A

REVIEW OF DISPENSING IN SOUTH AFRICA

by

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TO MY DEAR WIFE HAWA

WHO IS MY CONSTANT SOURCE OF INSPIRATION AND ENCOURAGEMENT

CONTENTS

CHAPTER FOUR - RESPONSES OF RELEVANT ORGANIZATIONS

CHAPTER FIVE - RECOMMENDATIONS

SUMMARY

The dispensing Medical Practitioner has become topical since 1984. On this issue, much confusion and ignorance prevails, both amongst members of the medical and allied professions and in the public mind. This study was undertaken to demonstrate some aspects of dispensing of medicines in South Africa and to consider the implications arising out of the application of legislation governing such dispensing of medicines by family practitioners.

The main objectives of this study were:

(a) To identify and ascertain the opinions and policies of all those who are involved and concerned with the dispensing of medicines.

(b) To determine the implications of all the legislation governing the dispensing of medicines on:

1. patient care
2. the dispensing of medicines by doctors (to their patients).

Information was gathered from a questionnaire sent to service/ consumer groups; from literature review of journals; publications and gazettes; and from legal consultations.

The results of the study indicated that:

(1) Professional Associations such as, Medical Association of South Africa, the Pharmaceutical Society as well as statutory bodies such as the South African Medical and Dental Council and the Pharmacy Council are concerned with issues such as 'trading in medicine ' and 'profiteering '. Inadequate patient care resulting from the physical, financial and economic hardships suffered by a majority of patients are issues which appear not to have been addressed by these bodies.

(2) The fundamental issues of "what is in the best interest of the patient " appears to be ignored in legislation pertaining to dispensing.

(3) Dispensing to patients became difficult due to the impractical stringent restrictions imposed by the legislation governing dispensing of medicines.

(4) The dispensing of medicines by a doctor is less time consuming, more convenient and cheaper for the patient as well as for the Sick Benefit Funds.

The results were discussed with respect to their theoretical and practical implications and the conclusion reached was that the dispensing legislation presently designed for first world communities, became totally impractical when applied to third world communities, and that most doctors dispense medicines in response to the needs of the individual communities they service.

Further research possibilities and recommendations were suggested in order to gain a greater understanding of the dispensing issue, which hopefully will assist to improve the quality of health care and also ensure the best possible advantage for the patient.

CHAPTER ONE - INTRODUCTION

1. (1) Introduction

1. (2) Objectives

1. (3) Methodology

1. (4) Background

1. (5) History of Dispensing and Medical Practice

Bibliography

1. (1) INTRODUCTION

The purpose of this study is to:

1.Review all aspects of dispensing of medicines in South Africa, and to consider its implications for the provision of patient care.

2.Contribute to improving the quality of general practice services, by having a much clearer understanding of the legalities governing the dispensing of medicines

3.Identify any deficiencies and prejudices prevalent within the dispensing legislation and in the functioning of some of the organizations concerned with the dispensing of medicines.

1. (2) OBJECTIVES

In this study the main objectives have been:-

1. To identify and ascertain the opinions and policies of all those who are involved and concerned with the dispensing of medicines.

2. To determine the implications arising from legislation for (a) Patient Care (b) in regard to dispensing of medicines.

3. To make recommendations in respect of the policies and practices of dispensing.

1. (3) METHODOLOGY

Information which was collected for the study was obtained from:-

1. Medical Journals

2. Pharmaceutical Publications

3. Government Publishers

4. Government Gazettes

5. Open Ended Questionaires

6. Consultations with attorneys, an advocate and a Senior Counsel

Information was collected from 14/7/85 to 31/5/86.

1.(4) BACKGROUND

In January, 1984, the President of the Pharmaceutical Society of South Africa, Mr. Don Sutherland, in a television debate bitterly criticized the dispensing medical practitioner, the accusation being one of profiteering, unfair competition and trading in medicines. The various media gave wide coverage. The dispensing medical fraternity was certainly caught unawares.

The amendment to the Medical Dental and Supplementary Health Service Profession Act of 1974 which now provided for the investigation of cases of alleged improper or disgraceful conduct by persons registered in terms of the said Act; and to further regulate the dispensing of medicines by a Medical Practitioner or Dentist; was unopposed in Parliament and it officially became an Act on 21 Dec 1984. A new era had dawned. Various parts of the country suddenly saw the mushrooming of dispensing doctors' committees. Memoranda justifying the right of the doctor to dispense medicines were dispatched to various members of Parliament, as well as to the Minister of Health. Government Gazettes were suddenly being sought. Hansard was

being thoroughly scrutinized for Parliamentary debates on the dispensing issue. Senior Counsel in many parts of the country were being consulted for clarification on legal interpretations. The Society of Dispensing Family Practitioners was formed to represent the interest of the dispensing doctor and his patient. There was also a sudden resurgence of the once dormant National General Practitioners Group; a sub-group of the Medical Association of South Africa which concerns itself mainly with general practice problems. In order to have a clearer understanding and appreciation of the problems under discussion, an insight into the history of dispensing and medical practice is imperative. This study is directed to elucidating the circumstances pertaining to dispensing of medicines in South Africa.

1. (S) THE HISTORY OF DISPENSING AND MEDICAL PRACTICE

Medical practice dates back as far as 3 500 B.C. when medicine and religion were inextricably intertwined. Ancient cultures firmly believed that both sickness and cures emanated from their gods. Therefore the preparation and administration of medicines was often the prerogative of religious leaders.

In Egypt, the land of the Pharoahs, priests became specialized medical practitioners, some only treating internal maladies, others dealing exclusively with diseases of the eye, the head or the teeth. They developed an extensive pharmacopeia which listed some 800 remedies and 700 drugs. One probably successful example was a preparation for crying children prepared from poppy seed, the basis of opium. The Egyptian god of medicine was named "Ph-ar-malei", from which words such as "pharmacy" are obviously derived.

The Greeks were the first to loosen the ties between medicine and religion. They used logic rather than magic in the treatment of disease. Careful diagnoses and selection of appropriate remedies were the concepts upon which their philosophy was based. Sadly medical knowledge and expertise became shrouded in the mists of myth and magic once more, as Europe plunged into the dark ages. It was the desert Arabians of yester-year who continued the progress of pharmacy. They developed procedures; including distillation and fermentation, to extract more than 2000 drugs from various sources. The Arabian provinces appointed inspectors, forerunners of our Medicines Control Council inspectors, whose task it was to prevent the sale of harmful medicines and food.

In Europe at the conclusion of the Dark Ages, attention was once again focussed on medicine. The population of cities exploded, travel increased dramatically and disease became rife.

Doctors and Pharmacists charged such exhorbitant prices for medicines of questionable efficacy that they were beyond the reach of the general public. Poor folk had no choice but to fall back on self-doctoring with patent medicines.

The inventors of these remedies had been bestowed with protected rights from the King. Although they became popular in England, it was in the Colonies that the patent medical industry sank roots and began to flourish. Faced with devastating diseases, such as Typhus, yellow fever, tuberculosis, and dysentery, the time for quackery was ripe. It is not difficult to picture the vast selections of potions and elixirs, all guaranteeing to cure everything from typhoid to in-growing toenails. By 1905 some 50 000 different patent medicines were available for sale, most of their originators pouring millions of dollars a month into advertising. In the seventeenth century, the medical properties of drugs could not be correctly estimated. Scientific methods

for proper evaluation were developed in the eighteenth and nineteenth centuries. Prior to that time experiments were conducted only on poisons, for with poisons the results are certain and immediate. Modern pharmacology, the study of the action of drugs, developed out of this early study of the action of poisons. The well known tale of Cleopatra testing the poison of her asp on her slaves before she applied it to herself is typical of the pharmacological methods of that time. One of the most energetic of the early pharmacologists was Mithridates, King of Pontus, in the second century before Christ. His pharmacological studies were made possible by the influence of Greek learning on Egyptian civilization. The early Egyptian physicians made considerable use of drugs. Their drugs were of the kind usually found in ancient civilization: a few effective remedies lost in a mass of substances of purely superstitious origin. For many centuries the medical system of the Egyptians was not subject to foreign influence, for the early Egyptians punished with death every stranger who entered their country. About 500 B.C.however they began to tolerate foreigners. Greek physicians came to Egypt and under their influence Egyptian medicine declined and was replaced by Greek medicine. Mithridates was versed in the Greek medicine of Egypt and undertook his pharmacological experiments to find an unusual antidote against poison.His attention centred largely upon snake venoms. These he administered to slaves, studying the effects and trying to find an antidote. After his death his recipe was discovered. This compound was known as Mithradaticum and with some variations in the hands of later physicians was developed into Theriac. In subsequent times theriac was more extensively employed than any other medicinal remedy. It contained from 37 to 63 ingrediants, all of which are worthless as remedies.

Theriac was used as a cure-all even up to a hundred years ago. It was taken internally in the treatment of all diseases and applied externally in the treatment of all wounds. Eventually Theriac became known as Treacle and when theriac was discarded as a remedy the term Treacle was applied to molasses. The sulphur and treacle administered to all young people a generation or two ago as a spring tonic was derived from this old belief of Theriac. Greek medical practice, as established by Hippocrates 500 years before Christ, did not include an extensive use of drugs. At the great University of Alexandria, however, a more extensive use of drugs was grafted upon Greek medical learning.After the fall of Corinth, Greek Physicians migrated to Rome. The Romans used many drugs. The combined influence of Greek, Alexandrian, and Roman medicine brought in an extensive use of drugs. The increasing importance of drugs led Dioscordes to compile a list of drugs, the first extensive Materia Medica. The substances listed in Dioscordes's book were worked into a system by Galen. This system was the medical religion of the Christian Era up to the seventeenth century. It has left it's mark on medicine even to this day. Galen was born in Pergamum in Asia Minor in 131A.D. He undertook the study of medicine at an early age, and then for eight years wandered from city to city,adding to his store of medical knowledge. Galen was an energetic experimenter, but his method was faulty in that he insisted on having a theory for every phenomenon, whether or not it had any basis in fact. His superficial theories displaced the more laboricus methods of Hippocrates which were based upon direct observation and logical interpretation.

According to Galen's theory, the body like the universe was composed of 4 elements - fire, air, water and earth. These elements represented the qualities of the body: fire was hot.

air was dry, water was wet and earth was cold. Health consisted in preserving each of these qualities in its proper proportions in the body. In health heat and cold were balanced and so also was dryness and moisture. Disease resulted when the balance between the four qualities was disturbed: and disease was to be cured by administering drugs to restore the proper balance. The various drugs had the four fundamental qualities of the body: some were cooling, others were heating, or moistening or drying.Drugs possessed these fundamental qualities in different degrees. Thus bitter almond was heating to the first degree and drying to the second degree while pepper was heating to the fourth degree and cucumber seeds were cooling to a similar degree. The common expression "cool as a cucumber" is derived from the therapeutic theory of Galen. Several thousand drugs were necessary for the Galenic system of therapeutics. A hundred or more drugs might be included in a single prescription. In Roman times the physicians themselves collected and prepared their own medicine. For many centuries after the Roman times, physicians continued to dispense their own medicines.

The apothecaries of Europe during the middle ages were drug peddlars.Apothecaries bills were exeptionally high in the 17th century and the cost of medicines was often exploited by physicians and surgeons as an excuse for running up their charges. The grocers were the original drug merchants even after the apothecaries were duly incorporated by James I in 1606. but in 1617, the druggists succeeded in shedding the grocers by means of a new Charter, after which time they had the physicians against them. The reason of this was that the apothecaries set up as practitioners, not only selling drugs but prescribing them. Extortion was the great failing of the apothecaries. In two drug bills of 1633 and 1635, cited by Handerson:

1. 4s 0 pence is charged for a 'glass of chalybeate wine'

2. 3s 6 pence is charged for a 'purge for your worship'

3. 3s 0 pence is charged for a 'purge for your son'

High as these were for the time, gross exploitation was practised by George Buller who, in 1633, charged 30 shillings a piece for pills and thirty-seven pounds and ten shillings for a boxful. In the reign of James II the College of Physicians prosecuted Dr. Tenant for charging six pounds each for a pill and a decoction and Pitt in 1703, stated that the apothecaries had been known to make 150 pounds to 320 pounds out of a single case and that the prescription charges were at least 90% more than shop prices. In 1687, the College of Physicians bound their fellows and licentiates to treat the sick and poor of London and its suburbs free of charge, which strained the situation still further and, in 1696, 53 influential physicians subscribed 10 pounds each to establish dispensaries for supplying drugs to the poor at cost price.

