Message from the Chairman

Mr Adolf Macheka
Chairman of council (2015 -2020)

As we come towards the end of the second half of my first year, as Chairperson of Council, I can only look back in amazement over the incredible pace of progress that the Council has made in realizing the goals set by the 15 September 2015 Strategic Planning meeting meant to lift the Council from 2015 to 2020 from where it had been placed by the predecessor Council.

The socio-economic challenges continue to provide a fertile ground for skills flight to the regional and international countries thereby exacerbating the already depleted numbers of health care providers in the country. This continues to have a negative impact on the much-needed quality of service as well as reduced financial resources for the Council. Notwithstanding, as I look back I take much satisfaction from the success that we enjoyed as Council due to the dedication of the members of the profession through the concept of self-regulation, despite the viability challenges facing our members of the profession who continue to attend Council and Committee meetings to deliberate and decide on Council matters.

Council continues to review Policies that guides its statutory operations. These amongst others include the review of the Policy on Administration of all Health Institutions. This Policy is meant to empower our members of the profession in managing health institutions, after noting a gap where non-medical CEOs were running medical institutions without the input of a Medical Director responsible to Council on professional and ethical issues by being knowledgeable on the issues that affect the professional operations of the institution. The Policy is also now applicable to all public institutions. The other Policy is that of the requirement for health institutions to have good record keeping system, which is critical in patient care.

Council has also embarked on continuous improvement of internal systems by maximizing the use of ICT. Council now has an in-house website after engaging a Systems Administrator in March 2016. The reviewed website is more informative to the profession as well as the general public. Council has submitted draft regulations to the Ministry for promulgation on the E-Health/Telemedicine. Work is in progress in the development of guidelines on Teleradiology and Telepathology.

Council has now developed a Service Charter that is being circulated to the profession for information about the services and functions of the Council. This was launched by the Honourable Minister of Health & Child Care on 17 November 2016 during the official opening of the Council Bulawayo offices. In line with one of the strategic goals of ensuring high standards of professional competence, on 13 October 2016 Council conducted the first ever registration examination as an additional assessment tool for assessing applications for foreign trained interns from unaccredited medical schools given the influx of returning Zimbabweans seeking registration from such medical institutions. According to the Council Policy, the unsuccessful candidates are given three chances to rewrite the examination and thereafter they will be required to join the 4th year local medical/dental training programmes. Foreign trained specialists currently do not require an examination. The acclimatization process in a Designated Health Institution is still operational.

The Council has continued to pursue the plans of the predecessor Council of increasing Council value of investments through the construction of a 30 seater Boardroom at cost of $333.000 as opposed to the original budgeted figure of $350 000, as well as renovating the Council administration offices shown in the report at a cost of $ 195.000 as opposed to the budgeted figure of $ 210 000. Council has also refurbished the Bulawayo offices which officially opened by the Hon. Minister of Health & Child Care on 17 November 2016 to serve our members of the profession from the southern region as well as the public from that region. Plans are underway to officially open the Harare office.

I am enormously indebted to the dedication of the Council members and profession who keep self-regulation healthy and vital through their active participation as well as support services by Secretariat and staff during this eventful year.

Mr Adolf Macheka
MB ChB (ZIMB) 1984
FRCS (EDINBURGH) 1993
SPECIALIST ORTHOPAEDIC SURGEON

From the Registrar's Desk

Josephine Mwakutuya

The performance based Strategic Plan for the Council is in line with the Government Policy. In this Newsletter we are reporting the strategic milestones which are monitored on a quarterly basis. The following are the strategic themes for the five year Council term of office from 2015 to 2020

1. Working with National, regional and International Partners,
2. Ensuring High Standards of Professional Competence,
3. Ensuring Professional Practice Guidance to doctors
4. Doctors Health
5. Governance Activities
6. Business Processes, Finance and Funding.

The above Strategic Themes were formulated following the scanning of the Council's external macro environmental factors, namely political, socio- economic, cultural, technological, legal and the global trend. This report will focus on the milestones from the Key Result Areas (KRAs) based on the 7s Model, being Strategy, Structure, Systems, Style, Staff, Skills and Shared Values as they relate to the statutory function of the Council, Registration, Education and Fitness to Practice supported by Technology and Processes. As the Secretariat, we are pleased to report on the outcomes of the set objectives as we continue to implement the Council strategic activities.

Josephine Mwakutuya
B COM MGT (HR) (ZOU) 2006
MBA (WUA) 2011
DIP Law Arbitration & Conciliation (UZ) 2016

PROGRESS ON THE COUNCIL STRATEGIC OBJECTIVES FOR THE PERIOD 2015-2020

KRA 1. EDUCATION

The Strategic Objectives include:-

- Promoting Council certified accredited educational programmes to the profession
- Enhancing quality education
- Equity distribution of specialist care

Promoting Council Certified Accredited Educational Programmes to the Profession

The Education & Liaison Committee (ELC) of Council through the Surgical Society of Zimbabwe (SSZ) and the Anaesthetic Association of Zimbabwe (AAZ) has successfully conducted the MDPCZ Trauma Course to 27 middle level doctors from 29 – 30 July 2016. The programme included practical and written papers. This was well accepted by the participants. Plans are underway to have a certified programme for the whole country akin to the ATLS course. This was a true testimony of the concept of self-regulation portrayed by SSZ and the AAZ who formed the Core Faculty that included the Chairman of Council Mr Adolf Macheka, Mr George A N Vera, Mr Collen Msasanure, Mr Matthew Wazara, Dr Samson Shumbairerwa, Dr Emmerson N Mutetwa and Dr Farai Madzimbamuto, Mr David Muchuweti, Dr Harunavamwe N Chifamba convened by Mr Aspect A V Maunganidze. Tribute goes to the Dean of the College of Health Sciences (CHS), Professor Midion M Chidzonga and Dr Farai Madzimbamuto for providing the Education Department of the CHS to successfully run the programme. The benefits of this programme in emergency care management cannot be overemphasized.

