PHYSIOTHERAPY, PODIATRY AND BIOKINETICS NEWS

Newsletter of the Professional Board for Physiotherapy, Podiatry and Biokinetics

September 2014

CHAIRPERSON'S NOTE

Prof. Nomathemba Taukobong
Chairperson

The term of the board is definitely coming to an end. The Minister has issued a call for nominations. The inauguration of the new board is expected by around June / July 2015. It has been an interesting and challenging experience at the same time. I can only give thanks, honour and glory to God Almighty for sustaining me as the chairperson of the board. I give thanks to the Almighty by bringing together a team that has respect for one another, devoted to working together and being geared on providing the best of what was humanly possible for the South African public. The benefit of hard work that each and every member of this board put into the activities of the board was hopefully received and acknowledged by the professionals registered in the ambit of the Radiography and Clinical Technology Board.

My life as a member of the RCT board started far back in 2001, when I was appointed by the then Minister of Health, Dr Manto Tshabalala-Msimang to join the board in mid-term. I was then groomed into all activities and functions of the board. Little did I know that I will be the chairperson of this board for two terms. It was God's unmerited favour that I was elected twice. Special thanks to the members of the board for trusting me with this responsibility. The major activities carried out during term one related to the development of the professional degrees, with the board taking the role of the standards generating body (SGB). The other steep battle related to gaining private practice for all four radiography categories. The second term was mainly focused on developing documents and guidelines for accreditation of the higher education institutions. In both terms, the board continued the tradition of having one open meeting to celebrate radiography and Clinical Technology Day. This was made to coincide with the World Radiography Day celebrations on 8th November of each year.

The highlights during this reporting year related to a) ensuring quality education and training for radiography and clinical technology students; b) development of guidelines to ensure that practitioners deliver quality service at all times; educating both the practitioners and members about services provided by the radiographers and clinical technologists as well as conducting research that will inform the possible extension of the scope of radiographers.

Starting with ensuring the quality

HIGHLIGHTS IN THIS ISSUE:

- Clinical communication in health care
- Patient's view
- Did you know
- Dual registration
- Is your practice correctly named

education and training, Diagnostic Radiography in Gauteng was greatly challenged. The challenge came from three areas, namely; i) there is a need to increase production of diagnostic radiographers to provide the much needed service in all levels of healthcare service delivery. This is the requirement from the National Department of Health. To be able to produce more diagnostic radiographers, there must be an increase in the number of clinical training facilities. This was a challenge because in Gauteng alone, there are four educational institutions offering Diagnostic radiography education and training. It was realised that the local clinical training facilities were not enough. The possibility of taking students outside Gauteng to gain clinical training in other provinces like Limpopo and Northwest were challenged by the way the contact sessions were structured in the education institutions. It was also not possible to have the students brought together in one clinical training facility because the facilities are accredited for specific educational institutions. The second reason was that each clinical training facility was accredited for a specific number of students. What I found to be a great challenge was the institutional autonomy which proved to be a treat to the growth and development of radiography as a profession. Meeting was called and facilitated by the board to look at the strategies that can be adopted to improve the situation without having to compromise the profession of radiography. It was decided that each institution must try by all means to approach other clinical facilities in their vicinity to provide clinical training platforms for the students.

With regards to development of the guidelines, the board has managed to develop guidelines for fluoroscopy procedures as well as Computerised Tomography. Mammography guidelines have been updated. The policy document from the Department of Health, radiation Control Directorate was revised and linked to the HPCSA guidelines for the practitioners making requests for medical x-rays. All referring clinicians are being sensitised on the dangers of radiation. In this line, referring clinicians are encouraged to check first that the examination they requests is justified. Radiographers on the other hand must optimise and apply limitation principles to reduce the amount of radiation dose that the patient is exposed to.

In educating the members of the public and the professionals at the same time, the board released two media statements. One statement was on mobile radiology and the warning for practitioners not to give their HPCSA numbers to any third parties. The other statement related on sleep studies.

