatre during the operation.

b. Council advised the Association that it was in agreement with the views of the Association, but that in exceptional cases it could include the "stand-by" presence in theatre of a medical practitioner if so required by the operating doctor.

Ref: April 1987 Vol 6 p. 364.

28.12 CARDIAC QUALIFIED THEATRE SISTER ASSISTING AT OPEN HEART OPERATIONS

Council informed a cardiothoracic surgeon of the policy on assistance at operations and that it was not permissible to use a highly qualified cardiac theatre sister to assist on a routine basis at open heart procedures.

Ref: October 1987 Vol 6 p. 365.

28.13 FURNISHING PATIENT WITH PATHOLOGY REPORT

Council advised the Head: Department of Human Genetics of a university that the patient's own practitioner was responsible for informing the patient of the result of a pathology investigation, but that Council was of the opinion that, in the circumstances as outlined, the pathologist in question could be considered to be such a practitioner. The circumstances outlined were that the Head would send a copy of the pathology report in respect of screening of a recessively inherited disorder, Tay Sachs disease, direct to the patient who had been tested. The report indicated whether the patient was a carrier of the gene and, if a carrier, how further information and, if necessary, counselling could be obtained.

Ref: October 1986 Vol 6 p. 366.

28.14 HOSPITAL AND THEATRE RECORDS

accredited by the Board for such training;

ee. reconstructive surgery shall not be deemed to be synonymous with cosmetic surgery;

ff. cosmetic medicine was the field that dealt with any non-surgical cosmetic procedures;

gg. cosmetic medicine was not confined to any specialty or discipline;

hh. registered practitioners should always act within the Medicine Control Council recommendations and in accordance with Rule 19 of the generic ethical rules of the HPCSA as appended:

"19. *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"

ii any practitioner performing

Council requested the Advisory Committee on Health, the Association of Private Hospitals, the Medical and Dental Associations, as well as the South African Nursing Council to give attention to the incomplete and inaccurate way in which some hospital and theatre records were being kept such as, for example the failure to have a uniform way for recording operation and anaesthetic times.

Ref: October 1987 Vol 6 p. 368.

28.15 KEEPING OF RECORDS

Following a request by a Committee of Preliminary Inquiry, Council expressed the view that records in respect of all patients must be kept by medical practitioners and dentists for a reasonable period; such records must contain sufficient clinical information with a view to subsequent treatment. See Booklet 11 : Guidelines on keeping of Patient Records.

Ref: October 1987 Vol 6 p. 369.

28.16 HEALTH EXAMINATION OF EXECUTIVE OFFICERS

Council advised to the National Management and Development Foundation that it did not see any objection to a project whereby provision would be made for the medical examination of executive officers. The purpose of the examinations would be to identify problem areas and treatment would not be given, but the patient would be referred to his or her own medical practitioner, if necessary.

Ref: April 1981 Vol 6 p. 370.

28.17 INTERNS ON DUTY IN CASUALTY SECTIONS

Council advised a Medical Superintendent of a provincial hospital of the criteria for intern training which state that it was not permissible for interns to be on first call at night to treat casualty and outpatients, without a medical officer or consultant at all times available on short notice.

Ref: October 1985 Vol 6 p. 371.

cosmetic medicine procedures which result in permanent anatomical and/or physiological changes shall be appropriately trained as for cosmetic surgery.

3. **In February 2008 the Executive Committee of the Medical and Dental Profession Board** considered the report and recommendations of the SGB Technical Committee and RESOLVED that report be referred to the Undergraduate Education and Training Committee for consideration.

4. **In March 2008 the Education and Registration Committee** considered the report and recommended that it be forwarded to the Board for implementation.

5. **In April 2008 the the Medical and Dental Professions Board**

a. NOTED the complement to the Board's administrative personnel for the excellent organisation for the workshop conducted in January 2008.

b. RESOLVED that –

i. the recommendations be accepted;

ii. assessment of competency of any such

28.18 STOMATOLOGIST

a. A dentist wrote that the designation "stomatologist " which had been adopted by the Department of Health, gave the impression that the person using such a designation was a specialist, whereas the person concerned was a general dentist.

b. Council advised the Director-General that it was of the opinion that the designation "stomatologist" could lead to confusion and that the designation "dentist" be used.

c. In October 1988 Council confirmed that the designation "stomatologist " had been accepted solely for use in the public service.

Ref: April 1986 Vol 6 p. 374.

28.19 "DICTATED BUT NOT READ"

Arising from a number of complaints, Council resolved that, as it may be to the disadvantage of a patient, Council viewed the use of the expression "dictated but not read" by a practitioner on reports to be undesirable.

Ref: October 1987 Vol 6 p. 375.

28.20 CUTTING DOGS' EARS

a. The Veterinary Council informed Council that it regarded the cutting of the ears of dogs by veterinarians as unethical conduct. Council was requested to respect this view and to inform members of the medical and dental professions accordingly.

b. Council decided that the Veterinary Council, the Medical Association and Dental Association be informed that Council supported the request by the Veterinary Council.

Ref: April 1988 Vol 6 p. 376.

28.21 HOME VISITS BY PRACTITIONERS

Council adopted the following policy with regard to the duty of practitioners in respect of home visits:

registered specialist in any particular cosmetic surgical procedure which has not formed part of specialist training should be by a training/examination body accredited by the Board for such training;

iii. the resolution be communicated to the stakeholders via the Board's newsletter

6 **In January 2010 the MDB SGB Steering Committee** RESOLVED that it be recommended to the Executive Committee of the Board that the media statement dated 13 October 2009 as contained in MDB SGB 17/JAN 2010, was merely a communication of the recommendations made by the SGB Steering Committee to the Board. These recommendations were not endorsed by the Board in order to become a policy and or ethical rule of the Board;

7. **In March 2010 the MDB Executive Committee** NOTED the recommendations made by the SGB Steering Committee endorse and adopt an Ethical Rule on who may perform cosmetic surgery. The Executive Committee of MDB RESOLVED that recommendations made by the SGB Steering Committee be

It was unacceptable to Council for a general practitioner to declare in advance that he or she would not visit his or her patients at home. In the light of practitioners' professional obligation towards their patients, it was left to the discretion of the practitioner to decide whether he or she would visit a specific patient at home or not. If required, a practitioner must be able to justify his or her conduct if unnecessary suffering or death were to follow his or her refusal to do a home visit. In case of an emergency, a practitioner was obliged in all circumstances to assist. If a complaint were to be lodged against a practitioner arising from his or her refusal to visit a patient at home, Council would consider each complaint on its merits.