Mr Matthew Wazara demonstrating to participants

Equity Distribution of Specialist Care

Council is pleased to have been part of the milestone of the inauguration of the East, Central and Southern African College of Physicians (ESCACoP) on 2 July 2016 in the resort town of Victoria Falls. 650 Physicians from 6 countries in the Sub-Saharan African region assembled in Victoria Falls to witness the official launch of the internationally recognized fellowship of ESCACoP. The objective of this Fellowship Programme ***"implementing the standards of health care throughout the East, Central and Southern African region by providing specialist training of physicians committed to lifelong learning"*** fits very well with the Council strategic themes of achieving High Standards of Professional Competence as well as that of Working with National, Regional and International Partners whose objective is to enhance quality education and ultimately equity distribution of specialist care. This cannot have come at an opportune time given the continued increase in the intake of medical students at the local institutions against a background of static and depleting resources. Establishment of this College without walls will have a positive impact in medical specialist care as well as enhancing the decentralization of internship training given the ever-increasing numbers of interns. The four tertiary institutions are proving to be inadequate. The Fellowship of ESCACoP was recognized as a certified accredited programme for Specialist registration by the Education and Liaison Committee of Council on 23 November 2016. This was duly confirmed by the Council on 6 December 2016. 60 currently registered Physicians who form the cohort of lecturers in this programme have been awarded Honorary Fellowship. A call out has been made on the Council website to register this specialist additional qualification.

Council is pleased that AAZ is also in the process of evolving a Fellowship programme through the College without walls. Council promotes and supports such programmes which are in line with its strategic objectives.

Elephant Hills 2 July 2016

Enhance Quality Education And High Quality Practice.

Accreditation of Medical Schools: Council has embarked on the accreditation process of Medical Schools. The process ensures that standards of medical education in the country meets the basic set global standards of medical education. The accreditation process will enable the Council to accredit both new and old medical schools and have them listed in the World Directorate of Accredited Medical and Dental Training Institutions. The ultimate objective is high quality practice as a result of quality education. The accreditation of the College of Health Sciences has resumed. The same process is being applied to NUST Medical School following the prescription of the NUST MBBS degree programme in 2012, as well as Midlands State Medical School in January 2016, an affiliate of the CHS. An accreditation committee has been established that will include a member from the region.

Council Registration Examination: One of the challenges noted by the 15 September 2015 Strategic workshop during review of the 2010 /2015 Strategic Plan was the influx of interns from unaccredited international medical schools, thereby compromising quality care as well as patient safety. The need to come up with an integrated effective registration process responsive to the changing environment could not be over emphasized. Through ELC and the Practice Control Committee (PCC), Council has come up with Guidelines for conducting registration examination as part of an assessment tool to foreign trained interns and general practitioners seeking provisional registration with the Council. We are pleased to report that, despite overwhelming resistance, Council managed to conduct the first ever registration examination to 7 interns and one medical practitioner seeking provisional registration. Only 2 interns and the post intern passed the examination. According to the Policy the unsuccessful candidates will be given three chances to re-write the examinations. Policy Guidelines can be accessed on the new Council website. The examination process will ultimately enable the Council to make an evaluation of the medical schools whose interns perform poorly and make a determination on whether to continue to accept graduates from the respective medical school, given that 'A' level science subjects are not a requirement in the recruitment of students in some of these international medical schools.
In addition to the registration examination, all foreign trained doctors seeking provisional registration with the Council are now required to have their qualifications and schools of training verified by the Education Committee for Foreign Medical Graduates (ECFMG) based in Philadelphia USA. The ECFMG verification also applies to doctors seeking specialist registration who will also be required to undertake the 3 months acclimatization under an identified specialist in a DHI with reports.

Philanthropic Specialists will be required to work under an identified specialist in their area of specialty. Foreign trained specialist electives will be required to fulfill the above requirements and work in a DHI under an identified specialist in the relevant specialty.

Emergency Medicine Training ATLS Courses: Having noted a gap in life support skills within the middle level doctors that has resulted in avoidable loss of life, the predecessor Council took a position that all casualty officers should have life support skills and that ELC should set up specific courses that will make a difference to the quality of care. The Surgical Society of Zimbabwe (SSZ) Matabeleland Chapter has been holding such courses twice a year. Through ELC, the SSZ Northern region conducted an MDPCZ Trauma Course on 29 and 30 July 2016 to 27 candidates.

The candidates were issued with certificates of attendance valid for 4 years. This was confirmed by the 4th October 2016 Council which resolved that future MDPCZ Trauma Courses, Council will issue certificates of competence to successful candidates who would have met the passing mark of 85% as well as certificates of attendance. Unsuccessful candidates will only be issued certificates of attendance for CPD purposes. Work is in progress to have a unified competence

based MDPCZ Trauma course, which will be offered to both the southern, and northern region middle level doctors.