The fourth activity related to the feasibility study that was conducted on the subject of role extension for diagnostic radiographers. It is important to note that the board was not side-lining other categories of radiography or clinical technology by focusing the study on diagnostic radiography. The decision to conduct this study with the focus on image interpretation and injection of contrast media was informed by the needs of both the professionals and service to the South African public. It was also a learning curve for the board. It was a tedious exercise but fulfilling when one looks at the outcome. It was the opportunity for the board to prove that radiography is a profession and as a profession, it is capable of providing justification for the decisions they arrive at. The board has arrived at a point where it can say; let courses be developed for diagnostic radiographers to be educated on injecting iodinated contrast media as well as reporting on the radiographs they have performed.

Last but not least, the consultation with the medical and Dental board on issues around ownership, licencing and operation of the X-ray emitting equipment as well as ultrasound equipment came out very clear that only practitioners who have been trained and deemed competent by an accredited educational institution can be licenced to operate the x-ray emitting equipment. The challenge that still remains relates to the Ultrasound equipment. Debates are continuing in this regard.

Lastly I would like to thank all staff members at the HPCSA who have contributed to the realisation of the strategic objectives of the board. It has not been a smooth sailing, but we all pushed forward and we can now count some successes according to the goals we have met. Thanks to all practitioners, those who always sent some words of encouragement, or highlight if things are not right on the website or even bring to the attention of the board some unethical practices that you see in the work places.

I salute you all.

Mable Kekana

Chairperson

CLINICAL COMMUNICATION IN HEALTH CARE

In health care, clinical communication skills (CCS) are vital to effective care and positive patient outcomes (Jarvis, Snadden and Ker 2009:265; Maguire and Pitceathly 2002:697). Studies reviewed by Stewart (1995:1424) indicated that effective clinical communication not only had a positive influence on the emotional, functional and physiological status of the patient, but also on symptom resolution and pain control. Henry, Fuhrel-Forbis, Rogers and Eggly (2012:297) added that nonverbal CCS, such as empathy and good listening skills, also improved patient satisfaction. Clinical communication is therefore a "central clinical function" and should be included in the education of all health care professionals (Stewart 1995:1424).

Good CCS form part of all areas within a health care setting and include the:

- forming and maintaining a relationship with patients, their fami-

lies and the rest of the health care team;
- gathering and sharing information with all parties involved;
- gaining informed consent;
- supporting problem-solving thus ultimately leading to good patient outcomes and effective interdisciplinary cooperation;
- providing reassurance to and alleviating distress in patients and their families;
- making best evidence-based decisions and communicating this with patients, their families and the rest of the health care team;
- communicating with patients, their families and the interdisciplinary team to reach a mutual understanding and a shared solution to problems (patient-centred health care approach);
- writing to and communicating with the health care team by means of written records, such as reports, referrals and patient files;
- communicating telephonically or by means of electronic media, such as e-mail and/or text messages; and
- communicating with legal services, with the media or even the press (Jarvis, Snadden and Ker 2009:265-266; Maguire and Pitceathly 2002:698).

Stewart (1995:1424) as well as Maguire and Pitceathly (2002:697) however elucidated to the fact that evidence showed that communication between health professionals and patients were no longer adequate and that it was an area of concern in health care. Areas of concern with regard to CCS that were highlighted included: the flow of information during the subjective evaluation; the flow of information during the discussion of the health management plan; the emotional support of the patient as part of communication; and lastly, the distribution of power and control in the physician-patient relationship. The problems regarding CCS are further underlined by Stewart (1995:1424) indicating that:

- 50% of psychosocial and psychiatric problems are missed;
- patients are interrupted on average after 18 seconds when presenting their problems;
- 54% of patient problems and 45% of patient concerns are neither elicited by the physician nor disclosed by the patient;
- patients and physicians don't agree on the main problem in 50% of visits; and
- patients are dissatisfied with information provided to them.