Ref: April 1988 Vol 6 p. 377.

28.22 TELEPHONE RESULTS OF URGENT LABORATORY INVESTIGATIONS

Council considered a letter from a pathologist (chemical) regarding problems which he experienced in communicating highly abnormal results to practitioners, and advised the pathologist that it was the responsibility of the referring practitioner to arrange for the receipt of results of urgent laboratory tests. It was desirable that the practitioner be informed of these results, but if this was not possible, the communication should be done according to the best judgement of the pathologist concerned.

Ref: April 1987 Vol 6 p. 379.

28.23 OVER USE OF DIAGNOSTIC AIDS

a. The Medical Association brought a letter from a medical aid scheme to the attention of Council which alleged that medical practitioners were inclined to use too many modern technical, diagnostic aids in the treatment of their patients.

b. Council resolved that the Deans of Faculties of Health Sciences/Medicine in South Africa be advised of this letter and the dangers and costs of over-utilisation of diagnostic aids which may be to the disadvantage of the clinical competence of medical practitioners.

Ref: October 1981 Vol 6 p. 381

28.24 METHODS OF STERILISATION OF MENTALLY DEFECTIVE FEMALE PATIENTS

referred to the Board and Council to be endorsed in order to become a policy and or ethical rule.

8 **In June 2010 Executive Committee of Council-**

aa. NOTED advise from the Acting Chief Operations Officer & General Manager: Legal Services that there was a need for Council to carefully consider the matter before taking action thereon as there was no provision in the Act that precluded general practitioners from performing cosmetic surgery and neither in the scope of practice which was wide enough to include the performance of cosmetic surgery by general practitioners. As such, Council could not adopt an Ethical Rule which contradicted the provisions of a superior legal framework, namely, the Act and the Regulations relating to the scope of practice of medical practitioners.

bb. NOTED FURTHER that –

i. an Ethical Rule which contradicted the Act and the Scope of practice would have no legal force;

ii it was however necessary for

a. A letter was received from the Director for Health of a province asking for advice on the method of sterilisation of mentally defective female patients, i.e. by hysterectomy or tubal ligation.

b. Council resolved that the Director be advised that Council was in agreement with the view that the method of sterilisation of mentally defective female patients was a medical decision which should be determined by the medical practitioner of the patient in question. Council wished to point out that there could be clinical indications to perform a hysterectomy in certain instances as set out in the letter.

Ref: April 1986 Vol 6 p. 382.

28.25 SURGICAL PROCEDURES FOR OBESITY

a. A practitioner informed Council that Bariatric Medicine was often ridiculed by medical practitioners and also that the Medical Schemes Act excluded all treatment of obesity from its benefits.

b. Council advised the practitioner that bariatric medicine was not a speciality recognised by Council, that his letter contained inaccuracies (Council never indicated that obesity was not regarded as a serious condition, nor that surgery was not an acceptable method of treatment for this condition in the right circumstances). However, Council was concerned about instances where this operation was concealed under another name. Council was not responsible for the views expressed by individual medical practitioners and was also not responsible for the services paid for by medical aid schemes.

Ref: April 1986 Vol 6 p. 383.

28.26 IMPORTING OF MEDICAL EQUIPMENT

a. A specialist attached to a university enquired whether he could undertake the importing and distribution of a new catheter. He would not be directly or personally involved in the marketing or distribution of the equipment, but this would take place by association. He enquired whether, if a practitioner made a new discovery, he or she could patent that discovery.

Council to emphasise the importance of training that must be undertaken and level of experience that a practitioner should have to can be allowed to perform cosmetic surgery; and

iii a recommendation that the matter be referred back to the Standards Generating Body of the Medical and Dental Professions Board which should be requested to develop a framework on the type of training that should be undertaken and the level of experience that a practitioner should be exposed to for performance of cosmetic surgery as this would enable Council to determine what constitutes a sufficiently trained practitioner in respect of cosmetic surgery.

cc. RESOLVED that the matter be referred back to the Standards Generating Body of the Medical and Dental Professions Board which should be requested to develop a framework on the type of training that should be undertaken and the level of experience that a practitioner should be exposed to for performance of cosmetic surgery as this would enable Council to determine what constitutes a sufficiently trained practitioner in

b. Council advised the practitioner that it did not have an objection to his participation in an agency for medical equipment as set out in his letter, nor to the patenting of new discoveries, provided the Ethical Rules were complied with.

Ref: April 1983 Vol 6 p. 385.

28.27 RESPONSIBILITY FOR PROVIDING EMERGENCY EQUIPMENT

a. A dentist advised Council that it was accepted practice that a dentist in private practice was responsible for keeping the necessary medicines and equipment for resuscitation of a patient in an emergency situation. The dentist enquired whose responsibility it was if the dentist was employed by, for instance, a mine or a governmental clinic, to provide the medicine and equipment for emergencies. He also wished to know who would be held responsible if such medicine and equipment had been withdrawn and an emergency situation were to arise.

b. Council advised the dentist that -

i. Council did not express a view as to who had to provide the equipment as set out;

ii. however, it was the responsibility of a practitioner to practise only in proper circumstances and with the necessary equipment.

Ref: April 1984 Vol 6 p. 386.