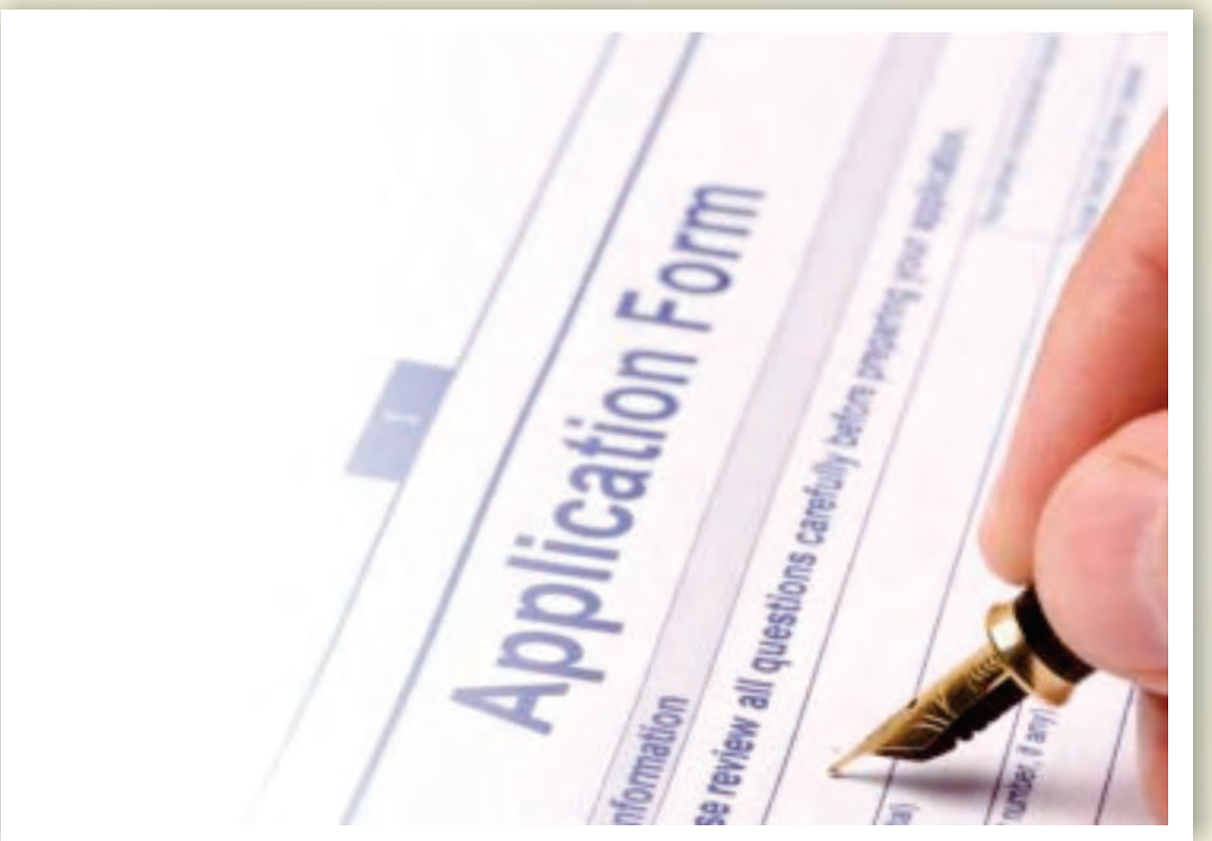
Mr George A N Vera (left), Dr Samson Shumbairerwa and Mr Mathew Wazara (right) demonstrating to participants.

Midlands State University (MSU) Medical School: Council is pleased to announce the approval of the MSU medical school, an affiliate of the CHS with effect from 26 January 2016. The approval, which was subject to recruitment of 20 students, was granted subject to initially commencing with basic sciences and monitoring by way of annual inspections until the exit of the first intake.

REGISTRATION

The strategic objectives are:

- Development of an integrated effective and efficient registration system.
- Promotion of high quality health care service delivery through enforcing specific minimum standards.
- Promotion of evidence based policies and practices through insightful research that promote patient's safety.
- Governance, customer stakeholder satisfaction and transparency in Council processes



Development of an Integrated Effective and Efficient Registration System.

The Practice Control Committee continues to hold bimonthly meetings to consider and approve applications for registration of practitioners, issue of license to practise as well as registration of premises. Council has developed a Bridging Policy that will expedite such applications following receipt of positive comments from members of the Committee by circulation, reducing waiting time to not more than a month of receipt of an application.

In line with Government Policy on 'Ease of Doing Business' Council with the HPA is coming up with a one stop shop in the processing of applications for registration of premises. Members of the profession will submit their applications for registration of their health premises to HPA which will disseminate the applications to the relevant Council for assessment as well as the other institutions such as the Medicines Control Authority of Zimbabwe (MCAZ) and the Radiation Protection Unit where necessary. The practitioner will then get the outcome of their application in a form of the registration certificate from the HPA without the need to go to other places. Plans are at an advanced level to have this efficient integrated system operational which will reduce the cost of registration of premises.

The one-stop-shop for applications of registration of premises is a positive step in having an integrated effective and efficient registration system process that is responsive to the changing environment.

Promotion of High Quality Health Care Service Delivery through Enforcing Specific Minimum Standards.