With the above mentioned problems with CCS, continued education for health care professionals in the area of communication could be valuable (Rotthoff, Baehring, David, Bartnick, Linde, Willers, Schäfer and Scherbaum (2011:170) as the value underlying the linkage of good clinical practice and good CCS are that better diagnosing can take place, better patient compliance and outcomes will be achieved and health care professionals will engage in safer practice, leading to less malpractice claims (Jarvis, Snadden and Ker 2009:265). However, only 2% of CME-certified events (in Germany) included some content on communication (Rotthoff, et al. 2011:173, thus leaving the majority of teaching and learning of CCS to undergraduate studies. Harrison, Hayden, Cook and Cushing (2012:414) also identified the need for continuous CCS training and therefore developed an on-line resource for both the academic and clinical setting. This on-line resource provides the opportunity to practice skills in providing feedback on CCS and thus focus on patient-centred care, as it is the key indicator of health care quality. This built on the myths of the past as it has been claimed that clinical communication skills cannot be taught, but evidence now proves that it can definitely be taught and improved by specific, focused teaching and learning activities (Jarvis, Snadden and Ker 2009:271). Rotthoff, et al. (2011:170) also highlighted the fact that experience does not automatically improve CCS and that the training thereof is thus essential and should be ongoing.

In South Africa (as a country with 11 official languages), health care professionals need to work across language and cultural barriers on a regular basis, further complicating the practice of good CCS. Pfaff and Couper (2009:520-522) suggest that this be addressed by the implementation of a number of strategies by health care professionals to improve patient care, satisfaction and the understanding between the practitioner and the patient. These strategies can include, amongst others: concentrating on communicative methods in the other language (rather than grammar learning); initially concentrating on listening rather than the speaking of the other language; then seeking opportunities to speak the new language; and finally recognising the importance of cultural learning (and not only language learning). Besides supporting the idea of teaching staff the most used language within a certain province to improve health care, Schlemmer and Mash (2006) also suggested the training and employment of professional interpreters as another solution to the language barrier problem within the health care system in South Africa.

Besides language and cultural barriers, Mercer and Reynolds (2002:S9) recognised the influence on empathy on patient outcomes and suggested that empathy plays a major role in health care outcomes and that it could be effectively taught to students in health care professions. They also recommend that empathy be assessed in these students by means of measuring the quality of care (of which empathy would be a major part). Another dimension of measuring quality of care and thus patient satisfaction would be the factor of time spent with the patient (Dugda-

le, Epstein and Pantilat 1999:S34). Even though it is also suggested as a component of health care education (as a part of the physician-patient relationship and CCS), the optimal length of visit and other factors related to time barriers are not clear (Dugdale et al. 1999:S34).

Lastly, also linked to patient outcomes, is the role understanding and effective communication between members within an interdisciplinary health team. These are two core competencies in delivery patient-centred care and thus optimising patient outcomes and could also be included in the training of health care professionals by the inclusion of inter-professional education and collaborative clinical practice (Suter, Arndt, Arthur, Parboosingh, Taylor and Deutschlander, 2009:41).

In conclusion, CCS are essential to the effective evaluation and treatment of patients as well as interaction with the health care team. CCS teaching and learning thus need to be included all stages of undergraduate training and then even to be built on progressively beyond these undergraduate studies, as part of CPD.

PATIENTS VIEW

by Ellen Ramatsui

Community Representative

Health professionals should understand and appreciate that they enter into a relationship with their clients/customers/patients who have rights. These are the members of the community whom the Council has the obligation to protect. They should respect and also make their clients aware of these rights. To mention a

few, these are the rights:

- Participation in decision making – health professionals should explain to the client what the treatment will entail and ensure that the client understands and agrees to go through with it
- Be treated by a named health care provider – The properly named health care provider will ensure that the client is assured that the service offered is from a properly registered and authentic practitioner as the credentials could be verified with the Council
- Informed consent – This implies the right to be informed about the procedure to be performed and the cost thereof. This will enable the client/patient to decide whether to accept or reject the offer. This should be done before treatment or therapy is offered to allow the client/patient a chance to make up his/her mind
- Be referred for a second opinion – In cases where a client is not showing any improvement after a reasonable number of sessions, he/she can request to be referred for a second opinion by another therapist
- Complain about the service provider – Information about ways to lodge a complaint should be freely available to the client/patient. This will instil confidence in the community about the service as it would have portrayed the willingness to listen to the complaints arising

Health professionals should also note that clients whether literate or illiterate, should be treated equally and with respect avoiding any unreasonable highly priced services and over servicing.