War was now joined not only between physicians and apothecaries, but an internicine wrangle broke out among the dispensarians and anti-dispensarians, the latter being, of course, favoured by the apothecaries.

A lively bout of scurrilous pamphleteering ensued and in 1699 Garth published "The Dispensary", a satirical poem, stating the injustice of the dilemma forced upon the physicians "to cheat as tradesmen or to fail as fools".

Formerly apothecaries diagnosed diseases of their customers and supplied them with the medicaments for treatment. This practice was looked upon by the physicians as being unfair, and in France and England in the 15th and 17th centuries there were continual disputes between them and the apothecary. In France the argument was settled in the 17th century in favour of the physicians. In England, however, the decision was against the physicians. Public sentiments there, in the 17th century, was strongly in favour of the apothecaries.

In the early part of the 18th century an apothecary who had prescribed medicines was arrested and tried as a test case. The trial aroused considerable partisanship. The apothecaries won out in the trial and were allowed to carry on a quasi medical practice until 1865 when the Law was changed to require a medical education as a prerequisite to the prescription of drugs.

South Africa sprung from the Cape of Good Hope - which was the unwilling off spring of the great maritime colonial powers of western Europe. Holland and England. Jan van Riebeeck (1619-1677) was destined to be the most celebrated Company's surgeon ever to land at the Cape on the Friday afternoon in April 1652. At the Cape discontentment between pharmacists and doctors has been recorded as early as 1795. In order to restore order and resolve chaos between the two professions the British Government licensed the medical practitioner and the apothecary. This has been considered to be an important medical reform after 1795 and was very typical of the genius for organization and administration that has been the most striking contribution of the british to colonial development the world over.

As early as 1807 the Supreme Medical Committee, the forerunner of our present South African Medical and Dental Council, laid down several principles for the future functioning of practitioners in the Cape Colony. Town and country were rigidly separated and in the town distinction was to be made between prescribing practitioners and dispensers of medicine. Town practitioners and apothecaries were placed in separate categories and each group was forbidden to encroach upon the field of the other.

By the passing of Act No 34, the Medical and Pharmacy Act of 1891, the Colonial Medical Council and Pharmacy Board were created. The eventual fate of the Colonial Medical Council was that it was absorbed into the South African Medical and Dental

1974 was the first Act of Parliament relating solely to pharmacies based on the statute book with the gazetting of Pharmacy Act No.53 of 1974. This Act superseded pharmacy's part in the Medical Dental and Pharmacy Act of 1928. For the first time pharmacy was recognized in South Africa as a health profession in it's own right.

1974 also saw the first gazetting of the Medical Dental and Supplementary Health Services Professions Act No.56 of 1974. The Act consolidated and amended the laws providing for the establishment of the South African Medical and Dental Council. For control over the training of and for the registration of Medical Practitioners,Dentists and Practitioners of Supplementary Health Service Professions: and to provide for matters incidental there to.

Section 52 of Act No.56 of the Medical. Dental and Supplementary Health Service Profession Act 1974 affirmed the Medical Practitioners or Dentist's rights to dispense medicines under certain conditions.

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CHAPTER TWO - LEGISLATIVE PROVISIONS

2. (1) Introductory Background

2. (2) The Legal Requirements for the Dispensing of medicines

2. (2) (1) The Medicines Control Act (Act 101 of 1965)

(a) Effective Control over the selling of Medicines and Listed Substances

(b) Pre- Packing of Medicines

(c) Labelling of Medicine and the keeping of a Prescription Pad

(d) The keeping of a Register for Schedule 7 Substances.

(e) Dispensing of Medicine of which the due date has expired.

2. (2) (2) The Medical and Dental Supplementary Health Services Professsions Amendment Act 58 of 1984.

(a) South African Medical and Dental Council Guidelines on Methods of Dispensing

(b) General Conditions for Dispensing

2. (2) (3) Implications of Legislation Governing Dispensing of Medicines

(2) (3) (1) Investigating Officer

(2) (3) (2) Dispensing and Compounding

(2) (3) (3) Trading and Profiteering

Bibliography

CHAPTER TWO

LEGISLATIVE PROVISIONS

2.(1) INTRODUCTORY BACKGROUND

On the 21st December, 1984, the Medical Dental and Supplementary Health Services Professions Amendment Act No. 58 of 1984 became law. This amendment introduced only one new principle and that was the introduction of a Register, by the South African Medical and Dental Council, for dispensing doctors. This meant that any doctor who dispensed medicines as defined in Section 52(1)(a) on the 21st December, 1984, had to complete an application form and submit it with a registration fee of R25.00 to the Registrar of the South African Medical and Dental Council before 20th March, 1985. Practitioners who wished to dispense medicines in the future in terms of section 52(2)(b) in the practice of their professions contemplated in Section 52(1)(a) were also required to complete the application form for registration and foward it together with the prescribed registration fee of R25,00 to the Registrar of the South African Medical and Dental Council. Such practitioners could only commence with dispensing activities once their application for registration has been finalised. Some 3 300 doctors requested registration to dispense.

In response to the initial application, the Registrar of the South African Medical and Dental Council sent an official certificate to practice, in May, 1986. The certificate makes available to practitioners convenient proof of current registration as dispensing doctors, as prescribed by Section 52 of the Medical Dental and Supplementary Health Service Professions Amendment Act no.58 of 1984.

This certificate to practice is valid for only one year. Such a

certificate in future will be issued upon payment of the annual fee to persons as evidence that they are registered with the Council. The Registrar of the South African Medical and Dental Council in his notification which accompanied the certificate to practice, has given guidelines for the dispensing of medicines by a general practitioner or dentist.

These guidelines will be discussed more fully in the ensuing chapter under METHODS OF DISPENSING OF MEDICINES and GENERAL CONDITIONS FOR DISPENSING. The dispensing of medicines in general practice is governed by :

1. The Medicines Control Act (Act 101 of 1965)
2. The Medical Dental and Supplementary Health Services Professions Amendment Act No.58 of 1994.
3. Ethical Rule 28 of the South African Medical and Dental Council which states "A DOCTOR SHOULD NOT PLACE HIMSELF IN ECONOMIC COMPETITION WITH A PHARMACIST"
4. The Pharmacy Act of 1974 (Act 53 of 1974)

The various Acts and their implications are discussed below.

2.(2) THE LEGAL REQUIREMENTS FOR THE DISPENSING OF MEDICINES

The Department of National Health and Population Development, and the South African Medical and Dental Council, have compiled certain guidelines for the dispensing of medicines by doctors.

2.(2).(1) THE MEDICINES CONTROL ACT (ACT 101 OF 1965)

Certain aspects of the legal requirements are discussed in terms of the practical implications for dispensing doctors.

(a) effective control over the sale of medicines and listed substances

In accordance with the stipulations of section 22 of the Act and Section 52 of the Medical, Dental and Supplementary Health Services Professions Act(Act 56 of 1974, as amended) a doctor may personally dispense medicine to his or his partner's patients only. Furthermore, in order to ensure effective control, in the doctor's absence, unauthorised persons should not have access to medicines and listed substances.-he must, for example, have adequate lockup facilities.

It is therefore illegal for any employee, who is not a medical doctor to dispense medicine. The layout of the practice, and of the pharmacy in particular, is also of the utmost importance in preventing unauthorised access as mentioned above.

In this regard note must be taken of Section 33 of the Medicines Control Act, viz. that an employer will be deemed responsible for any act or omission on the part of an employee, unless, among others, it can be proved that i) the employer did not connive with or permit the act or omission and ii) the employer took all reasonable precautions to prevent such an act or omission. The fact that an employer had forbidden a specific act or omission will in itself not be accepted as adequate evidence that he had taken all reasonable steps to prevent such an act or omission.

(b) PRE-PACKING OF MEDICINES

Section 14 and Regulation 15 made in terms of the Act stipulate that it is not permissible to pre-pack medicine in the dispensary or the practice because this process is subject to the registration requirements of the Medicines Control Council. It is therefore illegal, for example, to re-pack medicines from bulk packaging into smaller containers with a view to selling it at a later stage. However, it is permissible to dispense from

bulk packaging to a specific person a supply not exceeding the quantity required for treatment.

It must be borne in mind that dispensing in this manner will only be possible if adequate facilities exist. The basic requirements are a spacious working slab, easily accessible shelves, comfortable desk and adequate lighting.

The obvious intention of the act is that the quality level required during the production process must be maintained during the distribution process. In terms of the stipulation of section 14 it can be concluded that the conditions under which medicines are stored in the pharmacy or dispensary must receive close attention as well. eg. exposure to sunlight or high temperatures, the availability of a fridge for the storage of sensitive vaccines, insulin, etc. and cleanliness in general.

c) LABELLING OF MEDICINES AND THE KEEPING OF A PRESCRIPTION PAD

Every medicine dispensed must be labelled (Section 18) and the following information must appear on labels:

(i) The name of the medicine, except in cases wherein the interest of the patient, the doctor wishes to withhold it.

(ii) The name of the patient.

(iii) Complete directions for the use (if applicable).

(iv) The name and business address of the doctor.

(v) The reference number , cross reference to the permanent record of the prescription (the date of dispensing can be used as a reference number).

In terms of Section 22 A and Regulation 28 a prescription pad or other permanent record must be kept.

The following information must be recorded:

(i) The name and address of the patient.

(ii) The preparation form and quantity of the medicines.

(iii) Date of dispensing.

(iv) Reference number of label (see comment above).

A further important point is that all samples received and dispensed must be labelled and recorded in the prescribed manner.

(d) THE KEEPING OF A REGISTER FOR SCHEDULE 5 SUBSTANCES

In terms of Sections 22 A (9) (b) (iii) and 5 (e) and Regulation 25 a register must be kept of Schedule 5 substances in the prescribed manner. Registers conforming to the prescribed lay out and that are suitable for use in an average practice with a low turnover in these substances, can be obtained from the local pharmaceutical wholesalers.

Each receipt and handout must be recorded in the register on the date of the transaction. The register must be balanced on the last day of March, June, September and December, which means that the stock must be physically checked and that the doctor must certify by means of an inscription against these dates that the stock and register tally. The doctor must also keep a record of receipts of all schedule 5 and schedule 6 substances and must retain such records for at least three years.(regulation 24)

(e) DISPENSING OF MEDICINE OF WHICH THE DUE DATE HAS EXPIRED

The Act defines the expiry of medicine as the date whereafter the strength and other characteristics indicated on the label of the medicine will not be preserved. After this date the medicine may no longer be sold to the public.

The safety, quality, and therapeutic effectiveness of the medicine cannot be guaranteed after the expiry date and it is therefore a contravention of the law to sell such medicine.

RECORD OF MEDICINES DISPENSED

From the Regional Director, Department of National Health and Population Development, Durban.

It is incumbent upon the dispensing doctor that relevant records should be kept. Such record may be in the form of a card, file or book-record. If an entry is made on the patients record-card, this could result in problems of confidentiality arising when Inspectors appointed in terms of Section 28 of Act 101/65 require to have access to the dispensing record. It could even occur that such record is required as "an exhibit" which can also cause embarrassment. The Regional Office of the Department of National Health and Population Development will appreciate the necessary co-operation of all doctors who undertake dispensing.

2.(2).(2) THE MEDICAL DENTAL AND SUPPLEMENTARY HEALTH SERVICES PROFESSIONS AMENDMENT ACT 58 OF 1984

The relevant section of the Gazette reads as follows:-

"52.(1)(a) Every medical practitioner or dentist whose name has been entered in the register contemplated in subsection (2) shall, on such conditions as the Council may determine in general or in a particular case, be entitled to personally compound or dispense medicines prescribed by himself or by any other medical practitioner or dentist with whom he is in partnership or with whom he is associated as principal or assistant or locum tenens, for use by a patient under treatment of such medical practitioner or dentist or of such other medical practitioner or dentist: Provided that he shall not be entitled to keep an open shop or pharmacy.

(b) The Council may, on such conditions as it may determine, exempt any medical practitioner or dentist from the requirement of registration contemplated in paragraph (a), and may, after an investigation, withdraw such exemption.

(2) The registrar shall keep a register in which he shall enter, at the direction of the Council, the name and such other particulars as the Council may determine of a medical practitioner or dentist.

(a) who within three months after the commencement of the Medical, Dental and Supplementary Health Services Professions Amendment Act, 1984, submits proof to the satisfaction of the registrar that at such commencement he compounded or dispensed medicine as contemplated in subsection (1)(a) in the practice of his profession; or

(b) who informs the registrar in the prescribed manner of his intention to compound or dispense medicine in the practice of his profession as contemplated in subsection (1)(a).