Council has developed a number of Polices meant to guide the profession with a view to promote high quality health care service. These include:

a) **Record Keeping Policy**: this Policy was developed having noted the apparent lack of appreciation of the importance of record keeping system, as a powerful tool that enables doctors to track the patient's medical history and assist in continuity of health care with the primary purpose of providing quality care to patients. Medical records are also critical in that they provide evidence in litigation, an issue that has been of concern to Council as often Council has found it difficult to conclude some cases due to unavailability of medical records. The Policy that is applicable to all health institutions and registered practitioners provides guidelines on organization of medical records, record keeping, retaining medical records, access to medical records by patients, patient's requests for transfer, and more importantly the time that a practitioner can keep medical records. The Policy is now available on the Council website.

b) **Telemedicine Policy: Council embraces technology in health care delivery:** Telemedicine is in a constant state of evolution. It is advancement in technology that provides opportunities for new approaches to the delivery of health care to the changing environment. This Policy should be read together with the legislation on Medical Tourism which is awaiting promulgation by the Honourable Minister of Health & Child Care. The Telemedicine Policy, which was adapted and adopted from Councils stakeholders, the International Association of Medical Authority (IAMRA), aims to set out Council's expectation from registered medical and dental practitioners who practice telemedicine. The Policy applies to Council registered medical and dental practitioners regardless of where the practitioner or the patient is physically located. The Policy amongst other things provides guidelines on tele-prescriptions. The Policy also provides guidance on tele- prescription and also addresses expectations for doctors practising telemedicine across borders. The Policy can now be viewed from the Council website.

c) **Administration of Health Premises Policy**: The reviewed Policy makes it a mandatory requirement for every health institution to have a post of Medical/Dental Practitioners in Charge who in other institutions is called Clinical Director, Medical Director or Medical Superintendent. This officer who should be in possession of a valid license to practice in terms of S.92 of the Health Professions Act (Chapter 27:19), shall be registered with the Council as a Medical or Dental Practitioner. The Policy Guideline is actualized by a draft Statutory Instrument that is awaiting promulgation by the Honourable Minister of Health & Child Care due to the importance of the responsibilities of the Medical/Dental Practitioner in Charge/Clinical Director/Medical Superintendent or Medical Director. This Policy is accessible on the Council website

d) **Medical and Dental Practitioners Council Surgical Check List Guidelines:** These Guidelines were developed after noting the continued increase of numbers of cases investigated by the Preliminary Inquiries Committee of Council where adverse outcomes had occurred due to omissions of standard procedures to be taken on patients prior to operations. The guidelines which have been disseminated to all health institutions can also be accessed by members of the profession from the Council website.

e) **Staffing requirements for recovery units:** Council has developed guidelines on minimum standards for recovery units staffing levels. This followed an inquiry held by Council where a patient with a diagnosis of Obstructive Sleep Apnea and epistaxis headaches and deafness was taken to theater for excision of post nasal tumor myringotomy and grommets insertion having been administered pethidine. This high risk patient was taken into the recovery room after the procedure and was extubated by a State Certified Nurse as opposed to an ICU trained General Nurse. The guidelines which will be posted on the website shortly provides the minimum staffing levels according to the condition of the patient after an operative procedure in the three main post-operative conditions of the patients thus, the reception stage, where the patient may be unconscious or emergent from that state, the staffing ratio should be 1 patient to 1 nurse, the second stage of the stabilization period, where the patient is self-ventilating with no airway adjuncts or needing respira tory assistance the staff ratio should be 1 nurse to 2 patients then finally the fit for discharge condition where the patient has met all the local discharge criteria, is stable and comfortable the staffing ratio should be 3 patients to 1 nurse. These guidelines will be circulated to all health institutions with theaters.

f) **Practitioners Drug Screening Protocols:** Council through its Health Committee has a function of rehabilitating impaired practitioners due to medical conditions or substance misuse during their course of duty, thus affecting their effectiveness in their professional practice. It has therefore become necessary to screen such practitioners through the Health Committee. Council has developed a tool that provides guidelines on the screening process that inter alia includes random requirement for blood tests without prior warning to the practitioners. The Policy is available of the Council website.

g) **Amended CPD Guidelines:** Renewal of license to practice is subject to submission of 50 CPD points by 30 September of each year. 50% of the points (25 points) should be from the practitioner's area of practice. Council has now amended Section 7 on Procedures for collating CPD points.' ***It is now the responsibility of an accreditor body to collate and submit CPD points of professionals that fall within their accreditor body, regardless of whether the said professional is a member of the association or not.***' The accreditor body can impose a levy for collating and submission of the CPD points to Council for the non-members of the respective association. The concept of CPD demonstrates the spirit of self-regulation by the profession as Council does not have the capacity to manage CPD activities. In recognition of our members of the profession who maintain their registration whilst residing out of the country and periodically visit home to practice on short periods, Council through ELC has approved a new provi sion on Section 5.3 of the CPD Guidelines that enables such practitioners to accrue at least 13 CPD points from activities directly organized by their local respective accreditor body. This is subject to proof that the practitioner is indeed based out of the country. The amended CPD Gu idelines are available on the Council website.

h) **Amendment of Section 4.3 of the Specialist Registration Policy of 2011.** As part of the assessment of foreign applications for specialist registration, it is now a requirement by Council for the applicants to submit proof of the specialist registration from the country of training. Section 4.3 of the Policy for specialist registration has now been amended to reflect this requirement and these guidelines are accessible on the Council website.

i) **Amendment of Section 2 of the Policy for Re-registration and issue of licence to practice to practitioners who have been out of practice.** The accommodative approach by the Council to ease the registration of returning Zimbabweans with a view to

encourage their return to provide the much needed health care service has led to the amendment of this Policy.