DID YOU KNOW?

Record Keeping

Did you know....?

- It is compulsory to record the **time, date and place of every consultation**
- All official documents and record keeping must be signed with **both a signature and the initials and surname of the HCP in block letters**
- Health records should be stored in a safe place for **no less than six (6) years** as from the date they become dormant; in the case of minors records should be kept **until the minor's 21st birthday;** in the case of **mentally incompetent patients records should be kept for the duration of the patient's lifetime**

For more interesting information on Keeping of Patients Records, see **Booklet 14.**

Over Servicing, Perverse Incentives and Related Matters

Did you know....?

- Health care practitioners shall not provide a service or perform certain procedures to be performed on a patient that are **neither indicated nor scientific or have been**

shown to be ineffective, harmful or inappropriate through evidence-based review
- Health care professionals **shall not advertise or endorse or encourage the use** of any health establishment or orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance or health related product or health related service in a **manner that unfairly promotes the practice of a particular health care practitioner or a health care facility for the purpose of financial gain or other valuable consideration**
- Health care practitioners **shall not engage in or advocate the preferential use** of any health establishment or medical device or health related service or prescribe any orthodox medicine, complementary medicine, veterinary medicine, or scheduled substance, **if any financial gain or other valuable consideration is derived from such preferential usage or prescription or the advocacy of preferential usage by the health care professional**

For more interesting information on Overservicing, Perverse Incentives and Related Matters, see **Booklet 5.**

Making Professional Services Known

Patients are entitled to protection from misleading promotional, advertising or improper competitive activities among health care professionals. Publications improperly drawing attention to the title or professional attainments or personal qualities or superior knowledge or quality of service of a particular health care professional or improperly drawing attention to his or her practice or best prices offered, may be construed as unprofessional conduct.

Did you know..?

- **Photographs** on notifications is **not permissible**
- **Information on professional stationery** may only include the following: name(s), profession, registration category and number, registered qualification, academic qualifications, address(es), telephone number(s), hours of consultation and practice number.
- **Logos** on professional stationery may be used, but graphics or **pictures may not depict anatomical structures;** logos and graphics should not be misleading, and may not be used on outside signs.

For more important information consult HPCSA's Guidelines for Making Professional Services Known.