"52 A(3) The Council may, after an investigation, direct that the name of any person be removed from the register contemplated in subsection (2), or prohibit him for a specified period from making use of the right contemplated in subsection (1).

(4) The Council may determine fees to be paid for the entering of a name in the register contemplated in subsection (2)".

(a) SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL GUIDELINES ON METHODS OF DISPENSING

"Medicines may be dispensed by a medical practitioner or dentist provided:-

(i) It is done on such conditions as the Council may determine in general or in a particular case.

(ii) The medicine must be prescribed by himself or his partner.

(iii) The medicine must be for the use of his own (or his partner's) patients.

(iv) The medicine must be personally compounded.

(v) The dispensing must be incidental to his practice.

For the purpose of the above guidelines the Council has defined dispensing as:-

"The compounding, preparation or mixing of medicine, or medical or chemical substances to be sold or supplied as medicine and the mixing or sale or supply of medicine."

(b) GENERAL CONDITIONS FOR DISPENSING

"In terms of Section 52(1) (a) Council has determined that practitioners could only disperse under the following general conditions:-

A complete record of medicine (except medicine and injections dispensed in consultation rooms) must be kept in which the following is reflected:-

(a) Substantiated with invoices, the price, quantity and name of the supplier.

(b) Medicine in stock which must be balanced at the end of each year ie. the end of February."

2.4.3 IMPLICATIONS OF LEGISLATIONS GOVERNING DISPENSING OF MEDICINES

Section 41(a) of Act No.58 of the Medical Dental and Supplementary Health Services Professions Amendment Act of 1984 empowers the Registrar of the South African Medical and Dental Council to appoint an investigating officer with the approval of the President of the Council. His job will be to carry out investigations at the instance of the Registrar.

An investigation may be instituted:-

1. Into alleged contravention of, or failure to comply with any provisions of the Act.
2. In order to determine if any provision of this Act applies to a registered person.
3. Into a charge, complaint, or allegation of improper or disgraceful conduct by a registered person.
4. Into the affairs or conduct of a registered person, if requested to do so by a person by reason of allegation confirmed upon oath.

The registrar or investigating officer will have very wide powers of entry of any premises and seizure of books, documents and other objects. In terms of the Act the investigating officer may enter premises at any time "reasonable to the proper performance of his duty". He may enter a premise with the approval of the President and without prior notice to the person involved. Failure on the part of the practitioner to produce a book, etc., or to furnish an explanation to the registrar or investigating officer will constitute a criminal offence punishable by a stiff fine and/or imprisonment.

The amendment was certainly not welcomed by the dispensing medical fraternity, particularly in regards to the wide powers accorded to the investigating offficer.

Expert legal opion on this Section 41(a) is discussed below:-

(a) In terms of section 41 A (3) (a), the Investigating Officer is required to submit a report of his investigations to the Registrar of the Medical Council.

(b) This report which is equivalent to a complaint only, cannot be challenged in a court of law because it is only a report and not a FINDING. This report is devoid of any legal status.

(c) The Medical Council alone is empowered to make a finding provided that the procedures to enable it to arrive at such a finding are properly carried out in the first place.

(d) If the Medical Council finds a practitioner guilty of misconduct, its finding can be attacked in the Supreme Court only on two grounds.

(i) ON PROCEDURAL GROUNDS:

For example where the Medical Council based its findings simply on statements submitted to it by the Investigating Officer and without having the statements of witnesses tested by cross examination of such witnesses.

(ii) Where the decision of the Medical Council is so grossly unreasonable that no reasonable man could have come to that conclusion. This is a particularly heavy onus to discharge. It is on this ground that the decision of the South African Medical and Dental Council in the Biko case was challenged in the Supreme Court and eventually reversed on an application brought by Professor Frances Ames, Professor Ickias and Dr. Variawa.

(e) The qualifications of the investigating officer are left undefined.

(f) The period over which books and documents have to be retained is not specified in the Act. The maintenance of registers of drugs by doctors and pharmacists may be governed by Acts such as the Medicines Control Act No. 101 of 1965 and the Pharmacy Act of 1974. The practical solution may lie in the retention of books and documents over a reasonable period.

(g) In making his investigation, the investigating officer is entitled to have access to such documents as relevant evidence of disgraceful conduct. Although not relevant per se, documents relating to profits and loss and income and expenditure may become relevant in investigations relating to profiteering, overcharging and other similar offences.

(h) The reference to the Criminal Procedure Act in section 41 (a) (i) (c) finds applicability where the practitioner consents to the admission of the statements. The said section relates to those statements which can be handed in without the witness being subjected to cross examination. To sum up this aspect, the expert legal view is that whereas in the past, the Medical Council had no real teeth to investigate contraventions, the new section now provides the teeth by means of the Investigating Officer and the Registrar.

2.2.3.2 DISPENSING AND COMPOUNDING

(a) SECTION 52 (a)- relates to the supply of any medicines mentioned in schedule 1,2,3 or 4 to the Medicines and Related

Substance Control Act 101 of 1965 by a registered nurse in accordance with the direction of a medical practitioner in circumstances where the consulting rooms of the Practitioner are not situated within a reasonable distance of a retail Pharmacy. Here no new principle is introduced because the question of a reasonable distance from a retail pharmacy was inherent in the 1974 Act.

Whereas previously the secretary for Health had the power to grant authority, now the power rests in the Council. Whereas previously the person who could supply was an enrolled nurse. now it has to be a registered nurse.

(b) Section 52(A) or for that matter the entire Medical Dental and Supplementary Health Services Professions Amendment Act No. 58 of 1984, cannot be attacked in a court of law.

Unlike certain other legal systems, such as that of United States of America, in South Africa an Act of Parliament cannot be attacked on grounds of unreasonableness or vagueness. The only exception is, if a law impinges on the equality of the English and Afrikaans languages.

(c) SECTION 52 (1) (A)

(i) The basic change is that whereas previously the right to personally dispense and compound medicines flowed from the fact that the person was a medical practitioner, now that right will flow only after the name has been entered in a register.

(ii) Any doctor who has been dispensing and compounding would as of RIGHT have his name placed on the register.

(iii) The ONLY NEW PRINCIPLE INTRODUCED is the Register and Registration is facilitated, because it is quite unnecessary to show public interest. The existence of a number of pharmacies in the immediate vicinity will be irrelevant.

a. The potential problem is the attitude of the Medical Council to the Act. Whether it understood the law before the amendment and whether it intends enforcing its provisions. In other words, will the Medical Council take a closer look at Section 52?

b. If by "personally compounding and dispensing" means that one has to act like a pharmacist, dispensing doctors will have a problem whether the present amendment is there or not because the requirement was present in the 1954 Act.

c. On the other hand 'compounding and dispensing" needs to be examined more thoroughly. In 1926 medicines were mainly compounded medicines. Presently most medicines are manufactured and packed by highly skilled pharmaceutical organisations. Therefore the concept of compounding and dispensing must be examined in the light of this change.

Although most medicines are prepacked, the doctor has still to exercise some discretion. For example, in expectation of epidemics and ordinary ailments, if the practitioner packs the shelves with bottles and packets of medicines and tablets clearly labelled, then he can, after examining the patient, direct his nurse, whether she is a registered nurse or not, to write on the label the name of the patient and simple directions and to hand it to the patient, then the practitioner can be said to be "personally dispensing" the medicines. All that is required of his assistant is that he/she be able to read and to perform simple clerical duties of writing out the name of the patient and the directions.

The legal experts definition of dispensing in 1988 is :-

"Distribution of medicine and drugs through expert and

This certainly differs from the South African Medical and Dental Council's definition of dispensing - "the compounding, preparation or mixing of medicines, or medical or chemical substances to be sold or supplied as medicines and the mixing or sale or supply of medicines".This definition had relevance in 1928.

If therefore the abovementioned steps are taken, it is the legal expert's view that the doctor has "personally compounded and dispensed" and can be a basis for a defence against a disciplinary charge.

(d) SECTION 52 (A):

It is the legal expert's view that this section showed most promise provided the basis of the exemption is widened. As it stands now, once authority is granted, the practitioner needs simply to direct the registered nurse to supply the particular medicines to the patient.The present basis of the exemption is the absence of a pharmacy within a reasonable distance from a doctor's consulting rooms. If the basis can be extended to include economic, physical and financial hardship to patients, then practitioners serving the poor sections of the community could apply for necessary authority from the Medical Council.

(e) (a),(b),(c) TRADING AND PROFITEERING

Section 52 (1) (a) of Act 56 of the Medical Dental and Supplementary Health Services Professions Amendment Act 1974 stipulates that a registered dispensing doctor shall not be entitled to keep an open shop or pharmacy. By inference an "open shop or pharmacy" refers to trading and hence by implication profiteering.

The dispensing doctor's all- inclusive fee of medicines plus consultations to his private patient is well below the recommended consultation tariff of the Medical Association of South Africa. The problem arises with the medical aid patient, who is charged a gazetted tariff for his consultation and the

price for medicines supplied to him. It is on issues such as these that pharmacists accuse the dispensing doctors of trading and profiteering.

However, it is the author's contention that the costing of medicines to Medical Aid patients be a separate subject of research at some later stage, the mechanics of which will not be discussed presently. Suffice it to say that neither the South African Medical and Dental Council nor the Medical Association of South Africa have given definite guidelines on the question of costing of medicines. A joint declaration in 1981 by the Medical Association of South Africa and the Pharmaceutical Society of South Africa vaguely indicates that the "Medical practitioner may only recover his basic costs as well as the direct variable cost on the medicines handled by him: he may not, however dispense with profit as his motive".

The formula for determining the various cost structures has never been determined and hence this joint declaration has no scientific bases or validity.

The question of the prohibition against profiteering on the supply of medicines was discussed with the legal experts, as the Act and the Amendment does not specifically prohibit the making of profit.

The legal experts opinion was:-

1. It is true there is nothing in the Act which says that a Medical Practitioner cannot make a profit on the sale of medicines but if it is found there is profiteering on a substantial scale, that practitioner can be found guilty of disgraceful conduct.
2. A medical protitioner can make reasonable profit on the sale of medicines provided that such profit does not form a substantial portion of his income.

3. The rule of thumb percentage of 25 could be considered as reasonable.eg. "5% of income from consultation and 25% of income from the sale of medicines.

Two points emerge from the opinion viz:-

(a) The profit per script must not be unreasonable.

(b) The proportion of total income must not emanate predominantly from profit on sale of medicines.

There will be further discussion on the various aspects of "trading" in medicines, as well as what constitutes "trading" in the succeeding chapters.

In the important notice to all medical practitioners and dentists on "Dispensing of Medicines" sent by South African Medical and Dental Council in February 1985, five guidelines were determined by them for medical dispensing:-

(1) It is done on such conditions as the Council may determine in general or in a particular case.

(2) The medicine must be prescribed by himself or his partner.

(3) The medicine must be for the use of his own (or his partner's) patients.

(4) The medicine must be personally compounded.

(5) The dispensing must be incidental to his practice.

For reasons best known to the South African Medical and Dental Council guidelines (4) and (5) stipulated above have been omitted in the notification which accompanied the certificate to practise as a dispensing doctor, received in May, 1986. However, the February, 1985 guidelines under general conditions of dispensing remains unaltered in the May, 1986 notification.

Why the omission of Guidelines (4) and (5)?

What inferences can one draw?

What conclusions can one deduce?

These are some of the questions to which answers may not be answerable. Nonetheless, I'll ask a basic case trial in the near future will throw some light on this legalistic maze.

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CHAPTER THREE - DISPENSING AND PATIENT CARE

3. (1) Introduction

3. (2) The Dispensing Doctor and his patient

(2) (1) Medical Aid Patients

(2) (2) The Private or Fee Paying Patient

(2) (3) Sick Benefit Funds

3. (3) Other advantages of Dispensing to Patients

3. (4) The dilemmas and implications of dispensing

3. (4) (1) Economic

(a) Capital Outlay

(b) Storage

(c) Administration

(d) Packaging

(e) Direct Losses

(f) Bad Debts

(g) Medicine Levies

(h) Medicine Limits

3. (4) (2) Time

Bibliography

CHAPTER 3

DISPENSING AND PATIENT CARE

3.1 INTRODUCTION:

Health is a universally accepted human right. (THE FIRST ARTICLE IN THE CHARTER OF THE WORLD HEALTH ORGANISATION) and therefore the means for achieving it should be guaranteed by every civilized state to all citizens.