28.28 ORTHODONTIST TREATING PRIVATE PATIENT IN PROVINCIAL CLINIC

Council advised the Superintendent of a provincial dental service that Council did not have any objection to his request that a private orthodontist be permitted to treat his private patients in a provincial dental clinic. However, this should be a temporary arrangement until the work in progress had been completed.

Ref: April 1980 Vol 6 p. 387.

28.29 CARDIAC REHABILITATION CENTRE BELONGING TO PHYSICIAN

respect of cosmetic surgery.

Once developed, the framework would be published for comment and thereafter adopted as a Guideline on what constitutes sufficient training and experience for the performance of cosmetic surgery.

dd. FURTHER RESOLVED that the General Manager: Legal Services be invited to the meetings of the Standards Generating Body of the Medical and Dental Professions Board where this matter would be reviewed.

9. In **October 2010 the Medical and Dental Professions Board** RESOLVED that the item be referred to the SGB Steering Committee to define formal structured training, i.e. “adequate training” required for Medical Practitioners performing cosmetic surgery as reflected in the ruling of the Board.

APPLICATION FOR NON-CLINICAL REGISTRATION

The Medical and Dental Professions Board at its meeting on 9 June 2017 -

a. A physician informed Council that he had purchased a building with a view to starting a cardiac rehabilitation centre by means of exercises. The exercises would take place under his personal supervision, in collaboration with a biokinethetist, a nurse and two physiotherapists. His consulting rooms were in the same building.

b. Council advised the physician that it did not see any objection to the sharing of facilities, subject to Council's policy regarding co-operation between registered persons in teams and the establishing of health teams, as well as the Rule relating to covering of the Ethical Rules (i.e. Rule 8), and that separate accounts were to be rendered by the professional persons involved.

Ref: April 1986 Vol 6 p. 388.

28.30 LOCAL AUTHORITY ESTABLISHING CLINIC FOR EMPLOYEES

Council advised the Medical Officer of Health of Johannesburg that Council could see no objection to the City Council establishing a minor ailments clinic for city employees which would be conducted by medical and nursing staff employed by the city health department at no cost to employees. The clinic was to deal with simple complaints only, while serious conditions would be referred to the private practitioner concerned.

Ref: April 1986 Vol 6 p. 389.

28.31 MULTI-PROFESSIONAL CLINIC

a. A Secretary for Health informed Council that there was an urgent need to establish multi-disciplinary clinics near the Sun City area to cater for the health needs of thousands of residents, employees and visitors to the area. Approaches were made by groups of doctors who were prepared to establish and operate such clinics, provided certain conditions would be met. One such condition was that the clinics be established and operated through the medium of a company incorporated in terms of company law.

b. Council informed the Secretary that Council could see no objection to the establishment of clinics by medical practitioners to provide facilities for medical practice as set out in his letter, provided that the use of such facilities was open to any

NOTED that the Education and Registration Committee at its meeting held on 24 March 2017 NOTED that there were increasingly practitioners wishing to be registered on the non-clinical register while occupying positions where they were required to provide medical advice or required to oversee a Clinical Department in some cases.

Section *17 (1)(a)(iii) of the Health Professions Act, stated that "No person shall be entitled to practise within the Republic any health profession registrable in terms of this Act; the giving of advice in regard to such defects, illnesses or deficiencies; unless he or she is registered in terms of this Act"*

RESOLVED that –

1. the Secretariat be tasked to implement the legislation as prescribed and communicate to all stakeholders that Non-Clinical registration meant that a practitioner could advise but could not be involved in clinical intervention or clinical management while being on the non- clinical register.

2. should practitioners manage patients clinically, they had to maintain clinical independence as they would be held accountable for

interested practitioner and was not restricted to a particular practitioner or group of practitioners; and provided further that Council's ruling regarding the practising of medicine by incorporated bodies was adhered to. Ref: April 1981 Vol 6 p. 390. **28.32 PATHOLOGY LABORATORY CONDUCTED BY GENERAL MEDICAL PRACTITIONER** a. A factory medical officer informed Council that he had completed a degree course in toxicology and asked for approval to establish a clinical laboratory for the purposes of diagnosis and medical surveillance of employees exposed to toxic or potentially harmful chemicals in the factory environment. b. Council advised the practitioner that, subject to the requirements of the Rule relating to the performance of professional acts by practitioners (i.e. Rule 21), Council could see no objection to what was proposed. Ref: April 1981 Vol 6 p. 391. **28.33 POST MYOCARDIAL INFARCTION REHABILITATION CENTRE** Council informed a specialist physician that Council could, in principle, see no objection to the establishment of a post myocardial infarction rehabilitation centre, provided a patient was either referred to a medical practitioner who was using the centre, by the patient's own medical practitioner or was the patient of a practitioner participating in the scheme; Council's Ethical Rules and its ruling on the practising of medicine by incorporated bodies were not to be contravened in any way. Ref: April 1981 Vol 6 p. 392. **28.34 PRIVATE PRACTICE IN COMMUNITY HEALTH** a. The Head: Department of Community Health of a university enquired whether it would be acceptable for a specialist in community health to operate a private practice directed at the management of health services, conducting of epidemiological	the advice and intervention and they should therefore change their category of registration to that of clinical active practitioners; the Secretariat should revisit the definitions of non-clinical practice to clarify meanings of *providing medical advice* and *management of patients* and provide a report at next Board meeting.

surveys, operating of occupational health services (non-clinical) and a consultancy in respect of all of the above.

b. Council advised the said Head that Council could see no objection against a specialist in Community Health having a private practice as set out in his letter, provided such specialist restricted his or her practice to his or her speciality and in this regard his attention was invited to the resolution adopted by Council in April 1987.

c. In April 1987 Council confirmed a recommendation of the Specialists Committee (Medical) that it again be recorded that, except in an emergency, it must not be expected of a specialist in Community Health to render personal clinical services, but that such services may take place to a limited extent during the education and training of registrars in Community Health.

Ref: April 1988 Vol 6 p. 393.