A practitioner who had an unrestricted license to practice and has been out of practice for a period of 2 to 3 years will be required to undertake a period of 6 months orientation in a DHI under an identified supervisor with reports submitted to Council. A practitioner who had an unrestricted license to practice and has been out of practice for a period of 3 to 5 years will be required to orient in a Designated Health Institution (DHI) under an identified supervisor for a period of 12 months, with 3 monthly reports from the department of medicine, surgery and 4 monthly reports from the departments of paediatrics and O&G. Finally a practitioner who has been out or practice for more than 10 years will be subjected to a Council registration examination. The same Policy applies for applicants seeking specialist re-registration. The aim of these Council Polices is to ensure high quality care by enforcing specific minimum standards. Council has noted with grave concern applications from practitioners who leave clinical practice doing other things for long periods of time and wish to come back to clinical practice. Practitioners are encouraged to maintain their registration and attend to CPD activities to stay current.

i) Good Medical Practice

Self-Referral of Patients: Council through the PCC has been concerned about the emerging trend by some practitioners who are opening multidisciplinary practices thereby leading to patients being referred from either the general practitioner or Nurse/Midwife to the Specialist who works in partnership with the general practitioner and the Nurse. At times the Specialist will be the Practitioner in Charge of the Nurse/Midwife practice. Whilst appreciating the need for one stop shop, Council has been concerned about the issue of self-referral which is deemed to be a violation of Section 21 of the Medical Practitioners Professional Conduct Regulations published in S.I 41 of 2004 which provides for the patient's right to consult other practitioners, as well as the violation of the constitutional right of choice.

However, in line with the changing environment and in the interest of the patients, Council through the PCC decided to come up with a concept of Group Practice which was advocated by the ZIMA Annual Congress in August 2016. A subcommittee comprising general practitioners and specialists has been established and is in the process of developing guidelines on the scope of Group Practice. It is believed that the concept of Group Practice will benefit both the practitioners as well as the patients whom we serve. The profession will be kept informed.

Medical Tourism: Council has received disturbing reports from the profession on visits to the country by some unregistered foreign doctors who have been performing medical examinations to Zimbabwean patients in hotels with a view to refer them for specialist care abroad. This concern has been brought to the attention of the Permanent Secretary for Health & Child Care who has assured Council that the government will take steps through the immigration department to identify such tourists and take appropriate action.

The draft Statutory Instrument on Medical Tourism has been forwarded to the Honourable Minister of Health & Child Care for promulgation.

Governance, Customer Stakeholder Satisfaction and Transparency in Council Processes

Effective Collaboration: The impact of the work of the Council has been made possible by being part of the wider environment focused on ensuring the safety of the patient.

JRMO Employment Contract: The recent impasse between the JRMOs and the Health Services Board (HSB) that resulted in the refusal by the JRMOs to sign the contracts of engagement introduced by the Health Services Board (HSB) in March 2016 has been of concern to Council. Some of the provisions of this contract violated the right to maternity leave by female JRMOs during their period of training, a constitutional right enshrined in S. 65 (7) of the Constitution of Zimbabwe Amendment Act (No 20) of 2013. The salary was also not included in the contract as well as unclear mechanisms of labour dispute resolutions. The statutory period of 30 months internship as provided in the Health Professions Act (Chapter 27:19) was not indicated. As a result of this impasse, the JRMOs delayed resuming their training, a situation that has had negative effects on the patient care and safety. In line with its strategic goal of enhancing stakeholder relationship by positively contributing to the development of a wider environment that is focused on patient safety, Council suggested amendments of the JRMO contract to reflect fairness which have been considered by the authorities resulting in the amendment of the JRMO contract.

Council and Its Committees: It is important to note that Council functions through its Committees whose majority of members are **NOT members of Council.** These are drawn from members of ZiMA and various Professional Associations, an evidence of the concept of self-regulation which is in line with the precepts of **good corporate governance through inclusivity, and transparency.** Most Council Policies are based on best practice from both regional and international stakeholders such as Association of Medical Councils of Africa (AMCOA) and IAMRA who are some of its major stakeholders.

Ensuring public awareness of Council functions: Council attended the Zimbabwe International Trade Fair in Bulawayo from 26 - 30 April 2016 and the Zimbabwe Agricultural Show in Harare held from 22 - 27 August 2016. Meeting the public was refreshing as members of the public were informed of the role of the Council as well as the good work that the members of the profession are doing in their day to day practice.

Council launched its Service Charter during the official opening of the Bulawayo Council office on 17 November 2016. The Service Charter amongst other things enables the Council to inform the public and its stakeholders its business processes.

Official opening Honourable Minister of Health & Child Care

Meeting Intern doctors at work: visits were conducted on 11 July 2016 at United Bulawayo Hospitals and Mpilo Central Hospital and 23 June 2016 at Parirenyatwa Central Hospital to see junior doctors at work and to understand their concerns. Council has provided feedback to the Hospital Doctors Association. Council continues to play an advocacy role on issues confronting our junior doctors.

Financial Management: Council continues to produce quarterly financial statements and monthly management accounts which are subjected to scrutiny by the Audit Committee of Council comprised of non-members of the Council who include a Finance Director of the Ministry of Health & Child Care and a legal member of Council. All Council expenses which are according to the budget are approved by the Business and & Finance Committee. Both Committees meet on a quarterly basis. Council is pleased to report to the profession of yet another unqualified audit report since the dollarization of the economy in 2009. Council Financial Statements are subjected to annual audit within the first three months of the year in line with the Finance Management Act (Chapter 22:19)

New Council Face: Prudent management of financial resources since 2009 has resulted in the new face of the Council as well as acquisition of the Council office in the Southern Region for our members of the profession. Council has proceeded with the culture of investments started by the predecessor Council.

Before

Construction of external works in progress

BOADROOM

FITNESS TO PRACTICE

The strategic objectives are:

- Enforcing high standards of professional conduct
- Enhancing high quality care practice
- Enhancing fitness to practice

Enforcing High Standards of Professional Conduct

Good Medical Practice Code of Conduct: The Preliminary Inquiries Committee (PIC) has adapted and adopted a Code of Conduct on Good Medical Practice from the New Zealand Medical Council, one of our strategic partner within IAMRA that will be circulated to the profession upon renewal of registration and initial registration by all practitioners with a view to educate the profession.