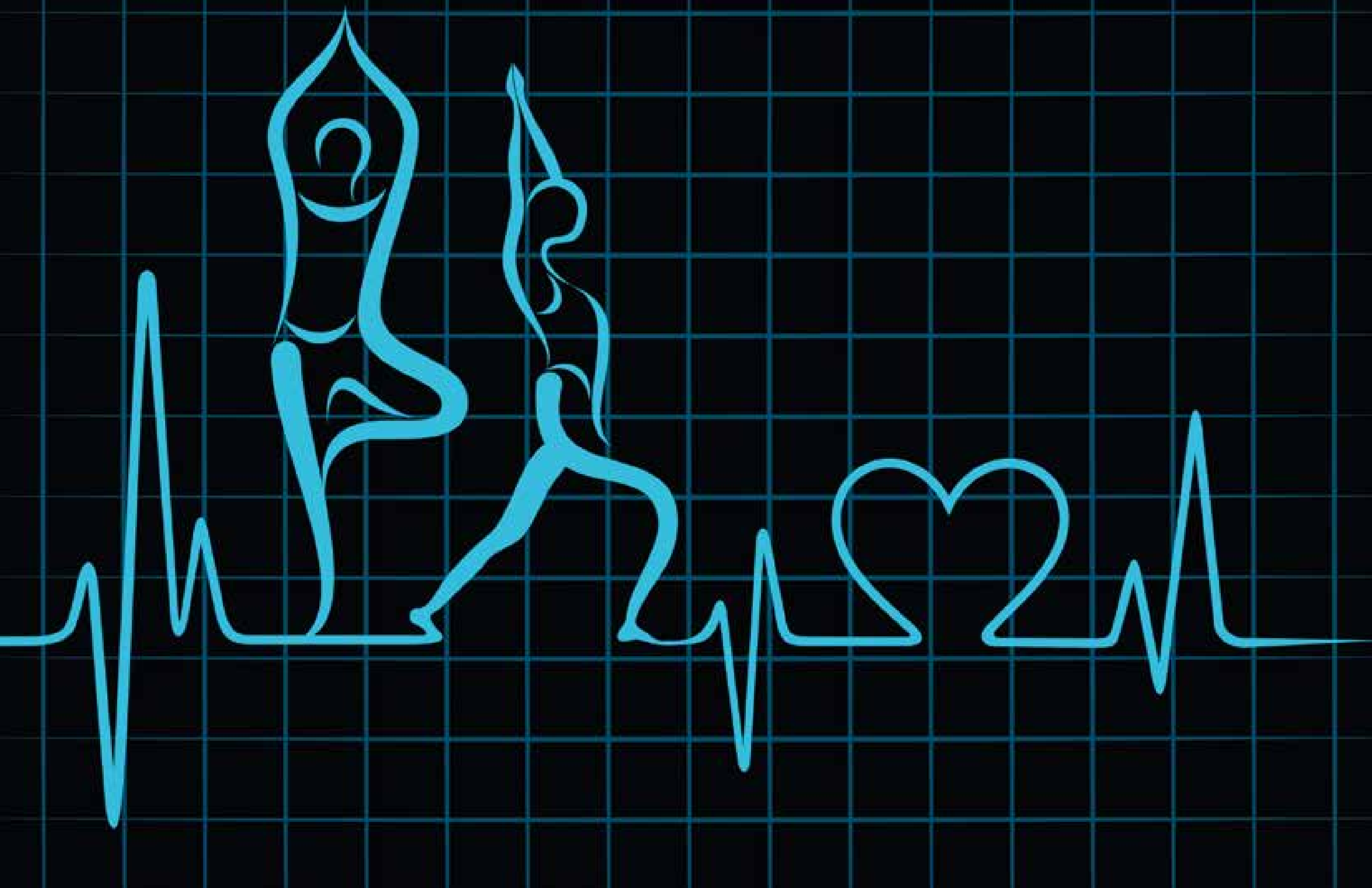
Continuing Professional Development

Did you know..?

- **Accreditors are groups or institutions appointed by a Professional Board** on the basis that they meet the criteria set out by the HPCSA CPD Committee. The role of the Accreditor is to review and approve applications for the provision of CPD activities **(within its profession's ambit)** by organisations and individuals without accredited service provider status; to **monitor these activities and to revise continuing education units (CEUs) allocated where the provider failed to comply with the rules and regulations of the CPD guidelines**
- **Accredited Service Providers** are the profession specific higher education institutions and departments, professional associations or formally constituted professional interest groups who meet the specified criteria and have been accredited by the Board / Accreditor to present learning activities for Continuing Professional Development. **Accredited Service Providers are required to apply annually on Form CPD 2 to a Professional Board or its designated Accreditor to be formally accredited to offer CPD activities.** (Important message from PPB Board: Accreditors providing CPD activities may not accredit their own activities)
- **If you have attended a course developed for various members of the multidisciplinary team, you may only utilise those skills / aspects of the course relevant to your profession in practise.**
- According to the Health Professions Act 56 of 1974, a health professional, who is providing education or training in South Africa, but not residing permanently in South Africa, must be registered with the HPCSA for the period of time determined by the relevant professional board in order to provide such education or training legally.1qaAqQa

For more important information consult the latest Continuing Professional Development Guidelines for Health Care Professionals.

IS YOUR PRACTICE CORRECTLY NAMED?