28.35 SCHOOL OF YOGA CONDUCTED BY PRACTITIONER

a. A practitioner who had studied yoga for one year enquired whether he could write articles on yoga for publication through the lay press, and could run a school of yoga simultaneously with his general practice, but in separate premises, and whether he could advertise the school of yoga through the press.

b. Council advised the practitioner -

i. of the Rule relating to advertising (i.e. Rule 1) and the policy of Council with regard to the publication of articles in the lay press (see Booklet 5 Guidelines on Making Professional Services Known);

ii. that it was not permissible for a practitioner to establish a school of yoga on the basis as envisaged in his letter.

Ref: October 1981 Vol 6 p. 394.

28.36 INSTITUTE FOR SLEEP RESEARCH

a. A neurologist wished to found an institute for sleep research in South Africa. The aim

of the organisation would be to gather basic information on the incidence, variety and distribution of sleep related problems in South Africa; to conduct clinical research into selected sleep disorders; and to provide a clinical service to sleep disorder patients. In order to make the public and practitioners aware of the existence and aims of the institute, media coverage would be necessary.

b. Council informed the practitioner that Council would suggest that what he proposed in his letter should be done under the auspices of a university.

Ref: October 1988 Vol 6 p. 395.

28.37 PRIVATE SPORTS CLINIC

a. Two medical practitioners and one physiotherapist advised that they envisaged establishing a private sports clinic to examine and advise treatment for acute sports injuries. The treatment would be administered either by themselves or by practitioners of the patient's choice. The fees to be charged for the services rendered, would be a set fee, payable to the clinic and not to the individuals.

b. Council informed the practitioners that Council noted the contents of their letter and was of the opinion that they should practice on an individual basis, that the term "sports clinic" should not be used and no advertising should take place.

Ref: April 1988 Vol 6 p. 396.

28.38 SPORTS HEALTH PRACTICE

Council informed the Medical Association that the conducting of a sports health practice was subject to the Rule relating to advertising (i.e Rule 1) and Council's policy regarding health teams.

Ref: April 1986 Vol 6 p. 397.

28.39 WORKSHOP IN ADVANCED LIFE SUPPORT

Council advised the Head: Department Paramedical Services of a technikon that Council could

see no objection to a proposed workshop on advanced life support to be offered to a group of medical practitioners on a one evening per week basis to provide hands-on experience and that registration of training institutions for this purpose with the Council was not required.

Ref: October 1986 Vol 6 p. 398.

28.40 HEALTH SHOP

a. A practitioner said that he had already retired from active medical practice and, intended to open a retail business and more specifically, a health shop in which he would personality be active.

b. Council advised the practitioner that, while his name appeared on the register of medical practitioners, what he envisaged was not permissible.

Ref: April 1987 Vol 6 p. 399.

28.41 INFLUENZA VACCINE PROGRAMME

a. The Medical Association forwarded a letter to Council by the Director of Medi-Clin Services, who was a pharmacist, advising that that company offered a unique method for the administration of a flu vaccine. At no cost to patients, one of the Director's nursing sisters could vaccinate patients by using a needleless vaccinator, pushing the small dose of the vaccine into the skin painlessly with a stream of air. The Association was of the opinion that the said company, a business undertaking, was entering the field of clinical medicine by offering services which were the province of family practitioners.

b. Council advised the Medical Association that the proposed programme was not permissible and that the Association should consider referring the matter to the South African Pharmacy Council, as well as to the South African Nursing Council.

Ref: October 1987 Vol 6 p. 400.

28.42 EXECUTIVE HEALTH CLINIC

Council resolved that it was not permissible to establish an executive health clinic on the basis of such a clinic being staffed by a nursing sister, a medical technologist, a radiographer and an administrative management. Modern and innovative medical technology was to be employed, including laboratory and radiographic facilities. It was envisaged that the clinic would provide an essential service for the modern business community and aimed to function as a reference mechanism, rather than to undertake the treatment of its clients. The tariff envisaged would be the tariff laid down by the Minister of Health.

Ref: October 1983 Vol 6 p. 401.

28.43 PRACTITIONER WITH LIMITED REGISTRATION TREATING PRIVATE PATIENTS

Council informed the Superintendent of a state hospital that it could not agree to his request that a medical practitioner in the employ of that hospital could treat private patients in the hospital against part payment. The Superintendent was advised that the patients concerned could be treated as hospital patients.

Ref: April 1982 Vol 6 p. 402.

28.44 SUSPENDED DENTIST APPOINTING LOCUM TENENS

a. Following a professional conduct inquiry, a dentist enquired whether he would be permitted to engage a locum tenens to attend to his patients during the period of his suspension. The locum tenens would be paid by the dentist in the usual fashion. Alternatively, the dentist enquired as to whether he would be permitted to appoint a locum tenens on the basis that the salary of the locum would be equal to the total amount of fees earned by the locum during the suspension period.

b. Council advised the legal advisers of the dentist that what was proposed in their letter, was not permissible.

Ref: April 1982 Vol 6 p. 404.

28.45 EXCLUSION OF NEGLIGENCE OF HOSPITAL PERSONNEL

a. The Department of Commerce alleged that certain private nursing clinics and provincial subsidised hospitals were including provisions into their contracts with

patients which amounted to the exclusion of responsibility by the hospital for negligent conduct of hospital personnel.

b. Council advised the Department that Council was of the opinion that, although exclusion contracts entered into between hospitals and patients as referred to, did not fall within the jurisdiction of the Council, such contracts did not exempt medical practitioners from their ethical responsibilities or disciplinary steps being taken against them by Council.

Ref: April 1987 Vol 6 p. 405.

28.46 CONSENT FORMS FOR STERILISATION

a. The Health Matters Advisory Committee recommended that, in view of the importance of male and female sterilisation as a contraceptive method, nurses should be permitted, to complete the consent for operation forms, sign as witnesses and explain the procedure to patients. The doctor must, however, ensure compliance with the above and counter sign accordingly.

b. Council advised the Committee that Council had no objection against the recommendation. Council, however, wished to point out that, by counter signing the consent form, the medical practitioner concerned accepted final responsibility for the fact that the patient had been fully informed regarding the procedure to be carried out (see also Booklet 15: Seeking Patients' Consent: The Ethical Considerations).