Health accordingly is fundamental to life and cannot be treated as a commodity; it should be free of market forces so that need, rather than the ability to pay, determines access to health care.

The deteriorating socio-economic conditions of the majority of people characterized by high rates of unemployment, and a soaring cost of living, makes it imperative that at a minimum, health services are available to all.THE INFANT MORTALITY RATES, THE AVERAGE MONTHLY EARNINGS and THE HOUSEHOLD INCOMES of the different race groups clearly demonstrate the dilemma.

The tables listed below (Race Relation Survey 1984) clearly demonstrate the pathetic state of the majority of the people:-

TABLE 1

OFFICIAL INFANT MORTALITY RATES

According to Racial Groups in South Africa

	1981	1982
African	80	80
Coloured	59.2	59.2
Indian	18,9	20.7
White	13,3	13,4

TABLE 2

Average monthly earnings of workers in all sectors of the economy,excluding agriculture and domestic service, According to Racial Groups in South Africa

	African	Asian	Coloured	White
1979	R156	R278	R210	R665
1981	R228	R412	R309	R963
1983	R310	R584	R417	R1210

TABLE 3

Household incomes for the different race groups According to Race Groups in South Africa

	African	Asian	Coloured	White
1980	R136	R505	R344	R918
1982	R204	R819	R548	R1380
1984	R273	R1072	R624	R1834

The ideal differs greatly from the reality and the position is further complicated by the dual system of health care delivery in South Africa:-

1. Fee for service for the "haves"
2. Government sponsored systems for the "have nots"

However,the "have nots" who make up the bulk of the population comprising mainly of Africans are also compelled to seek fee for service health care.This quite often results from disorganization, inadequate facilities and the totally unsatisfactory treatment meted out to them at Government institutions.

Historically the legislations dealing with health care in South Africa has ignored the needs of the majority of the population comprising Africans,Indians,and Coloureds.The legislators also appear to have a tunnel vision approach in making assumptions about medicine and health which it valid,may only be so in relation to the privileged white minority.

The assumptions are quite problematic in that :-

1. It assumes that the determinants of health and illness are predominantly biological so that patterns of morbidity and mortality have little to do with the social and economic environment in which they occur.
2. It is assumed that medicine is a science and that it is possible to separate a doctor from his subject matter(the patient). Hence it is assumed that medicine, because it is scientific, should not be tainted by wider social and economic considerations.

There is a very serious need to consider the relationship between the biological and social, between health and illness and the society in which it occurs. From the many studies undertaken on the social and economic needs of the communities the obvious conclusion reached is, that the burden of ill health and poor services is borne by the very communities that are serviced by a large number of dispensing doctors. This being an important determinant leaves little or no alternative for the vast majority of general practitioners but to dispense medicines.

In order to appreciate the perspectives and the convictions of dispensing doctors, it is important to take a close look at the dispensing doctor and his problems and the categories of patients he services.

3.2 THE DISPENSING DOCTOR AND HIS PATIENTS

South Africa has a unique situation whereby a first world and a third world live side by side with one another, in terms of their own 'group areas'.

Dispensing medical practitioners in urban areas not only service urban patients of all races but are also consulted on a fee for service basis by a large number of patients from the peri-urban and rural areas who make tremendous sacrifice in terms of time

a priority issue to them, takes precedence over any inferior service no matter how accessible it may be.

These are the communities who despite having to suffer unemployment and economic deprivation, value the continuing care and the continuity of care, so essentially vital and fundamental to primary health care. After a consultation most of the patients require medication. The prescribing of medication in most instances symbolizes that a firm diagnosis has been made by the doctor. This medication can be given by a doctor in the form of a script and it is then the patients responsibility to get the medicine.

However, since time immemorial, medical practice has been historically and traditionally marked by a few basic identifying facts: the inherent right of the general practitioner to physically examine his patient and to dispense medicine to him and the choice accorded to his patient to receive such medication from him, or by means of a prescription from a chemist. In fact it is part of the whole therapeutic process towards care and well being of the patient.

In the South African context dispensing doctors cater for patients falling into three categories. They are:-

1. The patient belonging to one of the many registered and non-registered medical aid societies.
2. The private or fee paying patient.
3. The sick benefit fund patient.

1. MEDICAL AID PATIENTS

Here the patient is a member of one of about 250 Medical Aids. About 225 are registered in terms of Medical Schemes Act and 25 are not registered. Approximately 80% of the white population is covered by medical aid schemes. Only 4% of blacks belong to Medical Aid schemes. (Hansard 23 March 1984: 5 col. 3032). Many

medical fees have limitations built in disincentives.

Medical schemes in this country provide for the needs of a select sector of our society. In the first instance, they are all linked to employment one way or another. In other words the economic system has an interest in maintaining the health of its workers and their immediate families (particularly the higher paid employees).

Secondly if one examines the racial and economic distribution of the membership of these schemes one sees that it is the group which enjoys political rights that is being catered for.

On the other hand if one examines the majority of the population who are in the greatest need as measured by statistics of mortality and morbidity (Botha 1985) one notices that the bulk of them are neither economically active nor have any political rights. Hence there seems little chance in the future of their health care needs being provided for by this system.

Table 4 below indicates the number of people covered by various medical schemes (Report by the Registrar of Medical schemes for the year ended 31/12/1983).

Table 5 and 6 analyses the membership of Industrial Council Medical Schemes (Deus Deliner 1977) and compares Exempted Schemes in 1982 with the number of workers covered by Industrial Council (Budlender 1984).

These tables show little has changed over the last 11 years.

TABLE 4

MEDICAL SCHEME MEMBERSHIP STATISTICS 1982

ACCORDING TO RACIAL GROUPS IN SOUTH AFRICA

SCHEMES	WHITES	COL.	IND.	AFRIC.	TOTAL
MEDICAL AID					
Members	1 034 405	90 665	35 416	50 893	[illegible]
Dependants	1 690 558	186 825	93 662	131 608	[illegible]
TOTAL	2 724 963	277 484	129 077	182 501	[illegible]
MEDICAL BENEFIT SCHEMES					
Members	122 257	30 833	3 819	64 685	[illegible]
Dependants	230 160	42 944	4 647	69 649	[illegible]
TOTAL	352 417	73 777	8 466	134 336	[illegible]
EXEMPTED SCHEMES					
Members	150 557	160 256	54 811	95 795	[illegible]
Dependants	245 805	161 306	37 040	72 264	[illegible]
TOTAL	396 362	321 562	91 851	168 059	[illegible]
GRAND TOTAL COVERED BY VARIOUS SCHEMES	3 473 742	672 833	229 394	484 896	4 [illegible]
POPULATION ('000) (est)	4 688	2 729	854	21 890	30 [illegible]
% OF POPULATION COVERED BY SCHEMES	75%	25%	27%	2%	1[illegible]%

TABLE 5

Membership of Industrial Council Medical Schemes(1971)

ACCORDING TO RACIAL GROUPS IN SOUTH AFRICA

	WHITES	COL.	IND.	AFRIC.	TOTAL
No. of workers covered by all I.C's (1971)	218 686	192 915	61 386	537 475	1 010 562
No. of workers covered by medical aid schemes	145 865	40 593	7 017	549	194 024
No. of workers covered by medical benefit schemes	10 629	76 316	31 127	40 468	158 540
% of all workers covered by schemes	72%	61%	62%	8%	35%

TABLE 6

Approximate Membership of Industrial Council Schemes (1982)

ACCORDING TO RACIAL GROUPS IN SOUTH AFRICA

	WHITES	COL.	IND.	AFRIC.	TOTAL
No. of workers covered by all I.C's (1982)	207 357	281 561	65 959	715 345	1 267 222
No of workers covered by exempted schemes	146 028	159 480	54 782	95 573	455 863
% of all workers covered by schemes	70%	57%	83%	13%	36%

Table 4-6 indicates that 78% of the Whites are covered by registered medical aid schemes whereas only 42% of the other race groups are covered by medical aid schemes.

Further, when one examines the contribution rates of medical aid schemes one notices that, although the monthly contributers are graded by income, the lower income members pay proportionately more. In addition, if one takes into account the tax abatement that can be claimed, the high income earner ends up paying less for health care than the low income earner. The figures indicate that only 36% of all workers who could be covered are covered (compared with 35% in 1971). Although the percentage of Africans covered has improved, only 13% of elegible workers are covered.

From the above comparisons it can be clearly seen that medical schemes cover the rich, urban, employed(usually the white people) and fail to cover the poor, rural or unemployed(usually the black people).It is tragic that both the State and the Medical Schemes, base health care needs on two assumptions:-

1. That Health Care Services can be treated as commodities, to be bought and sold in the free market.
2. That through this operation of medical schemes in the free market health care needs will be most efficiently met.

The Minister of Health and Welfare on introducing the second reading of the recent Medical Schemes Amendment Bill, stated that in his opinion "the market mechanism will compel the respective parties to act in a realistic way" and that "we all have to guard against being compelled to move away from the free market system."

2. THE PRIVATE OR FEE PAYING PATIENT

These are patients who have no form of medical insurance. They include the whole spectrum of the population from the senior executive, self employed on one end, to the skilled and unskilled employee, the unemployed and the pensioner at the other end.

Because of the socio-economic circumstances, the vast majority of fee paying patients are low income patients not belonging to either a benefit or a medical aid society and include the unemployed, pensioners as well as the self employed and the skilled and unskilled employee. They are only able to afford primary health care provided by the dispensing doctor, because of the all inclusive lower charges of the dispensing doctor.

Here the doctor charges a fee between R12,00 and R14,00 for consultation plus medication. The medical aid scale of benefit is presently R13,60 for consultation only.

The recommended tariff of Medical Association of South Africa for a consultation alone is over R19,00.

The doctor cannot divorce himself from the social reality of the communities he services and for the same reason a doctor chooses to serve on panels of benefit societies, he has to accept the reality and reduce his fee which is an all inclusive one. This reduced fee basically also subsidises the cost of medicine dispensed to private patients.

3.SICK BENEFIT FUNDS

They are registered in terms of the Industrial Concilliation Act. Medical Benefit Funds have a contract with a panel of doctors. These doctors get paid by the Scheme for looking after members when sick. Benefit Funds are the only schemes, which workers with low wages can afford.

Benefit Funds are exempted from certain provisions of the Medical Schemes Act, enabling them to fix a fee with their panel doctors. This fee is far lower than the suggested consultation fee accepted by Medical Aid Societies. The Medical Association of South Africa's position has been that these fees have been unrealistically low. Not withstanding this, many doctors in our communities have chosen to serve on these panels in order to make health care available to low- income communities. These doctors serving on panels are contractually bound to dispense medicines to 'panel patients'.

In Cape Town two of the larger benefit funds are:-

1. Cape Town Municipal Workers Medical Benifit Fund .
2. Cape Clothing Sick Fund.

Together these funds make health care available to about a quarter million people in the Peninsula.

These funds basically offer a consultation and medication service by the doctor appointed on the "panel". A lesser fee is fixed for the doctor - anything between R3,00 and R5,00 per consultation. Medicines are charged for to the Sick Fund at a much lower price than Mims. Some Sick Funds have a ceiling of R5,00 for the total medicines supplied.

In Pietermaritzburg the National Union of Leather Workers is the single largest Sick Benefit Fund, catering for 5008 workers. At the first consultation the member pays R1,00 and the Sick Benefit Fund pays R12,60 for a consultation plus medicines supplied. For repeat consultation the Sick Benefit Fund pays R6,30 inclusive of medicines supplied.

Benefit Funds are unable to function without the low tarrifs charged by panel doctors. Since Benefit Fund patients constitute a large section of dispensing practice, it is clear that it would be catastrophic to thousands of people in South Africa if doctors stopped dispensing.

Unfortunately dispensing has been seen in the context of the Medical Aid situation, and the other two aspects ie. the Benefit Fund and the low income private patient are completely ignored in the debate that rages. Even when medicines are dispensed to Medical Aids, the doctor charges a Mims price which is fully acceptable to the Medical Aid Society and Medical Association of South Africa. John Ernstzen of RAMS has clearly stated that the cost of medicines to medical aid is less when supplied by dispensing doctors.

The dispensing doctor does not charge:-

1. Dispensing fee
2. A 'broken batch' or 'open stock' fee
3. 'Added water' fee
4. 'Cost of Container' fee
5. 'Photocopy of Script' fee
6. 'After Hours' fee

7. G.S.T.

The above exclusions are surely important considerations in keeping the cost of medicines down in South Africa. In fact many Medical Aids prefer that the doctor dispenses as they save on these charges.