The Executive Committee through the PIC continues to investigate complaints from the public as well as investigating maternal and table deaths that occur within 24 hours of an operative procedure. The following reflects numbers and nature of complaints received by the Council. This should be read in conjunction with the 2016 Disciplinary Bulletin that contains a sample of disciplinary cases that were held by the Council for the education of the profession. The Council continues to remind the profession to seek guidance whenever seized with a disciplinary case as often practitioners argue or rush to seek legal defense, understandably being their constitutional right, but, as well said by the predecessor Council Chairman, Professor Innocent T Gangaidzo, "***Doctors enrich lawyers whilst impoverishing themselves***" These are professional matters that lawyers do not understand. The practitioner ends up explaining themselves to the Committee and the lawyer adopts a culture of wanting to prove the case beyond reasonable doubt when in fact these inquiries are adjudicated and doctors are found guilty on a balance of probabilities. The doctors end up paying the Council Prosecutor as well as their lawyer unnecessarily. Thus, ***enriching the lawyers whilst impoverishing themselves.*** It is important to note that when a case is referred to a Disciplinary Committee, it would have passed though the PIC, EXCOM, peer reviews, interviews and opinions from relevant professional

associations and finally the Disciplinary Committee. All these Committees are comprised of different members. Guidance from the Council on such matters is part of Council function of guiding the profession.

Enhancing High Quality Care Practice

Over confidence by doctors in training: Council is concerned about the attitude of some trainee doctors who take private patients to theater to do operations beyond their capacity leading to adverse outcomes without consulting their seniors. This has been prevalent in Obs & Gyn. It is important for the Registrars in training to note that they are not allowed to do private cases whilst still under training, unless under an approved mentorship by the Council. Should the practitioner end up with a disciplinary inquiry, they will be judged in the same manner as the specialist in the relevant area.

Maternal Deaths: Council has noted a steady increase in maternal deaths as shown figure 1 below. This has been largely contributed by lack of capacity on the part of the GMOs posted to the districts as well as inadequate anaesthetic services now prevalent in the Central Hospitals. Nurse Anaesthetist are being requested to provide anaesthetic services to complicated cases. Council in its advocacy role has also taken up this matter with the Honourable Minister of Health & Child Care in terms of Section 30 (e) of the Health Professions Act (Chapter 27:19). With regards to the issue of capacity by GMOs, Council through the Society of Obs & Gyn is in the process of developing a document that will show the common errors in the management of obstetric and gynecological cases by GMOs with a view to modify the management of such cases. All hospitals are required to report maternal deaths that occur within 24 hours of an operative procedure. Hospitals are encouraged to conduct audit meetings as this is deemed to be good practice.

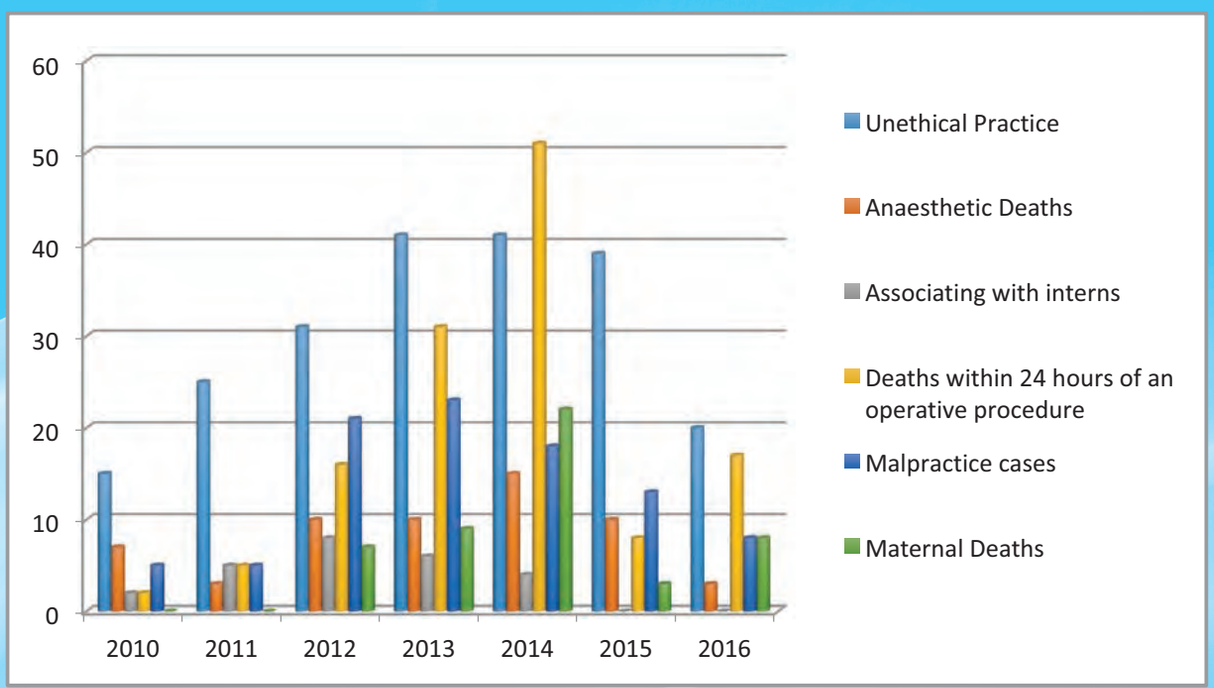
Elective private surgical cases: There has been disturbing reports of some specialists who are in the habit of doing elective procedures at midnight. Statistics have shown that majority of errors have been noted in surgeries done at night, given the prevailing challenges of inadequate staff to monitor patients from theatre, it is always advisable for practitioners to desist from such practice.