Ref: April 1987 Vol 6 p. 406.

28.47 VERIFICATION OF IDENTITY OF PATIENTS PRIOR TO TREATMENT

a. A number of cases had been reported to the Medical Schemes Investigation Bureau where practitioners had treated persons who were not members of those medical schemes which the group represented and that the practitioners concerned submitted accounts in the name of the persons whose membership cards had been presented. It, therefore, appeared that membership cards were fraudulently being used. The question arose whether practitioners had to verify the identity of their patients before commencing treatment.

b. Council advised the Bureau that -

i. practitioners should take reasonable steps to verify the identity of patients. However, if they were deceived after taking such steps, they could not be held responsible;

ii. medical aid schemes should, however, also take steps to prevent the abuse of membership cards.

Ref: April 1987 Vol 6 p. 407.

28.48 CONSENT TO OPERATIONS ON MINORS

Council informed a Medical Superintendent that -

a. the Superintendent of a hospital could give consent to operations on minors, provided that it was justified and indicated on purely medical grounds;

b. Council did not express a view on the legal aspects regarding the giving of consent to operations;

c. the requirements of the relevant employing authority and the provisions of the relevant legislation, such as the Children's Act, (now the Child Care Act, 1983 (Act No. 74 of 1983), should be complied with in this respect.

Ref: April 1988 Vol 6 p. 408.0

28.49 CONSENT BY SUPERINTENDENT FOR OPERATION ON MINORS

a. The Superintendent of a childrens' hospital stated that problems were being experienced in obtaining consent to operations, because children were often not accompanied by legally authorised persons or that they could not be traced. He suggested that the legal authority to grant consent to operations for "cold" cases which resorted under State departments, should be extended to medical superintendents.

b. Council advised the Director of Hospital Services of the relevant province that –

i. Council was of the opinion than it was the responsibility of the patient's medical practitioner to inform the patient about the operation and to obtain the required consent to the operation;

ii. Council agreed that permission should be granted to the medical superintendent of a hospital to give consent to an operation under the circumstances as set out above by the Superintendent.

Ref: October 1986 Vol 6 p. 409.

28.50 PRACTISING AS PRACTITIONER AND ATTORNEY SIMULTANEOUSLY

Council advised a practitioner that Council could in principle see no objection against the practitioner, who had been admitted as and attorney, practising both professions. However, the possibility existed that the observance of the Ethical Rules of the two professions might come into conflict and, should a complaint be received, Council would have to take cognisance of the matter.

Ref: April 1988 Vol 6 p. 410.

28.51 SOCIETY TO ASSIST PRACTITIONERS FINANCIALLY AFTER PROFESSIONAL CONDUCT INQUIRIES

a. The Registrar of Friendly Societies advised that he had received an application for the registration of a society which aimed to draw its members from, amongst others, the medical profession. The object of the society would be to provide financial relief to those of its members who experienced a loss of earnings as a result of a suspension from the practising of their profession following professional conduct inquiries due to negligent conduct. The financial benefit would be financed from members' annual contributions.

b. Council advised the Registrar that Council was opposed to the formation of a society to assist practitioners financially after a professional conduct inquiry as set out.

Ref: October 1983 Vol 6 p. 411.

28.52 BREACH OF CONTRACT BY PRACTITIONERS

a. A Secretary for Health advised that only 25% of doctors who had signed an agreement to serve his department in its hospitals for an equivalent number of years as the number of years during which they were assisted financially, had come back to serve their contracts for varying periods.

b. Council advised the Secretary that the matter as contained in his letter was a civil matter and as such did not fall within the purview of the Council. Council would, however, be prepared to investigate any complaint arising from civil actions.

Ref: October 1986 Vol 6 p. 412.

28.53 "UNDESIRABLE" AND "NOT PERMISSIBLE"

a. The Medical Association pointed out that the two expressions used to describe actions, namely "undesirable" and "not permissible" created confusion. The Association stated that particularly the expression "undesirable" caused problems as it did not necessarily mean that the action was not permissible.

b Council advised the Association that the words "undesirable" and "not permissible" in resolutions of the Council both indicated that the conduct referred to in such resolutions was unacceptable to Council.

Ref: April 1983 Vol 6 p. 413.

28.54 TREATMENT OF DETAINED PERSONS

a. A psychiatrist informed Council that a patient of his, who was a detainee under section 6 of the Security Act, was removed from his care without any consultation and he asked for Council's opinion on the matter.

b. Council referred the psychiatrist's letter to the Director-General of Health with the request that the matter be brought to the attention of the relevant authorities as Council was of the view that it was unacceptable to remove a patient from the care of the medical practitioner treating him as set out in the letter.

Ref: April 1983 Vol 6 p. 414.

28.55 PRACTITIONERS AND THIRD PARTY MOTOR VEHICLE INSURANCE CLAIMS

Council advised an attorney that, insofar as the ethical aspects were concerned, a doctor examining a patient in a third-party motor vehicle insurance case, should not ask questions of the patient, except to establish such answers as may be necessary to make a diagnosis and prognosis, since it was undesirable for medical practitioners to ask questions relating to the circumstances of the collision, unless they were essential to the medical examination.

Ref: April 1987 Vol 6 p. 415.

28.56 MOTOR VEHICLE INSURANCE ACT

Council considered a report by an Ad Hoc Committee and resolved that the Department of Health and the Directors of Hospital Services be requested, as a temporary measure, to make provision on hospital admission forms to indicate that a patient, in the light of circumstances, could possibly be a private motor accident patient or a patient with an injury on duty. This information would assist the part-time practitioner concerned to begin without delay to determine by means of investigations and interviews whether, in fact, the patient was a private patient and to treat him or her as such.

Ref: October 1988 Vol 6 p. 416.