3.3 OTHER ADVANTAGES OF DISPENSING TO PATIENTS

1. More complete service allowing for a much better and more cordial Doctor/Patient Relationship -an important factor in the quality of health care provided and received.
2. Patient Compliance - with prescribed therapy is undoubtedly better when the medicines are given by the doctor personally. The doctor has a better chance to motivate the need for, and the specific indication of individual medicines.
3. Cost awareness of medication

   The dispensing doctor is cost conscious as he has to buy quality medicines at keen prices. A survey by Consolidated Employers Medical Aid Society in 1982 showed an appreciably lower average cost per script when dispensing doctors were compared to non-dispensing doctors. A Cape Medical Plan survey also showed that dispensing doctors give less medicines per average script. For the patient it is decidedly cheaper.
4. Drug Side-Effects - can also be better anticipated and more pertinently assessed when drugs have been given by the doctor himself. The dispensing doctor will also tend to have an increased awareness of DRUG INTERACTIONS when he physically handles them together.
5. No additional Fees - are incurred when drugs are prescribed by a dispensing doctor.
6. Medicine is available to patients at all hours,at a moments notice.

7. Patients know what they are getting in value for the amount they pay.
8. Patient Convenience - In that it is a one stop visit and hence they save time.
9. Patients do not have to pay immediately. This is of particular importance to the medical aid patient.

3.4 THE DILEMMAS AND IMPLICATIONS OF DISPENSING

THESE ARE LARGELY:-

(a) Legal

(b) Ethical

(c) Economic

(d) Time Factor

The legal and ethical constraints have already been alluded to in chapter 2.

3.4.(1). ECONOMIC

(a) CAPITAL OUTLAY

Doctors acquire medicines on cheque with order on 30 day payment basis. Some drug firms slap on monthly interest if the account is not paid by the 25th. It is a known fact, that Medical Schemes Act allows medical aids to take anything from 90 to 120 days to pay accounts. In terms of the long recovery period, this represents a financial loss to the dispensing doctor. Some medical aids send the medicine cheque to the patient. This cheque very seldom reaches the doctor.

(b) STORAGE

And storage space presents a significant cost factor to the average dispensing practice.

(c) ADMINISTRATION

Drug accounts often call for extra staff and time. Medical Aids that are administered by Davidson and Ewing and the Medscheme Group require that their patient signs the script as soon as it is dispensed. The account plus copies of the script must be sent to the patient for re-signing and submission to the Medical Aid. This performance has to be repeated each month. This cumbersome procedure is an additional burden and an administrative nightmare.

(d) PACKAGING

Costs have been rising steadily over the years.

(e) DIRECT LOSSES

Expiry of drugs and breakages also constitute a loss of return on monies expended.

(f) BAD DEBTS

Dispensing doctors incur these and they are continuously growing in these times of rising unemployment.

(g) MEDICINE LEVIES

Charged per script by numerous medical aids are invariably written off by many dispensing doctors. This can be anything from R2,00 to R5,00 or up to 20% of the total script.

(h) MEDICINE LIMITS - Imposed by Medical Aids

These can be unrealistically low eg. R200, 00 medication for one year for a family of four. The dispensing doctor often provides the medicine gratis to the member and his family, if his medicine benefits are exhausted, and carries the patient until he is once again in benefits.

3.4.(2) TIME

The dispensing doctor has to perforce spend more time with the patient to complete the medical encounter viz. he has to set aside extra time per patient to instruct on how medicines are to be taken and the specific indications for medicines supplied - time for which he does not charge. The dispensing doctor has to spend extra time in purchasing drugs, administering accounts, doing stock control and supervising storage. Dispensing certainly entails extra work and sacrifice on the part of the doctor.

If one looks at the total dispensing situation(including the low income private and Sick Fund patients) and not just the 'cream' of medical aids, then it becomes obvious that the dispensing doctor is not making the "handsome" profit which the media and pharmacist would have the public believe.

Is the main feud between the Pharmacist and the dispensing doctor, entirely based on the profit motive?

It would appear that forty to fifty years ago, the number and distribution of retail pharmacy outlets and their distribution was very limited. In addition, Pharmaceutical formulations for the treatment of ailments and diseases, required the skilfull blending of numerous ingrediants. As time went on the number of Pharmacy Schools in South Africa increased. During the same period rapid development within the Pharmaceutical Manufacturing Industry has resulted in most of today's modern medicine being available in treatment packs manufactured under strict control of the modern Pharmaceutical manufacturing Industry which has virtually made blending of medicine obsolete.

We have a situation in South Africa today where there are more Pharmacy Schools than Medical Schools.Broken down to provincial level the doctor to pharmacy ratio are as follows"-

Transvaal	-	2:1
Natal	-	2,9:1
Eastern Cape	-	2,3:1
Western Cape	-	2,5:1
O.F.S	-	2,2:1

On the East Rand the ratio of one Pharmacy to every doctor is quite common. The ideal ratio which is the norm in most western countries, is one Pharmacist to ten doctors.

In the republic of South Africa there are altogether 2500 retail pharmacies, 4500 General Practitioners and 1800 Specialists in private practice.

The annual turnover of the drug manufacturers in South Africa is R350,000,000, of the wholesalers R427,000,000 and of the retail Pharmacies R630,000,000.

Every year 75,000,000 prescriptions are dispensed, which bring in revenue of R100,000,000 in dispensing charges alone. Copies for medical aid purposes (15c) bring in R6,500,000. A 10% surcharge is made for breaking a bulk pack, and this brings in R11,000,000. The mark-up from manufacturer to wholesaler is 15%. Dispensing medicines accounts for 40% of the average Pharmacies turn over. In some areas, Pharmacies outnumber doctors - in Alberton there are 35 doctors and 40 Pharmacies. Fifty five per cent of Pharmacies are controlled by two companies. (S.A.M.J. :VOL 68 (28/9/85 page 4 and 7.)

There appears to be a mark - up of almost R575,000,000 between the time the ethical product leaves the manufacturer and the price finally paid by the consumer.

Because of the automatic 50% mark up on drugs, the Pharmacist has been able to increase his profit above the rate of inflation and greatly increase his share of the total annual medical bill.

Further, many pharmacists belong to a wholesale group, from which they buy at wholesale prices to sell at full retail prices, plus R1,30 dispensing fee per item to gain, at the end of each financial year a not inconsiderable bonus.

The issue involves not only what is best and most convenient for the patients, an issue pharmacists and legislators seem to overlook, but also the vital cost effectiveness factor. It is tragic that both the Legislators as well as the Statutory Bodies tend to adopt a consumer-commodity approach to the dispensing issue.

The main concern of dispensing doctors is with patients and with medical services in general. The Pharmacists and Legislators have nowhere addressed themselves to the central problem namely "what is in the patients interest?"

Pharmacists and Legislators tend to perceive dispensing in purely physical terms of marketing and selling of medicines in rands and cents; in much the same way as that occurs over the counter when buying a camera or ornament.

To the dispensing doctor, after information is gained from a consultation, the providing of medicines to the patient becomes a total or partial symbol of his healing. The doctor and patient are intensely involved. The patient understands more, and is more involved with his own treatment - he becomes motivated.

Since prescribing is an inherent part of the doctor/patient relationship which is also a learning situation, then the actual dispensing of the medicine and the meaning it assumes in the relationship serves as a repeating and a re-inforcing power in the learning process. Not only does the patient's insight of himself and his disease improve, but also his insight regarding the doctors relationship to him.

Communication and dispensing between the doctor and his patient, is between person and person, which mutually involves understanding, empathy, appreciation, patience and respect. It cannot be conveyed by a prescription; it is not marketable and cannot acquire a price tag.

Dispensing improves the doctor's ability in assessing the global need of the patient in the framework of the disease entity and the economic determinant active within his environment.

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CHAPTER FOUR - RESPONSES OF RELEVANT ORGANIZATIONS

4. (1) Responses of Relevant Organizations

(1) 1. Statutory Bodies

(1) 2. Professional Associations

(1) 3. Service/Consumer Groups

4. (1) 1. (a) The South African Medical And Dental Council

(b) Department of National Health and Population Development

(c) The Pharmacy Council

(d) Competitions Board

4. (1) 2. (a) Medical Association of South Africa

(b) Pharmaceutical Association of South Africa

(c) National Medical and Dental Association

(d) The South African Academy of Family Practice

(e) Society of Dispensing Family Practitioners

(f) National General Practitioners Group of the Medical Association of South Africa

4. (1) 3. (a) Representative Association of Medical Schemes

(b) National Union of Leather Workers

(c) Pietermaritzburg Indian Child and Family Welfare Society

4. (1) 4. Statement By The President Of The S.A.M.D.C. And The PresidentOf The S.A. Pharmacy Board - 28/6/1985

4. (1) 5. Implications Of The Recommendations Of The Ad Hoc Committee Of S.A.M.D.C. And The S.A. Pharmacy Board.

Bibliography

CHAPTER IV

4.1. RESPONSES OF RELEVANT ORGANIZATIONS

Many organizations are either directly or indirectly affected and concerned with medical dispensing. For convenience these organizations will be divided into three categories:-

4.1.1. STATUTORY BODIES - :- (a) South African Medical and Dental Council.
(b) Department of National Health and Population Development.
(c) S.A. Pharmacy Council
(d) Competitions Board

4.1.2. PROFESSIONAL ASSOCIATIONS -:-(a) Medical Association of South Africa
(b) Pharmaceutical Association of South Africa
(c) National Medical and Dental Association
(d) The South African Academy of Family Practice.
(e) Society of Dispensing Family Practitioners
(f) National General Practitioners Group

4.1.3. SERVICE/CONSUMER GROUPS - :- (a) Representitive Association of Medical Schemes (RAMS)

(b) National Union of Leather Workers

(c) Pietermaritzburg Indian Child and Family Welfare Society

Open ended questionaires were sent to those organizations, stipulated under section 4.1.3.(Annexure 1)

The views of those organizations who already have a policy statement on medical dispensing, will be discussed first.

Let us examine the policy statements of the organizations mentioned.

4.1.1. (a) THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

Their policy and opinions have already been discussed in detail in chapter 2. The implications of guidelines on dispensing as set out in the joint statement by the President of The South African Medical and Dental Council and the Pharmacy Board will be discussed later in this chapter.

4.1.1. (b) DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

Certain aspects of the legal requirement, and the conditions for the dispensing of medicines by Doctors and Pharmacists in terms of the Medicine Control Act (Act 101 of 1965) have already been discussed in detail in Chapter II. The Minister of National Health and Population Development's Department's involvement in the dispensing issue will be discussed under the Pharmaceutical Society of South Africa's opinions and policies.

4.1.1. (c) THE PHARMACY COUNCIL (Previously Pharmacies Board)

The Council regretted that the joint statement on dispensing by medical practitioners which had been agreed upon by the

executive committee's of the South African Medical and Dental Council and the S.A. Pharmacy Council had not been confirmed by the South African Medical and Dental Council but had merely been noted. Hence the Pharmacy Council resolved on the recommendation of its executive committees, to adopt for incorporation in legislation, the principle that no medical practitioner should dispense medicines for gain where a pharmaceutical service was readily available. The Council also resolved to adopt the point of view that except in the case of medicines administered by a medical practitioner personally to a patient, he should not levy any fees or charges for medicine in addition to his consultation fee, and that if exceptions to this restriction should become necessary in the public interest, the Pharmacy Council should be consulted in the consideration of such cases. The Council resolved that legal opinion be obtained as to the exact manner in which the above mentioned principles could be incorporated in legislation and that the Minister of National Health and Population Development be approached as soon as possible with a request that the relevant legislation be amended as contemplated above in the interest "of the continuing existence of a strong pharmacy profession which was ultimately in the best interest of the public." The Council resolved to state publicly its policy that the Pharmacist due to his specialised training and knowledge of medicines was the specialist in the supply of medicines and that he should continue to fulfill this role.

4.1.1. (d) COMPETITIONS BOARD

The Competitions Board sees to the implementation of the Maintenance and Promotion of Competition Act No. 96 Of 1979.

This Act provides for the maintenance and promotion of competition in the economy for the prevention or control of restrictive practices and the aquisition of controlling interest in business and undertakings, and for matters connected therewith.

The Society of Dispensing Family Practitioners have requested the Competitions Board to look into certain restrictive practices which are contained in certain passages of the statement issued on the 28/6/84 following the meeting of an adhoc commitee of the South African Medical and Dental Council and the South African Pharmacy Board.

The Competitions Board was also asked by the Society of Dispensing Family Practitioners to look into the decision of some of the wholesalers not to supply medicines to dispensing doctors.