Failure to recognize emergency cases: Council has also noted a disturbing trend where practitioners fail to act in emergency cases leading to the loss of lives. Practitioners are being reminded of the ethical precept of do no harm and always act in the best interest of the patient.

Enhance High Standards of Practice

Ultrasound practice: Patient safety has continued to be compromised by the practice of ultrasound by unqualified personnel employed in some practices. Council realizes that an ultrasound scan (USS) is a critical diagnostic tool in the practice of medicine. Council made a resolution that practitioners should be adequately trained and knowledgeable to practice Ultrasonography. Practitioners are encouraged to employ qualified sonographers. Plans are underway to develop guidelines on the practice of ultrasonography by the Council through the Association of Radiologist and Radiotherapists of Zimbabwe (ARROZ).

CASES OF UNETHICAL PRACTICE 2010 TO 2016

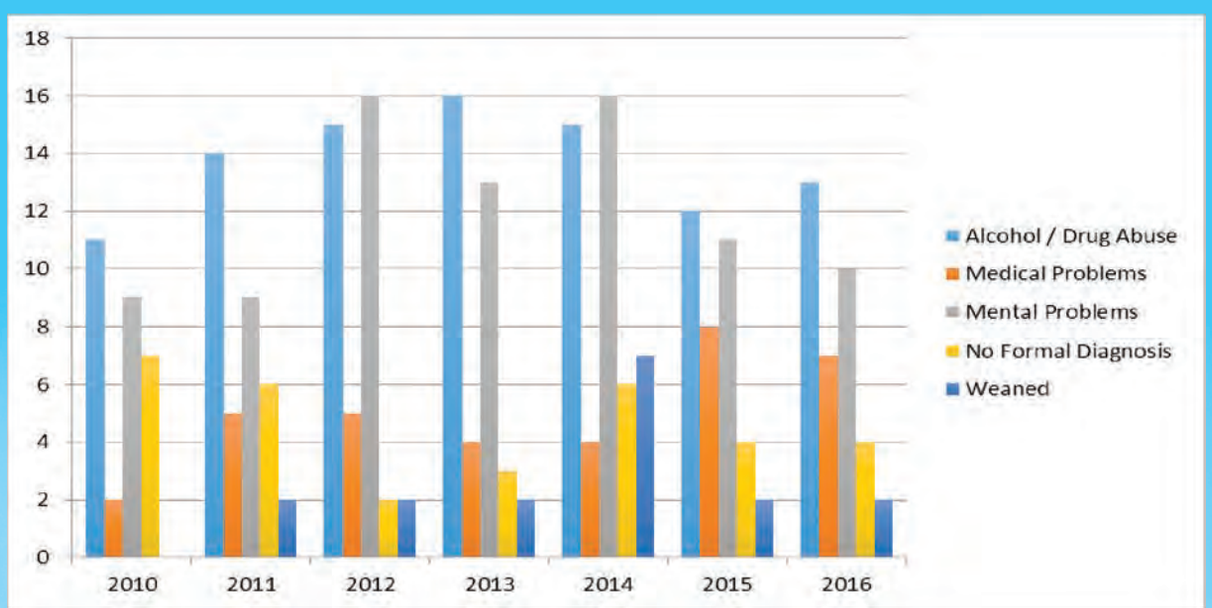


Unethical Practice cases	**212**
Advertising	28
Assault	5
Poor Communication	76
Unethical practice	65
Sick Leave cases	9
Neglect of duty	5
Practising without supervision	7
Fraudulent activities	16
Sexual abuse	1

FITNESS TO PRACTICE

Rehabilitation of practitioners: Council continues to rehabilitate impaired practitioners due to alcohol / substance use disorder and those with medical issues.

REHABILITATION PRACTITIONERS 2010 TO 2016



TECHNOLOGY AND PROCESSES

Council continues to enhance its performance through use of ICT

Update website

Council has developed an in-house website. Practitioners can now make their payments using the ECONET Biller Code No 44196 as well as swipe facilities for both the Bulawayo & Harare offices. Online payment for both our local and overseas members is now available All Council approved Policies and operational guidelines are accessible only to registered members of the medical and dental profession provided the practitioner sends an email to Council to get a password.

Website Homepage

Members Login section

Downloadable Forms section

UNETHICAL PRACTICE BY MEDICAL AID SOCIETIES.

Council continues to play its advocacy role through briefing meetings with the Honourable Minister of Health & Child Care on matters that affect the effectiveness of the profession as well as those of public importance in terms of S.30 of the Health Professions Act. The following specific issues affecting the profession such as

i) **Preferred Service Provider**:

ii) **Pre-authorisation**:

iii) **Limitations of Numbers of Emergency Visits to A Service Provider** :

iv) **Forced Use of AHFoZ Numbers:**

v) **Illegal Grading of Health Institutions by AHFoZ**:

vi) **Conflict Of Interest**:

vii) **Non Compliance of Statutory Instrument 41 of 2004**:

viii) **Redirecting Investigations**:

These concerns have been put to the Honourable Minister of Heath & Child Care and Council has been informed that all the issues will be addressed by the upcoming legislation that will be controlling the practice of all Medical Aid Societies in the country. Council has also been reliably informed that the proposed Bill has been sent to the Attorney General's Office for examination and approval of the principle and thereafter will be submitted to Council and stakeholders for comments before promulgation. The Ministry has further advised Council that a directive will be issued to AHFoZ to cease demanding illegal fees as well as inspections of health premises, a statutory function of the HPA.