28.57 HUNGER STRIKES IN HOSPITALS

a. The Secretary of a province asked for clarification concerning patients referred to provincial hospitals by the South African Prison Service who had verbally declared their intention not to partake in any form of feeding from the time of their admission to hospital. The question arose what the legal responsibility of the doctor would be with regard to further treatment in the event of the patient becoming unconscious.

b. The Director-General of Justice was requested to submit an opinion and he stipulated that there were only three possible grounds for medical intervention, namely -

   i. the patient's consent (or the consent of someone legally capable of consent on his or her behalf);

ii. necessity, i.e. cases where there was an overriding social interest at stake;

iii. an authorised administration which entitled a doctor to administer emergency medical treatment in those cases where, on account of the patient's condition, the patient was unable to consent.

c. The Director General of Justice further stipulated that a mere refusal to eat, could not as such be construed to be a tacit expression of a wish not to receive any nutrition - in particular by drip feeding. An explicit wish not to be drip fed, should have been expressed.

d. Council resolved that the provincial Secretary be informed that Council could not comment on the legal aspects of the matter as contained in his letter as such comment fell outside the purview of the Council. As far as the ethical issues involved were concerned, Council was of the view that the legal position, as set out in the letter from the Director General of Justice, was also applicable to the ethical situation of medical practitioners.

Ref: April 1988 Vol 6 p. 417

28.58 WORKMEN'S COMPENSATION CASES

a. A trade union adopted a resolution submitting to Council their strongest protest against the action of some doctors who refused to handle Workmen's Compensation cases. Certain doctors apparently refused to render emergency attention to such cases due to the inconvenience of having to wait for payment from the Workmen's Compensation Commissioner and also because the amount the doctor received was less than what could be charged if a private patient had been seen.

b. Council advised the trade union of a previous resolution of Council on the treatment by practitioners in emergency cases, i.e. that a practitioner is free to decide to whom he or she wanted to render a service or not. A practitioner may, however, be called upon to justify his or her action in the event of unnecessary suffering or death resulting from his or her refusal to render help to a patient. A practitioner was obliged to render assistance under all circumstances in emergencies.

Ref: April 1984 Vol 6 p. 418.

28.59 RESPONSIBILITIES OF MEDICAL PRACTITIONERS REGARDING STATUTORY AUTHORITY OF POLICE

a. A practitioner enquired whether it was lawful for a policeman to remove a patient from the direct care of a specific doctor with the latter being unable to prevent such removal.

b. An Ad hoc Committee was then appointed to investigate the matter. That Committee subsequently reported that legislation had been amended during the preceding few years to require that a police official may not set aside the order of a district surgeon or another authorised medical practitioner in respect of the nature or place of treatment of a detainee. On the contrary, there was a direct instruction to the police to request the district surgeon as soon as possible to examine a detainee and to ensure that his or her instructions were carried out, also in respect of the place of treatment.

c. In order to prevent the interruption of medical care to the possible disadvantage of the detainee in cases where the detainee had already been under the direct treatment of a medical practitioner (other than the district surgeon or other authorised medical practitioner), the Committee recommended that statutory provision should be made in such a case that a member of the police was obliged

to detain such a person at the place where he or she was being medically treated, until the district surgeon or other authorised medical practitioner could take over the treatment of the detainee.

Ref: April 1986 Vol 6 p. 419.

28.60 CONTINUOUS MEMBERSHIP OF OVERSEAS COLLEGES

Council decided that it did not require continuing membership of overseas colleges (of Medicine, Surgery etc.) as a condition for the registration with Council of qualifications obtained at such colleges.

Ref: April 1983 Vol 6 p. 421

28.61 RETURNING OF UNOPENED MAIL TO PHARMACEUTICAL MANUFACTURERS

a. It was brought to the attention of Council that it had been suggested to practitioners that they should return direct mail received from pharmaceutical manufacturers unopened. The possible consequences were pointed out to a practitioner returning unopened letters from a manufacturer which happened to contain information about side-effects or contra-indications of a particular medicine. Even details of the withdrawal of a medicine were relevant in that context.

b. Council informed the Pharmaceutical and Chemical Manufacturers Association that Council was of the view that it was hazardous for a practitioner to return direct mail from manufacturers of medicine unopened.

Ref: October 1982 Vol 6 p. 422.

28.62 USE OF COUNCIL'S LOGO

Council advised a glassware manufacturing company that Council could not agree to the use of Council's logo on glassware for members of the medical and dental profession.

Ref: April 1986 Vol 6 p. 423.

28.63 CANCER INFORMATION ON NATIONAL BASIS

a. The National Cancer Association advised that it was of the view that an information service should be established. The proposed cancer information service should be a national service, be full-time, should be supervised by a full-time supervisor and, in addition, should have voluntary workers who were suitably trained and able to assist (senior medical students should do an elective period in the service at a fixed rate per hour). The service should have a medical practitioner in overall control as adviser, full and detailed records should be kept and national advertising should be undertaken.

b. Council informed the Association that Council could see no objection to what was proposed in its letter with the exception that provision should not be made for formal participation by medical students against payment.

Ref: October 1983 Vol 6 p. 424.

28.64 CANCER INFORMATION TO PUBLIC

a. The National Cancer Association, via the Department of Health, alleged that various organisations were providing negative and incorrect information to the public and to cancer patients. The result was that patients often came to late for treatment.

Council resolved that information regarding cancer and the identification thereof could be provided by any person and that the National Cancer Association should play a major role in this regard.

Ref: April 1988 Vol 6 p. 425.

28.65 TRAINING COURSES

a. The Department of Manpower (now Department of Labour) asked for a decision regarding -

i. the extent to which the Act was applicable to the conducting of role play in training courses;

ii. the extent to which the Act was applicable in general to the presentation of training courses.

b. Council advised the Department that, in terms of section 16 of the Act, a practitioner had to obtain the permission of Council to present training as set out in the letter. It appeared to Council that the said training included acts pertaining to the profession of psychology as specified in section 37 of the Act (i.e. Act No. 56 of 1974).