The director of the Competitions Board informed the S.A. Pharmacy Council that the Board had received complaints connected with distribution and dispensing of pharmaceutical products and that in addition the Cabinet had directed the Board to co-ordinate competition policy in the public sector.

In the letter addressed to the Pharmacy Council a copy of which was sent to Medical Association of South Africa the following information on dispensing by medical practitioners was requested by the Board. In the letter, the Board wrote:

"Complaints relating to the distribution and dispensing of pharmaceutical products have been lodged with the Board in respect of Maintenance and Promotion of Competitions Act, 1979 (Act 96 of 1979). In addition, as early as October 1983 the Cabinet instructed the Board to co-ordinate the policy relating to competitions in the public sector.

In order to enable the Board to investigate the complaints and to perform this co-ordinating function, it would be appreciated if you could comment on the following before 29 November 1985:

1. Are you of the opinion that prescribed medicine should not be regarded as a commercial article in the normal sense of the word, particularly not at the point of dispensing?

2. Should there be any restriction on the dispensing of medicines by doctors? Please give a detailed explanation.

3. Acting on the assumption that no-one (pharmacists, medical practitioners, private hospitals and clinics) may make a personal "profit" from the mere "selling" of the medicines but that this income should comprise -

   (a) the actual purchase price of the medicines plus general cost (according to a realistically prescribed percentage); and

   (b) a professional fee for the service based on a motivated system:

      i) Should the principal and the elements of the "income" be the same for all persons involved in dispensing?

      ii) Are you of the opinion that the above-mentioned approach of no "profit" on the medicines upon dispensing has merit, particularly since the general cost and the professional fee for the dispensing service is determined reasonably and in scientific manner?

      iii) Are you of the opinion that medical practitioners should receive a professional fee for dispensing in addition to their professional medical practitioners fee?

      iv) Should the principles mentioned above be extended consistently to cover dispensing in hospitals, particularly private hospitals?

      v) Are you of the opinion that the average price of prescribed medicines will drop if the above-mentioned supposition of no "profit" on

4. What is your opinion concerning the principles contained in the joint declaration of the President of the South African Pharmaceutical Board and the President of the Medical and Dental Council on 29 June 1985 in connection with the dispensing of medicines by medical practitioners?

5. The Board will be pleased to receive any further information relevant to the dispensing of prescribed medicines, particularly with regard to methods for lowering the cost of medicines in respect of the general public."

This information was duly supplied by the South African Pharmacy Council.

4.1.2. (a) MEDICAL ASSOCIATION OF SOUTH AFRICA

In the joint declaration by the Medical Association of South Africa and the Pharmaceutical Society of South Africa published in April 1981 specific guidelines had been set out for medical dispensing. The joint declaration was made by Prof. J.N. de Klerk chairman of the Federal Council, Medical Association of South Africa and Gordon Dowsett the President of the Pharmaceutical Society of South Africa, annexure (2)

However in September 1985 the chairman of the Federal Council of Medical Association of South Africa Dr. R.D. le Roux welcomed the fact that the South African Medical and Dental Council and the Pharmacy Council had now issued clear guidelines on the question of the dispensing of medicines. Dr. le Roux stated that these guidelines as set out in the joint statement by the presidents of the South African Medical and Dental Council and the Pharmacy Council "to a large extent reaffirms the Medical Association of South Africa's policy on dispensing". According to Dr. le Roux the Adhoc committee's stand point on dispensing

does not differ much from the joint statements issued by Medical Association of South Africa and the Pharmaceutical Society of 1981.

These guidelines have as yet not been ratified or accepted by the full council of the South African Medical and Dental Council. The guidelines have been merely noted.

The implications of these guidelines will be dealt with subsequently in this chapter.

4.1.2. (b) PHARMACEUTICAL ASSOCIATION OF SOUTH AFRICA

In order to understand the Pharmaceutical Society's response it is imperative to follow events from 5 March 1983.

Early in March 1983 a Pharmaceutical Society of South Africa delegation comprising the President and Executive Director met with the Minister of Health (Dr. Nak Van der Merwe) and a 10 page memorandum on the "Trading Doctor" was handed to him. The Minister was sympathetic towards the delegation and asked for specific examples of trading doctor malpractice to be sent to him.

The Pharmaceutical Society's memorandum proposed a radius limitation to be imposed on dispensing doctors as well as a suggestion that a dispensing doctor be registered as such and be licensed on an annual basis. A memorandum with specific examples of trading doctors activities was immediately supplied to the Minister.

This was followed later in that month by a meeting with Professor Geldenhuys, President of the South African Medical and Dental Council and another meeting with Professor Guy de Klerk and Professor N. Louw representing the Medical Association of South Africa; Further negotiations took place with both Medical Association of South Africa and South African Medical and Dental Council with their first accepting the proposal to register dispensing doctors and later rejecting it.

The joint liasion committee of the Pharmaceutical Society and Medical Association of South Africa finally met in June 1983 after pressure had been brought to bear on Medical Association of South Africa by the Minister. A strong case was presented by the Society. This was followed by a memorandum detailing the Pharmacists situation as a result of the trading doctor activities. The memorandum was also sent to the Minister. An additional memorandum on the practical and financial implications of dispensing by doctors and purporting to demonstrate the excessive profits being made was also submitted to Medical Association of South Africa.

In response to the memoranda, a letter from the Medical Association of South Africa rejecting the Pharmaceutical Society of South Africa's contentions was sent to the Society in September 1983.

The Society responded by sending a list of 1209 names and addresses of doctors or medical practices to Medical Association of South Africa which was rejected out of hand by Guy de Klerk and the Federal Ethical Committee of Medical Association of South Africa.

The Proposal of a radius limitation was also subsequently rejected by Medical Association of South Africa. In November 1983 a letter was sent to the South African Medical and Dental Council requesting an interpretation of their ethical rule 28 and what was meant by a "doctor should not place himself in economic competition with a Pharmacist". The South African Medical and Dental Council did not reply. However, the Minister of Health and the Legislators were sympathetic to the cause of pharmacy and during March 1984 amending legislation to the Medical Dental and Supplementary Health service Professions Act was passed by parliament.

The contention was that the following problems would be addressed:-

. Conditions under which doctors could dispense

. Financial record keeping

. Registration

. An inspectorate with certain enabling powers was created

The subsequent letter which was sent out to practitioners by the South African Medical and Dental Council in December 1984 governing the conditions for dispensing medicines, has been rejected by the Pharmaceutical Society of South Africa. Both the South African Medical and Dental Council and the Minister was informed. The Pharmaceutical Society believes that the passing of the legislation has achieved exactly the opposite of what was intended. In the first few weeks some 2263 doctors had registered. The Pharmaceutical Society is becoming frustrated and cannot afford to wait any longer. The question being asked is "why is their future in the hands of the South African Medical and Dental Council"?

The doctor is increasingly involved in medicine distribution, -a role which the Pharmaceutical Society believes is in the confines of the pharmacist. With the legislation now in force, a doctor who wishes to dispense must register with the South African Medical and Dental Council. The question asked is why not with the Pharmacy Council? The Pharmaceutical Society is now dismayed that with a stroke of the legislative pen Statutory Bodies now control medicine distribution. It would be pertinent to conclude this section by quoting Donald Sutherland.

"The Pharmaceutical Society is not against the true dispensing medical practitioner, provided there is no pharmaceutical service readily available. We object to the fact that 1800 doctors are within five kilometers of a Pharmacy and are in fact

competing with the pharmacist on economic terms. We have proof that many of these doctors are breaking the law, as they are using unqualified, unregistered people to do their dispensing".

4.1.2. (c) NATIONAL MEDICAL AND DENTAL ASSOCIATION

Fundamental to National Medical and Dental Association's policy is the basic acceptance that in South Africa we have communities with different socio economic profiles and different access to the decision making process. The majority of the people fall in the lower income bracket and consequently their ability to pay for medical care is greatly limited. Hence the general practitioner plays the major role in providing medical care primarily because he is able to provide services. National Medical and Dental Association fears that restriction of dispensing by the general practitioner will have negative effects upon the provision of an essential service and upon the health of the people.

4.1.2. (d) THE SOUTH AFRICAN ACADEMY OF FAMILY PRACTICE

According to the Chairman of the South African Academy of Family Practice; "The Academy does support existing legislation which enshrines the general practitioner's inalienable right to dispense. It does not have any policy on the registration of doctors. However, it has reflected concern on the proposed restriction/curtailment of dispensing by doctors as it believes that this might result in the lowering of standards of Primary Care/general practice in South Africa since many South Africans might be deprived of their medications, especially where there was an all inclusive fee.

The Academy believes research should be done to ascertain the extent of dispensing in South Africa and to what extent this 'subsidised' health care in the form of medicines being dispensed where these might not have been. The Academy is still

As an Academic Body the whole issue of dispensing should be researched with the objective, as mentioned in mind"

4.1.2. (e) SOCIETY OF DISPENSING FAMILY PRACTITIONERS

This Society would like the South African Medical and Dental Council to rescind its ruling that doctors dispensing medicines must register with the Council.

The Society finds it surprising that the Council goes about restricting doctors from rendering an essential service, particularly the lower income group communities who benefit the most from dispensing.

The Society has reacted violently to the restraints laid down by the South African Medical and Dental Council on the dispensing of medicines. It has also requested the Competitions Board to look into certain restrictive practices.

The Society has totally rejected the guidelines recommended by the adhoc committee of the South African Medical and Dental Council and South African Pharmacy Council on the dispensing of medicines by doctors.

4.1.2. (f) NATIONAL GENERAL PRACTITIONERS GROUP OF THE MEDICAL ASSOCIATION OF SOUTH AFRICA

The sub-committee for dispensing doctors of the National General Practitioners Group was established in October 1985. This sub-committee is now the official voice of the various dispensing doctors committees throughout South Africa. Prior to October 1985 the case for the dispensing doctor had been handled by a number of un-coordinated organizations.

At a meeting at the Carlton Hotel in August 1985, followed by a second meeting in Port Elizabeth in September 1985, it was decided that differences of opinion between various groups should be ignored and that nothing could really be achieved without a co-ordinated approach by a recognized body. This resulted in the birth of the sub committe for dispensing doctors

of the National General Practitioners Group. The memorandum dated 3/12/85 of the sub-committee for dispensing doctors of the National General Practitioners Group, clearly state their policies and opinions. "The spirit and intention of existing legislation should be respected despite certain shortcomings and impracticalities, and some endeavour must be made to effect some change to the benefit of the dispensing doctor and his patient." The memorandum further states that there is no purpose in a consultation, if a doctor is unable to ensure whether his patient receives medication, once having made a diagnosis and the decision to treat. It is further stated that dispensing is part of a doctors responsibility and professional duty and that he should be free to dispense without any restriction.

According to the South African Medical and Dental Council giudelines on dispensing, one of the conditions stipulated is that "Dispensing should be incidental to a doctors practice and to his other professional duties". The National General Practitioners Group have motivated to the Parliamentary Committee of Medical Association of South Africa, that in order to avoid confusion the word "incidental" be replaced by the phrase "only a part of".

The memorandum strongly stresses that doctors must desist from commercializing dispensing and using terminology such as "profit" on medicines. Instead "compensation" received for services rendered would be more appropriate in keeping with the spirit and tradition of the dispensing doctor. For this reason Medical Association of South Africa's recommendation of charging 50% to the purchase price of drugs is an acceptable fee to the National General Practitioners Group , for this dispensing service rendered.

The National General Practitioners Group has made recommendations to the South African Medical and Dental Council to accept Medical Association of South Africa's formula for the costing of medicines.

The restriction on the prepackaging of medicines, and the voluminous clerical work involved, in record keeping, labelling etc. is deemed to be totally impractical, considering the work load and the type of patient population most dispensing doctors service.

The National General Practitioners Group fears that these impediments may discourage doctors from dispensing. This could have far reaching implications as there may be greater patient dependence on an already heavily over subscribed state medical service. Failure also to provide such a needed essential service could lead to uncalled for political unrest.

4.1.3. (a) REPRESENTATIVE ASSOCIATION OF MEDICAL SCHEMES

Did not respond to the open ended questionaire sent to them.

4.1.3. (b) NATIONAL UNION OF LEATHER WORKERS (PIETERMARITZBURG)

Responded to the open ended questionaire sent to them.

They "prefered the doctor to dispense medicines to his patients. Past experience had proven to them, that when prescriptions were issued at most times, the scripts found their way to the waste paper basket, the reason being that employees had no cash to pay the Chemist during mid-week especially.