Council has now taken a position that all practitioners seeking registration of health premises owned by Medical Aid Societies should comply with the provisions of Section 26 of Statutory Instrument 41 of 2004 before approval is granted. The regularization process of doctors already employed by Medical Aids Societies is in process.

KNOW YOUR REGULATIONS.

Employment with Medical Aid Societies S.25 (Statutory Instrument 41. Of 2004)

25. (1) Subject to subsection (2), no practitioner shall accept or take up any appointment in his professional capacity with a medical aid society or any other similar society or organization unless-

(a) A notice inviting applications for such appointment has been advertised in a newspaper; and

(b) Details of the proposed terms of employment are made available to the Council and all *bona fide* applicants; and

(c) The terms of employment are in writing, and set out clearly the professional services required, together with the fees or remuneration payable for such services; and

(d) The terms of the contract are on a basis which accords with the dignity of the profession and is not inimical to the interests of the public; and

(e) Provision is made in terms of the employment for -

(i) The practitioner to receive fees or remuneration exclusively from the contracting party; and

(ii) For the contracting party to be liable for such fees or remuneration.

(2) This section shall not apply to appointments made by the Public Service Commission or in terms of any Act.

No practitioner shall have a financial interest in an organization that advertises for patients such as:

a) a medical aid society
b) sick benefit
c) clinic or nursing home
d) any other association. ***(S.21 Dental Practitioners Professional Conduct Regulations S.I 190 of 2001 and S.17 of the Medical Practitioners Professional Conduct Regulations S.I. 41 of 2004.)***

Provision of Information S (2) of Statutory Instrument 93 of 1993.

(1) Every health practitioner and every health institution shall, as soon as may be practicable, and in any event, within fourteen days of a request referred to in paragraph (a) or of becoming aware of any information to which these regulations relate, provide or make available to the Registrar all relevant information which –

(a) Is required by the Registrar; or
(b) Comes to the notice of the health practitioner or health institution;

relating to any allegation, act, omission or practice which-

(i) May constitute improper or disgraceful conduct or gross incompetence; or
(ii) May form the subject of disciplinary action or proceedings under the Act.

(2) Without derogation from the generality of subsection (1), the information to be provided or made available in terms of that subsection shall include particulars of any relevant –

(a) Bodily injury, disability or death;
(b) Correspondence, report or other document;
(c) Investigation or inquiry ;
(d) Disciplinary proceedings, findings or measure
(e) Civil or criminal proceeding
(f) Settlement, compromise or agreement.

(3) Any person who contravenes or fails to comply with section 2 shall be guilt of an offence and liable to a fine not exceeding three thousand dollars or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.

Finally practitioners are obliged to submit reports on patients whom they would participated in their management to assist in Council investigations. Council does not pay for such a request as this is deemed to be not only a professional requirement but legal requirement in terms of S.30 (b) of S.I 41 of 2004.

Soliciting or touting for business by members of the profession some of whom are known to be giving kickbacks in return for referring patients for specialist care is a contravention of S .13 of S.I 41 of 2004.

Finally, Little Words to Remember

Please ensure that:

1. You are in possession of a valid practising certificate.
2. You are attending CPD activities.
3. You are practising in accordance with the conditions of your practising certificate.
4. Practitioners in your hospital or private surgeries are duly registered.
5. You always respond to Council inquiries.
6. Late submission of CPD points attracts a cumulative penalty of US$50.00

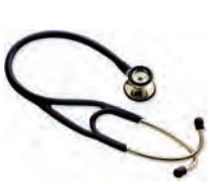
Obituaries

It is with deep sorrow that Council announces the passing on of the following members of the profession:-

Mr Maynard F Marikano
Dr Gideon Masokovere
Dr Nhlanhla Mgodla
Dr Collins Thembani
Dr Yogesh Nathoo
Dr Nehemiah Munyoro
Dr Mabasa Ndawana

Building Projects

Overview



Brief Overview of the Building Projects.

The newly designed Medical and Dental Practitioners Council of Zimbabwe Head Office premises is a modern and functional building standing out within its vicinity.

Boardroom Facility

The brief included a new Boardroom Facility consisting

- Boardroom (to accommodate a minimum of 60 people)
- Executive Dining facilities
- Modern Spacious Kitchen
- Ablutions facilities (including Separate Disabled use friendly Facilities)

The design of the new boardroom was a comprehensive process, which took into account the client`s requirements, environmental aspects, budget, and the need to create a modern structure, which will define the Co-operate aspects of the client.

The design brings up an Energy Efficient Building which maximises the use of Natural lighting and ventilation. The new design gives the whole facility a new image that is appropriate to its important function accommodating the Medical and Dental Practitioners Council of Zimbabwe. The new design moves away from the existing residential look and adopts a professional, cooperate feel, reflective of its function. The exterior was carefully calculated and coordinated that it gives an aesthetic view and also aimed at protecting occupant health and improving employee productivity

Concept design

New Office Building

Adjacent to the new Boardroom are the newly renovated and extended offices. The extended offices accommodates offices for the National Director, Finance Department, other Secretarial Departments and more spacious storage space.

The Brief includes

- Face-lifting of the old house to a new modern office building
- Extension of the Registrar's office
- Creating a spacious reception area
- Storage facilities
- General refurbishment of all office space

The new modern design transforms the original residential building into this magnificent office space. The old building was constructed in the 1950s, with Doric orders all- round the exterior and also in the interior for extra features, which were predominant in the era.

The idea was to transform the residential building into Modern Offices.

Consultants Team

Design & Project Management : Chetse & Mandy Architecture
Quantity Surveyors and Construction Management : BQ Fitzwilliam Partnership
Civil / Structural Engineers : T.J. Associates