According to Rule 5 of the Ethical Rules of Conduct for practitioners registered under the Health Professions Act, 1974, promulgated as Government Notice No R. 717 on 4 August 2006, a practitioner

- Shall use his or her own name or the name of a registered practitioner or practitioners with whom he or she is in partnership or with whom he or she practises as a juristic person, as a name for his or her private practice
- May retain the name of such private practice even if another practitioner, partner of such partnership or member of such juristic person is no longer part of such private practice: Provided that the express consent of the past practitioner or, in the case of a deceased practitioner the consent of the executor of his or her estate or his or her next-of-kin, has been obtained.
- Shall not use, in the name of his or her private practice, the expression "hospital", "clinic" or "institute" or any other expression which may give the impression that such private practice forms part of, or is in association with, a hospital, clinic or institute

Although specific reference to the inclusion of the particular profession of a health care practitioner is not made in the ethical rules, other references clearly indicate that practitioners should be in a position to reflect the profession or designator namely medical practitioner, physiotherapist, biokineticist, podiatrist etc. in conjunction with their names.

It was further indicated that the omission of the profession could mislead the public in that the public would be unable to identify the profession. To simply refer to "Smith, Ross and Partners" could imply that they are practising as attorneys or engineers.

Of utmost importance is the fact that information regarding a practitioner should be factually correct. Furthermore, information provided should not be misleading, derogato-

ry towards services rendered by other practitioners or to the detriment of any other practitioner.

In the case of the Professional Board for Physiotherapy, Podiatry and Biokinetics, it was ruled that "Biokinetics" in a practice name, for example "John Hoskins Biokinetics" would not be acceptable. The use of the name "John Hoskins Biokineticist" would, however, be acceptable – the reason being that "Biokinetics" refers to the profession and "Biokineticist" refers to the professional practitioner. The same will hold for other professions of the Board.

The name of a practice should be reflected, for example, as follows:
Geraldine Nel Physiotherapists
Rosemary Nkosi Biokineticist
Mark Jenkins Podiatrist

Dual Registration

Health practitioners who hold registration with more than one statutory council or professional board must ensure at all times that no conflict of interest arises from such dual registration in the rendering of health services to patients. Patients also need to be clearly informed at the start of the consultation of the profession in which the practitioner is acting, with informed consent obtained from the patient regarding the appropriate profession. Patients may not be consulted in a dual capacity and may not be charged fees based on dual consultation. The ethical rules which are applicable to the profession, in which the practitioner is acting at that time, need to be adhered to strictly. The health practitioner cannot refer a patient, while acting in one profession, to him/herself when acting in another profession.

Health practitioners who are registered in two professions are required to obtain 30 CEU's per profession per 12 month period. Practitioners registered in more than one category within the same professional board should accrue only 30 CEUs per 12 month period.

IN-HOSPITAL PHYSIOTHERAPY:

Pre-authorization a nightmare for patients

by MC Brand

Community representative:
Professional Board for Physiotherapy, Podiatry and Biokinetics

Some medical schemes, including one of the largest, require pre-authorization for in-hospital physiotherapy services. Very little can be done about this as it is their prerogative to do so. However, this requirement creates many problems due to pre-authorization not being obtained and consequently accounts not being paid by medical schemes.

Whose responsibility is it to obtain pre-authorization from the medical scheme? Is it that of the patient, the physiotherapist, the doctor or perhaps the hospital?

It appears that much uncertainty or misunderstanding exists amongst the general public about this issue. Sometimes physiotherapists obtain pre-authorizations on behalf of patients out of goodwill or for practical reasons and sometimes patients have the expectation that pre-authorization will be obtained by either the hospital or the physiotherapist. If it

is not done, the account is not paid and the patient is held liable for the outstanding amount. From time to time unhappy patients approach the HPCSA or their medical aids to complain about an account not paid due to a service not authorized.

The fact is that the lack of pre-authorization often leads to medical aids refusing to pay accounts because treatment was not authorized and in some instances service providers are reported to the HPCSA and complaints laid against them.