Ever since the present consultation and dispensing started, our National Health Fund is in a reasonable healthy financial position. Prior to this our "Sick Fund" was a very sick one and members were continuously restricted to the medicines they could get. Under no circumstances will the National Industrial Council of the Leather Industry which administers the sick fund revert to question 2." ie. (Do you prefer the doctor to consult only and to issue a separate prescription for medicines to be purchased from the Chemist?)

4.1.3. (c) PIETERMARITZBURG INDIAN CHILD AND FAMILY WELFARE SOCIETY

In response to the open ended questionaire, the following information was received:

1. It would be more convenient if the doctor dispenses medicine together with consultation.
2. It is also time consuming to go to a Chemist and wait for the medicines.
3. It probably will be less expensive if the doctor dispenses medicines as there is no uniformity in the price of medicines at the Chemist.

On numerous occasions reference has been made to the recommendations of a joint Adhoc committee, consisting of members of the South African Medical and Dental Council and the South African Pharmacy Council.

The central issues in the dispensing problem, appear to revolve around the question of Trading, Profiteering and proximity to a pharmacy, and unfair competition with a pharmacist.

In view of this it would be appropriate to review the adhoc committees recommendations:-

4.1.4 STATEMENT BY THE PRESIDENT OF THE S.A.M.D.C. AND THE PRESIDENT OF THE S.A. PHARMACY BOARD -28/6/1985

DISPENSING OF MEDICINES BY DOCTORS

"The Executive Committee of the S.A.M.D.C. on recommendation of a joint Ad Hoc Committee, consisting of members of the Council and the S.A. Pharamacy Board decided that the following statement in connection with legal conditions, regulations and policy with respect to dispensing undertaken by registered persons be made and brought to the attention of registered persons as follows:

1. That doctors may not keep an "open shop", that doctors "may

not trade in medicines" and that they have to comply with all the legal requirements with respect to the personal handling of dispensing, labelling and the keeping of records of dispensed remedies, registration of the activity of dispensing and the keeping of records regarding the purchase and sale of remedies, also that the dispensing by a doctor should be "incidental" to his other professional duties.

2. That the following acts by a doctor will be interpreted by the Medical Council as "trading" in medicines or that it will be considered as falling outside the scope of "incidental" dispensing (supply of medicine).

   2.1 The purchasing of medicines for practice purposes outside of one's practice i.e. in association with other persons or doctors.

   2.2 The prescribing or dispensing of medicine of a manufacturer or distributor in which the person himself or associated doctors or immediate family members have a direct financial interest.

   2.3 The joining of doctors in interest groups with the aim of purchasing medicine or who in spirit act as "trading doctors" or who advertise themselves as dispensing doctors.

   2.4 The dispensing of remedies to patients at a price greater than the suggested retail price of the Pharmaceutical Society minus 20%.

   2.5 The generating of a nett income from the dispensing part of the practice of more than 10% of the total professional nett income (see no 4).

   2.6 The rendering by the doctor of an account that does not specify seperately the parts relating to professional services and to medicine dispensed.

3. Where the S.A.M.D.C. receives information that doctors infringe the Act, regulations or policy with respect to dispensing, inspection of practices, if necessary, will be conducted and/or investigation will be conducted if indicated, with the strict implementation of disciplinary measures for which provision is presently provided for. This includes the possibility of a caution, a repremand, suspension or erasure, and the withdrawal or limitation of the right to dispense.

4. In deciding if a doctor "trades in" medicine in relation to abovementioned views, this will at present be judged in relation to point 2.5 above in terms of the reasonable availability of a pharmacy. It is also envisaged for the future that doctors working under special circumstances may apply for exemption from some of the afore mentioned provisions."

4.1.5. IMPLICATIONS OF THE RECOMMENDATIONS OF THE AD HOC COMMITTEE OF THE S.A.M.D.C. AND THE S.A. PHARMACY BOARD

The joint statement made by the President of the South African Medical and Dental Council and the President of the S.A. Pharmacy Board supporting the recommendations of the joint Ad Hoc committee, somewhat reflects the South African Medical and Dental Council's bias towards the Pharmacy profession.

A massive amount of almost R20,000 was incurred by the Transvaal Committee for dispensing doctors, in seeking legal opinion and advise and in despatching a legally drawn memorandum to the South African Medical and Dental Council critisizing and rejecting the recommendations of the Joint Ad Hoc Committee.

Furthermore a threat of an interdict against the South African Medical and Dental Council was also imminent, had the South African Medical and Dental Council fully ratified and accepted these recommendations. Over and above this many professional associations, already alluded to in this chapter intensely

pressurised the South African Medical and Dental Council to totally reject the joint Ad Hoc Committees recommendations.

As a result these recommendations were not ratified but merely noted, when the full Council of the S.A.M.D.C. met in October 1985. However these recommendations will once more be tabled for discussion when the full Council of the S.A.M.D.C. meet again in October 1986. The sub-committee for dispensing doctors of the National General Practitioners Group as well as various other professional associations have totally rejected these recommendations.

On carefully scrutinizing these recommendations as well as the dispensing legislation, it becomes evidently clear that the Pharmacy profession has been afforded legal protection against the dispensing doctor at the expense of the patient, who has been given no consideration whatsoever.

At this stage it would be pertinent to review as to which members of the South African Medical and Dental Council served on the Ad Hoc Committee:

1. Dr. J.A. van der Riet (Retired G.P., attached to universities, hospital, Bloemfontein)
2. Dr. G.J. Pistorius (Department of Family Practice, O.F.S. University.)
3. Dr. A.M. le Roux (Superintendent, Nelspruit Hospital.)
4. Professor Frans Geldenhuys (President S.A.M.D.C., Department of O&G, University of Pretoria.)

From the description of the medical practitoners it would be relevant and important to know their background as regards competence to judge this issue. Was any scientific research undertaken which motivated their decision? Why were the country's dispensing doctors numbering some 4000 not even consulted on this issue? On what information did they judge? There appear to be no answers to these questions.

It is tragic that the South African Medical and Dental Council has failed to fulfill one of its major obligations. If ethical codes and rules are formulated to protect patients interest, then the question asked is, why shackle the dispensing doctor with such stringent restrictions, if patients interest is foremost?

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CHAPTER FIVE - RECOMMENDATIONS

5. (1) Recommendations

5. (2) Conclusion

Bibliography

CHAPTER 5

5.1. RECOMMENDATIONS

As a result of the Pharmacy profession's campaign against the dispensing doctor, it has become imperative for dispensing doctors to establish a permanent secretariat, which would be able to explore the benefits of outside research, marketing and lobbying organizations, and, to ensure the best possible advantage for the general practitioner.

It is hoped that some of the functions of the permanent secretariat would be to :-

1. Constantly monitor Parliamentary debates, on all aspects which affect the profession.
2. Prevent the enactment of legislation deleterious to the profession and to health care as a whole.
3. Provide accurate and in-depth information to politicians at all levels on the needs of the profession.
4. Concern itself with providing Medical Association of South Africa with realistic data on costing of medicines and and fee structures in general practice.
5. Act as ombudsman on behalf of the dispensing profession in its dealing with governmental bureaucracy and the South African Medical and Dental Council.
6. Provide an insight into and report on the medico political scene, covering all aspects of health care in South Africa.

It is envisaged that with the formation of the sub-committee for dispensimg doctors of the National General Practitioners Group the concept of a full time secretariat in the near future will become a reality. Preliminary estimates indicate a capital investment of R300,000 to launch and maintain a campaign. A request of R100 per dispensing doctor has been made.

The legal experts have recommended that any proposed amendment to the Medical Dental and Supplementary Health Services

Professions Act 58 of 1984, has to be scientifically motivated. This means that it must be shown that the Amendment will be in the interest of patients who cannot afford to buy medicimes from a pharmacy. They strongly feel that no other consideration can be of any relevance.

Section 52(A) of the Medical Dental and Supplementary Health Services Professions Act 58 of 1984 if amended showed most promise, provided the basis of the exemption is widened.

If amended Section 52(A) will read as follows:-

"The Council may, if it is of the opinion that the consulting rooms of a medical practitioner contemplated in Section 52 (1) (a) are not situated within a reasonable distance of a retail pharmacy, or is of the opinion that the substantial practice of such medical practitioner consists of patients for whom it would be an economic hardship to obtain medicine from a retail pharmacy or for whom such a retail pharmacy would be unsuitable having regard to their physical and other relevant circumstances, grant authority, subject to such conditions as it may deem fit to impose, for the supply by any person who is in the employment of such medical practitioner and who is registered as a nurse under the NURSING ACT 1978 (Act No. 50 of 1978), of any medicine mentioned in Schedule 1,2,3 or 4 to the Medicines and Related Substances Control Act 1965 (Act No. 101 of 1965), to any person under the treatment of such medical practitioner: Provided that such supply shall take place in accordance with the directions of such medical practitioner"

The following recommendations will have to be made immediately to the sub-committee for dispensing doctors of the National General Practitioners Group:-

1. They must indicate to Medical Association of South Africa of the proposed Amendment to Section 52(A),and Medical

Association of South Africa must persuade the Minister of Health and the South African Medical and Dental Council to give the proposed Amendment consideration.

2. They must also indicate to Medical Association of South Africa that a memorandum substantiating the need for the proposed Amendment will be submitted to them.

3. Social welfare organizations must be informed of the consequences, as a result of the restrictions in dispensing. They can be an effective pressure group on Medical Association of South Africa and the South African Medical and Dental Council.

4. Socio economic surveys and assistance of academicians substantiating the claim that an Amendment to Section 52(A) is an absolute essential, and that without it, many thousands of poor patients will suffer great harm and loss.

5. The service of an "Health economist" of an international calibre such as Professor W.D. Reekie of the Wits Business School should be enlisted, to scientifically research that dispensing is actually very economical and to the advantage of the patient.

6. A comprehensive and independant study into the relationship between dispensing doctors and the delivery of health care in South Africa, as well as the legal and business implications of the dispensing restrictions, should be commisioned -this will ensure that the medical profession has sufficient evidence on which to base its case.
   There are specialist firms such as Ernst and Whinney Management Services Limited, Cape Town, who have the

7. One of the most important prerequisite would be that no matter what scientific study is undertaken, the study should have the full backing of Medical Association of South Africa. In addition Medical Association of South Arica must be requested to approach the necessary decision-makers in order to clear the way for an effective presentation of the medical profession's case, backed by the results of the study.

8. A request to be made to all Medical Universities to include Medical dispensing and its implications in the curriculum.

9. The assistance of Pharmaceutical experts must be obtained to determine whether the quality of medicines, once decanted and prepacked is still able to maintain its therapeutic efficacy, safety and quality. If opinions support decanting and prepacking then patients will benifit cost wise and the doctor and his staff time wise -time which could be fruitfully spent consulting and explaining.
   The motivation will have to be made to the Department of National Health and Population Development, in terms of the Medicines Control Act 101 of 1965.

If Section 52(A) is amended, many difficulties will be obviated as the employment of a registered nurse will now no longer be determined by the proximity to a Pharmacy, but rather by the circumstances of the patient. She will be able to dispense under the supervision of the doctor, Schedule 1 to 4 medicines. This would also overcome the problem of "personally compounding and dispensing", and will also ensure effective control, in the doctors absence of the the dispensary and Stock Room.

The definition of what constitutes "trading in medicines", the "costing of medicines to Medical Aid patients", and the question of profit; relevant and important as it may be, unfortunately falls outside the ambit of this dissertation.

5.2. CONCLUSION

This review clearly indicates that the dispensing legislation, presently designed for first world communities, become totally impractical when applied to third world communities. 80% of the deprived and voiceless population referred to as the third world, will suffer grave consequences, if the Legislators apply the letter of the law. The old aphorism "you pay the same price as a white, but earn the salary of a non-white", is as realistically true today, as it was two decades ago.

The present recession, the falling value of the rand, the 20% increase in the cost of medical services, and the continually increasing cost of basic foodstuffs and necessities, must further aggravate the socio-economic status of the communities serviced by dispensing doctors.

The purpose of legislation should ideally be to protect patients from unscrupulous exploitation and profiteering from both the doctor and the pharmacist. The present Act certainly restricts the doctor, but affords the patient no protection whatsoever from the pharmacist. The single most important and fundamental issue, has, as yet never been addressed in the legislation, that is, "WHAT IS IN THE BEST INTEREST OF THE PATIENT?"