Ref: October 1985 Vol 6 p. 426.

28.66 REGISTRATION OF BLIND PERSONS

a. The Department of Health pointed out that, in terms of the Blind Persons Act 1968 (Act No. 26 of 1968), every person applying to be registered as a blind person had to be

examined by a medical practitioner whose name had to appear in a list compiled by the Minister after consulting the Council. The Department proposed that the names of all registered ophthalmologists be placed on such a list and, secondly, that in cases where the services of such ophthalmologists were not readily available, the examinations could be carried out at provincial hospitals and clinics.

b. Council agreed to proposals by the Department.

Ref: April 1983 Vol 6 p. 428.

28.67 MEDICAL SERVICES TO JEHOVA WITNESSES

a. A Medical Superintendent of a hospital enquired what the correct conduct would be in the following cases where a blood transfusion was regarded as necessary in the treatment of a patient, namely –

i. a Jehova's witness over the age of 18 years, who could personally give consent (or refusal), who refused that blood or any blood product be administered to him or her;

ii. the wife (or husband) of a Jehova's witness who was the patient and not in a position to personally refuse the administration, but where the husband (or wife) refused;

iii. in the case of the minor child of a Jehova's witness.

b. The Superintendent also wished to know whether he could contact the media in this regard.

c. Council advised the Superintendent that -

i. firstly, the medical practitioner had to act according to the wishes of the patient;

ii. secondly, the Superintendent of a provincial hospital may give the necessary authorisation, unless the patient recorded his or her wishes personally prior to admission;

iii. in the third case, the provisions of the Children's Act (now the Child Care Act, 1983 (Act No. 74 of 1983), were applicable.

c. Council regarded it to be undesirable for the Superintendent to be in touch with the media regarding the matter.

Ref: October 1980 Vol 6 p. 429.

28.68 PRACTITIONER REFUSING TO ADMINISTER BLOOD PRODUCTS

a. The Head: Department of Paediatrics of a hospital stated that a student-intern who was a Jehova's witness, refused to order or to administer any blood product to patients.

b. Council advised the Head that Council was of the opinion that a practitioner had to place the interests of his or her patient first and that, where a patient was disadvantaged by the views of a practitioner, such practitioner would be held responsible for his or her actions.

Ref: April 1987 Vol 6 p. 430.

28.69 JEHOVA WITNESS PRACTISING MEDICINE

a. The Dean of a Faculty of Medicine advised Council that a final year medical student who was a Jehova's witness was convinced that it was unacceptable to transfuse blood or blood products. Council was asked for a ruling on whether or not the MB ChB degree could be conferred on that student.

b. Council resolved that -

i. Council accepted that the final year examination for the MB ChB degree of the relevant University was based on generally accepted and sound scientific principles. Council had serious reservations in considering a person who was not prepared to carry out the procedure as set out in the Dean's letter, to be a competent person to practise medicine;

ii. the MB ChB degree of the relevant University was recognised by Council for registration purposes and any person holding that qualification and who applied for registration, could not be refused unlimited registration.

Ref: October 1980 Vol 6 p. 431.

28.70 ATTENDANCE OF AUTOPSIES

a. The head of department at a university enquired whether it was ethically correct for a general practitioner to make himself available to act on behalf of the family (i.e. as an expert observer) while a pathologist (forensic) conducted the examination.

b. Council advised that there was no ethical objection which could prevent a general practitioner from attending an autopsy as an observer on behalf of the family.

Ref: October 1986 Vol 6 p. 432.

28.71 CONDUCTING OF AUTOPSIES

a. A Committee of Preliminary Inquiry expressed concern about autopsies being conducted inadvisedly or even incompetently and, although the Committee was aware of the difficult circumstances under which autopsies often were carried out, it felt that Council should pay further attention to the matter in general.

b. The Executive Committee referred the matter to the Medical and Dental Education Committee. That Committee then advised that it was of the opinion that district surgeons ought to attend short courses on the conducting of autopsies.

c. Council noted the resolution of the said Committee.

Ref: October 1986 Vol 6 p. 433.

28.72 DENTAL EXAMINATIONS AND PREVENTIVE PROGRAMMES

Council informed the director of a research group in dental epidemiology at a university that it did not

see an objection to persons registered under the Act or the Nursing Act from being used to examine persons in order to determine the effectiveness of dental preventive programmes, provided the registered person retained responsibility for his or her professional activities.

Ref: April 1980 Vol 6 p. 435.

28.73 EMERGENCY TREATMENT BY NURSES

a. A senior medical officer at a mine hospital was periodically confronted with employees collapsing with acute chest pain. He experienced difficulties to obtain the services of their doctors and had accordingly issued instructions to his paramedical staff which consisted of nurses.

b. Council informed the medical officer that Council noted that the procedures as set out in his letter would be performed by nurses in emergencies only and Council could see no objection to what was proposed; Council suggested that he also consult with the Nursing Council.

Ref: October 1980 Vol 6 p. 436.

28.74 NURSES INFORMING PATIENTS ABOUT OPERATIONS AND OBTAINING CONSENT

a. The Nursing Council alleged that it was required of nurses to complete consent forms for operations, to sign these as witnesses, to obtain the signature of the patient and to explain the operation procedure to the patient.

b. Council advised the Nursing Council that Council did not see any objection to the signing of the operation consent form by nurses as witnesses. Council was of the opinion, however, that it was the responsibility of the medical practitioner to inform the patient about the nature of the operation. See also Booklet 15: Seeking Patient's Consent. The Ethical Considerations.

Ref: October 1984 Vol 6 p. 437.

28.75 PUBLIC SCREENING USING GLUCOMETERS

a. The Lions Club enquired whether it was permissible for their members to do blood-sugar testing. They would be instructed on the correct use of a glucometer; the service was rendered to the public free of charge and persons with high or too low readings were merely informed that they should attend their doctors or local clinics for further examination.

b. Council resolved that the Club be advised that Council suggested that nurses be used to carry out public screening by means of glucometers.