Although it remains the responsibility of the patient to obtain pre-authorization, it is not always practically possible. Therefore, physiotherapists and other service providers must be cognisant of this possibility and communicate clearly and timeously the requirement of pre-authorization to their patients. Effective communication is the key to prevent unhappiness and unnecessary investigations by the HPCSA.

e-Bulletin

The e-Bulletin is a monthly electronic-newsletter from the Council.

We are looking for new ways of strengthening our communication with you.

Through this short but informative read, we would like to touch on important issues for the professions and also share relevant information with you.

E-Bulletin is a platform to engage with you, so please ensure we have your correct contact details.

Please send us an email to update your details: records@hpcsa.co.za
PPB News is a newsletter for practitioners registered with the Professional Board for Physiotherapy, Podiatry and Biokinetics.

It is produced by the Public Relations and Service Delivery department, HPCSA building, 2nd floor, 553 Madiba (Previously Vermeulen) street, Arcadia, Pretoria.
Practitioners are encouraged to forward their contributions to Ludwe Matanzima at ludwem@hpcsa.co.za

General Information

For any information or assistance from the Council direct your enquiries to the Call Centre:

Tel: 012 338 9300 / 01
Fax: 012 328 5120
Email: info@hpcsa.co.za

Where to find us:

Physical address:
553 Madiba (Previously Vermeulen) Street
Corner Hamilton and Madiba Streets
Arcadia Pretoria

Postal address:
P O Box 205
Pretoria
0001
Working hours:
Mondays - Fridays: 08:00 - 16:30
Weekends and public holidays – closed

Communication with the Board should be directed to:
P.O. Box 205
Pretoria,
0001

Education and Training
Registration of Foreign qualified practitioners
Accreditation and evaluation
Internships in Medical Orthotics and Prosthetics
SGB and ETQA (standard generating and quality assurance)
Naledi Mphafudi
Tel: 012 338 3951
Email: naledim@hpcsa.co.za

Professional Board Secretary
General administrative support
Meeting arrangements
Bongi Nzuza
Tel: 012 338 9460
Email: bongin@hpcsa.co.za

Registration and Restoration
Registration - Students SA Qualified
Voluntary Erasure
Restoration of name to the Register due to non-payment or Voluntary erasure
registrationgroup@hpcsa.co.za

Examinations
Geraldine Kintu
Tel: 012 338 9497
Email: geraldinek@hpcsa.co.za

Acting Professional Board Manager
Ethical matters
Scope of profession
Policy development, review and implementation
Strategic initiatives
Budgeting
Communication
Seetha Reddy
Tel: 012 338 3920
Email: seethar@hpcsa.co.za

Certificate of Good Standing/Status, certified extracts, verification of licensure
Stanton Prinsloo
Tel: 012 338 3940
Email: stantonp@hpcsa.co.za

Continuing Professional Development (CPD)

Helena da Silva
Tel: 012 338 9413
Email: cpd@hpcsa.co.za

Raylene Symons
Tel: 012 338 9443
Email: raylenes@hpcsa.co.za

Change of contact details
Email: records@hpcsa.co.za

Ethical queries, human rights, ethics and undesirable business practice:
Ntsikelelo Sipeka
Tel: 012 338 3946
Email: ntsikelelos@hpcsa.co.za

Service Delivery
Compliments and Complaints
Email: servicedelivery@hpcsa.co.za
Tel: 012 338 9301

Complaints against practitioners
Legal Services
Fax: 012 328 4895
Email: legalmed@hpcsa.co.za

Copyright and Disclaimer

The copyright in the compilation of this newsletter, its name and logo is owned by the Health Professions Council of South Africa. You may not reproduce this newsletter, or its name or the logo of the Health Professions Council of South Africa that appears in this newsletter, in any form, or for commercial purposes or for purposes of advertising, publicity, promotion, or in any other manner implying their endorsement, sponsorship of, or affiliation with any product or service, without the Health Professions Council of South Africa's prior express written permission. All information in this newsletter is provided in good faith but is relied upon entirely at your own risk. By making use of this newsletter and its information you agree to indemnify the Health Professions Council of South Africa, Employees and Service Providers from all liability arising from its use.