Ref: April 1987 Vol 6 p. 439

28.76 PROCEDURES PERFORMED BY NURSES IN THEATRE

Council informed the Superintendent of a hospital that it was not permissible for a nurse to perform the following procedures: Circumcisions; suturing of wounds involving muscle tissue; suturing severed tendons; drawing up of drugs into a syringe for an anaesthesiologist; amputating fingers and toes; aspirating knee joints; doing skin grafts; excising cysts; and doing skin biopsies.

Ref: October 1988 Vol 6 p. 440.

28.77 NON-MEDICAL PERSON AS HEAD OF STUDENT HEALTH SERVICE

Council advised a university that it did not see any objection to the appointment of an unregistered person as head of a student health service, provided such person did not perform any medical acts.

Ref: October 1984 Vol 6 p. 441.

28.78 MEDICAL PRACTITIONER BEING MEMBER OF ASSOCIATED HEALTH PROFESSIONS COUNCIL

Council advised the Medical Association that, in the light of the composition of the South African Council for Associated Health Professions as provided for in the 1982 Act, Council did not see any objection to the appointment of a medical practitioner to that Council.

Ref: April 1986 Vol 6 p. 444.

28.79 MIDWIVES PERFORMING SURGICAL PROCEDURES

a. The Heads of departments of obstetrics and gynaecology at universities, requested that clear guidelines be given as to the circumstances under which operative procedures might be undertaken by midwives with the proposed advanced diploma in midwifery and in neonatal science.

b. Council resolved that the said Heads be informed that Council could not agree to the performance of surgical procedures by midwives (caesarean sections and tubal ligations) as envisaged in the proposed diploma.

Ref: October 1981 Vol 6 p. 447.

28.80 HEAD OF BLOOD TRANSFUSION SERVICE

Council advised the National Blood Transfusion Service that Council was of the view that all medical matters in a blood transfusion service had to be the responsibility of a medical practitioner. Council could see that the administrative head of such a service need not necessarily be a medical practitioner.

Ref: October 1986 Vol 6 p. 449.

28.81 TAKING OF ELECTRO-ENCEPHALOGRAM BY TECHNICIAN

Council adopted the proposal by the Medical Association, namely that an electro-encephalographic technician may take an EEG and that it was desirable that the medical practitioner who reported thereon, also saw the patient in consultation.

Ref: October 1983 Vol 6 p. 450.

28.82 INTRAVENOUS INJECTIONS BY FIRST AIDERS

Council informed the Council for Mineral Technology that it could see no objection to the training of persons in the employ of that Council who held first aid certificates, to administer intravenous injections in emergencies only.

Ref: April 1984 Vol 6 p. 455.

28.83 NON-MEDICALLY QUALIFIED REPRESENTATIVES IN THEATRE DURING SURGERY

a. The Executive Committee of the Interim Council resolved that non-medically qualified representatives of companies marketing sophisticated equipment for use during surgery may attend during surgery to offer advice on the use and monitoring of equipment: Provided that -

i. the presence of such a representative was the responsibility of the surgeon, anaesthetist, or theatre assistant, depending on the nature of the service to be rendered and the field in which the representative would be working;

ii. such representative did not "scrub" or assist as envisaged in Council's policy on assistance at operations;

iii. the patient's consent was obtained and recorded beforehand;

b. The Executive Committee of the Medical and Dental Professions Board resolved that the previous resolution of the Interim Council be confirmed, but that subparagraph ii be rescinded and replaced by the following stipulation, namely –

ii. the assistance of such representatives would be limited to the assembly or disassembly of instrumentation.

Ref: MDB Exco: Aug 1999, Item 42

28.84 MEDICAL VIDEOS

With reference to a request by a medical practitioner for a ruling on the making of medical videos, the Medical and Dental Professions Board resolved that it be recorded that the making of medical and dental videos and their screening for educational purposes on the internet would be permissible on the following conditions:

a. Such videos to be available for viewing only to medical and dental practitioners,

b. Permission be obtained from the patient concerned prior to making and screening such videos.

c. The patient be impossible to identify.

Ref: MDB: Sept 1999, Item 40

28.85 REFRESHMENT STATIONS IN WAITING ROOMS

The Executive Committee of the Medical and Dental Professions Board resolved that setting up a refreshment station in the waiting room of a medical practitioner or dentist would be permissible with the proviso that such facility should only be available to the patients of that medical practitioner or dentist and not to the public at large

Ref: MDB Exco: May 2001, Item 70

28.86 ESTABLISHMENT OF FRESH BREATH CLINICS

The Executive Committee of the Medical and Dental Professions Board resolved that –

a. all treatment modalities and scientific knowledge of disease treatment should be made available to all health care professionals and not only to a select few;

b. in terms of the Ethical Rules of the Board, a medical practitioner or dentist may not be involved in the promotion of any health care product;

c. the establishment of fresh breath clinics in South Africa could, therefore, not be endorsed.

Ref: MDB Exco: April 2000: Item 34

28.87 PERFORMANCE OF OVERTIME DUTIES BY HEALTH CARE WORKERS/PRACTITIONERS

The Executive Committee of the Medical and Dental Professions Board –

a. resolved that –

i. the matter of overtime duties by medical practitioners/ health care workers was viewed to be a labour relations matter between the relevant employer and employees; ii. the Medical and Dental Professional Board could not be seen to intervene in the domestic affairs of another Statutory Body, except when patient care was compromised; iii. the matter should, therefore, be taken up with the relevant Head of Health; b. subsequently resolved that – i. the previous resolution be upheld; ii. it be pointed out, however, that a medical practitioner remained personally responsible for the care and treatment of his or her patients for as long as they required such care and treatment; iii. it was within the professional responsibility and 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 would be held professionally accountable for his or her actions. Ref: MDB Exco: Dec 1999, Item 49	