It is the authors opinion that due to the restrictive nature of the dispensing legislation, every dispensing doctor will fall foul of the law at some stage. To function within the legal confines of the legislation is virtually impossible, and will leave doctors with the only available alternative, and that is to stop dispensing. The far reaching consequences of such an

Act, will lead to chaos and disaster for the majority of the patient population serviced by dispensing doctors.

Dispensing is a matter of economical and political relationship, and consequently, political decisions influence and determine doctors' decisions to dispense or not. However, most doctors dispense medicines in response to the needs of the communities they service.

The medical profession will need to become more politically involved, and try collectively, to overcome any legal impediments and obstacles, as well as to change those features, which are antithetical to good health in this country.

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APPENDIX

(1) Questionnaire

(2) Medical Association of South Africa and

Pharmaceutical Association Declaration

(3) Government Gazette

Medical Dental and Supplementary Health Services

Professions

Amendment Act No. 58 Of 1984

KINDLY COMPLETE THE QUESTIONNAIRE BELOW

1. Do you prefer the doctor to consult and dispense medicines to his patients?

| YES | NO |

OR

2. Do you prefer the doctor to consult only and to issue a separate prescription for medicines to be purchased from the chemist?

| YES | NO |

REASONS

JOINT DECLARATION BY THE MEDICAL ASSOCIATION OF SOUTH AFRICA AND THE PHARMACEUTICAL SOCIETY OF SOUTH AFRICA

Prof. J.N. de Klerk
Chairman: Federal Council, Medical Association of S.A.

Gordon Dowsett
President: The Pharmaceutical Society of S.A.

EACH medical practitioner and each pharmacist is personally responsible for his own conduct.

In order to foster good relations between medical practitioners and pharmacists and to ensure inter-professional ethical conduct, the Medical Association of South Africa and the Pharmaceutical Society of South Africa are happy to bring the following to their members' attention:

a) **With respect to medical practitioners,** attention is drawn to the fact that dispensing of medicines is subject to the following conditions:

1. That the medical practitioner must personally dispense medicines (mixing or preparing) except where the Secretary for Health in accordance with the provisions of section 52A of the Medical, Dental and Supplementary Health Service Professions Act, — in the case where he is aware that the consulting rooms of a medical practitioner are not situated within a reasonable distance from a retail pharmacy, grant authority subject to such conditions as he may deem fit to impose, for the supply by any person who is in the employment of such medical practitioner and who is registered or enrolled as a nurse under the Nursing Act of any medicine mentioned in Schedules 1, 2, 3 or 4 of the Medicines and Related Substances Control Act, to any person under the treatment of such medical practitioner: provided that such supply shall take place in accordance with the directions of such medical practitioner.
2. A medical practitioner may supply medicines only to his own patients or the patients of his partners or of another medical practitioner with whom he is associated as principal or assistant or locum tenens.
3. A medical practitioner may not keep an open shop or a pharmacy and may not place himself in economic competition with a pharmacist. In other words, he may not dispense the prescriptions of other medical practitioners (whether specialists or general practitioners).
4. A medical practitioner may not involve himself in the manufacture of merchandise, sale, advertisement or promotion or any other activity amounting to trading in any medicine described in the Medicines Control Act. This does not prohibit a medical practitioner acquiring shares in a public company which manufactures or markets medicines or while in a specific appointment in the employ of a pharmaceutical concern, performing such duties which normally relate to such an appointment.
5. A medical practitioner may only recover his basic costs as well as the direct variable costs on the medicines handled by him; he may not, however dispense with profit as his motive.
6. A medical practitioner may not accept or receive from a pharmacist any commission or other reward in connection with a prescription.
7. A medical practitioner may not prescribe or give preference to any medicine in such a way that this action will result in any advantage to him.
8. A medical practitioner (or his staff) may not refer or recommend any prescription to a specific pharmacy.
9. A medical practitioner may not advertise in any manner the fact that he dispenses.
10. A medical practitioner must ensure, according to the provisions of the Medicines Control Act, that the necessary controls and book records are kept in respect of medicines dispensed by him.

b) **With respect to pharmacists** their attention should be drawn to their not committing the following actions:

1. The substitution or omission of ingredients in a prescription without consulting with the prescriber or obtaining his approval.
2. The expression of critical comment to a patient about the composition or merits of a prescription or about the professional ability of the prescriber.
3. Establishment or occupation of a pharmacy in premises through which there is an entrance to or an exit from a medical practitioner's consulting rooms.
4. Establishment of direct radio or telephone communication between a pharmacy and medical practitioner's consulting rooms.
5. The recommending of a patient to a specific medical practitioner.
6. Participating in the preparation of secret prescriptions or cipher prescriptions.
7. Diagnosis and treatment of illnesses where the available information indicates that the person should be referred to a medical practitioner.

MEDICAL, DENTAL AND SUPPLEMENTARY HEALTH SERVICE PROFESSIONS AMENDMENT ACT, 1984 Act No. 58, 1984

GENERAL EXPLANATORY NOTE:

[ ] Words in bold type in square brackets indicate omissions from existing enactments.

Words underlined with solid line indicate insertions in existing enactments.

ACT

To amend the Medical, Dental and Supplementary Health Service Professions Act, 1974, so as to replace certain obsolete expressions and references; to make provision for the designation of additional members of the executive committee of the South African Medical and Dental Council; to provide for the investigation of cases of alleged improper or disgraceful conduct by persons registered in terms of the said Act; to further regulate the dispensing of medicine by a medical practitioner or dentist; and to do away with the determination by the said Council of fees for medical services rendered to members or dependants of members of registered medical schemes; and to provide for incidental matters.

(Afrikaans text signed by the State President.)
(Assented to 17 April 1984.)

BE IT ENACTED by the State President and the House of Assembly of the Republic of South Africa, as follows:—

Amendment of section 1 of Act 56 of 1974, as amended by section 1 of Act 33 of 1976, section 12 of Act 36 of 1977, section 1 of Act 52 of 1978 and section 1 of Act 38 of 1982.

1. Section 1 of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (hereinafter referred to as the principal Act), is hereby amended—

(a) by the substitution for the definition of "Minister" of the following definition:

"'Minister' means the Minister of Health and Welfare:"; and

(b) by the deletion of the definition of "tariff of fees".

Amendment of section 5 of Act 56 of 1974, as amended by section 2 of Act 52 of 1978.

2. Section 5 of the principal Act is hereby amended—

(a) by the substitution for paragraph *(a)* of subsection (1) of the following paragraph:

"*(a)* the **[Secretary for Health]** Director-general: Health and Welfare;"; and

(b) by the substitution for subsection (2) of the following subsection:

"(2) The member referred to in subsection (1) *(a)* may designate an officer of the Department of Health and Welfare who is a medical practitioner, to act in his stead as an alternate member of the council.".

Amendment of section 10 of Act 56 of 1974.

3. Section 10 of the principal Act is hereby amended by the substitution for subsection (1) of the following subsection:

"(1) There shall be an executive committee of the council consisting of the president, the vice-president, the **[Secretary for Health]** Director-General: Health and Welfare (or, in his absence, the officer designated in terms of section 5 (2)) and not less than five other members of the council designated by the council, of whom not less than three shall be medical practitioners, one shall be a dentist and one shall be a member appointed under section 5 (1) *(b)* (iv).".

Amendment of section 11 of Act 56 of 1974, as amended by section 3 of Act 52 of 1978.

4. Section 11 of the principal Act is hereby amended by the deletion of subsection (2A).

Insertion of section 41A in Act 56 of 1974.

5. The following section is hereby inserted in the principal Act after section 41:

"Manner in which certain investigations may be instituted.

41A. (1) The registrar may with the approval of the president appoint an officer of the council as investigating officer for the purposes of this section.

(2) If the registrar deems it necessary, he may with the approval of the president and on such conditions as the council may determine, appoint any person, other than a member of the council or of a professional board, who is not in the full-time employment of the council as investigating officer for a particular investigation, or to assist the investigating officer contemplated in subsection (1) with a particular investigation.

(3) A person appointed in terms of subsection (2) shall, for the purpose of the investigation in question, have the same powers and duties as the investigating officer contemplated in subsection (1).

(4) The registrar shall issue to every person appointed under subsection (1) or (2) a certificate to the effect that he has so been appointed, and, in the case of a person appointed for, or to assist with, a particular investigation, that he has been appointed for such investigation, and in the exercise of his powers and the carrying out of his duties that person shall on demand produce such certificate.

(5) If the registrar deems it necessary for the achievement of the objects of this Act, he may institute or cause to be instituted an investigation—

(a) into an alleged contravention of, or failure to comply with, any provision of this Act;

(b) in order to determine if any provision of this Act applies to a registered person;

(c) into a charge, complaint or allegation of improper or disgraceful conduct by a registered person;

(d) into the affairs or conduct of a registered person, if requested to do so by a person by reason of allegations confirmed upon oath.

(6) The registrar or an investigating officer who carries out an investigation in terms of this section may—

(a) at any time reasonable for the proper performance of the duty, with the approval of the president and without prior notice enter upon, enter and search any premises, and carry out such an investigation and make such enquiries as he may deem necessary;

(b) while he is on the premises or at any other time request any person found on the premises to immediately or at a time and place determined by the registrar or investigating officer—

(i) produce to him any book, document or thing relating to, or which he on reasonable grounds believes to relate to, the matter which he is investigating, and which is or was on the premises, or in the possession or custody or under the control of that person or his employee or agent;

(ii) furnish such explanations to him as he may require in respect of any such book, document or thing;

(c) at any time and at any place request any person who has or is suspected on reasonable grounds of having in his possession or custody or under his control any book, document or thing relating to the matter which he is investigating, to produce it immediately or at a time and place determined by the registrar or investigating officer, examine such book, document or thing, make extracts from and copies of the book or document, and request any person to furnish such explanations to him as he may require in respect of any entry in that book or document;

(d) seize any book, document or thing which in his opinion may afford evidence of any alleged contravention of, or failure to comply with, any provision of this Act, or of any alleged improper or disgraceful conduct contemplated in this Act, and retain that book, document or thing until any criminal or other proceedings in terms of this Act have been disposed of or until it has been decided not to proceed with any contemplated proceedings.

(7) The registrar or investigating officer shall give a receipt to the person to whose affairs any book or document seized under subsection (6) relates, and that person may make copies thereof and extracts therefrom during office hours and under such supervision and on such conditions as the registrar or investigating officer may determine.

(8) *(a)* The registrar or an investigating officer who carries out an investigation under this section, shall compile a report of the investigation, and a report compiled by an investigating officer shall be submitted to the registrar.

(b) (i) If such a report reveals *prima facie* evidence of improper or disgraceful conduct contemplated in this Act and no complaint, charge or allegation regarding the conduct in question has been made for the purpose of an inquiry in terms of section 41 or 48, such report shall be deemed to be a complaint made for that purpose, and the registrar shall serve a copy thereof on the registered person concerned.

(ii) If such a report reveals *prima facie* evidence which in the opinion of the president makes it desirable that an inquiry in terms of section 51 be instituted, the registrar shall serve a copy thereof on the registered person concerned.

(c) To the extent that such a report contains statements of witnesses which would have been admissible as oral evidence at an inquiry in terms of section 41, 48 or 51, the provisions of section 213 of the Criminal Procedure Act, 1977 (Act No. 51 of 1977), shall apply *mutatis mutandis* in respect of those statements at such an inquiry.

(9) *(a)* A person who carries out or assists with the carrying out of an investigation in terms of this section, shall keep or assist in preserving secrecy in respect of all facts which come to his notice in the performance of his functions, and shall not disclose any such fact to any person except the registrar, the president, the council, the professional board concerned, or the public prosecutor concerned in the case of an offence in terms of this Act, or by order of a court.

(b) Notwithstanding the provisions of paragraph (a), no personal particulars regarding a patient shall be disclosed to any person except by order of a court or with the consent of the presiding officer at an inquiry contemplated in section 41, 48 or 51.

(10) (a) If the council at an inquiry in terms of section 41, 48 or 51, or in a case referred to the council by the registrar, is satisfied that the person contemplated in subsection (5) (d) had no reasonable grounds to ask for an investigation, the council may order that the costs of the investigation by the registrar or the investigating officer concerned, or such portion thereof as the council may determine, be paid by that person to the council.

(b) Such an order shall be executed as if it were a judgment in a civil case in a magistrate's court.

(11) Any person who—

(a) refuses or neglects to produce any book, document or thing, or furnish any explanation to any person who is in terms of this section authorized to ask therefor, or who furnishes an explanation knowing it to be false;

(b) hinders or obstructs the registrar or an investigating officer in the exercise of his powers or the carrying out of his duties;

(c) pretends that he is the registrar or an investigating officer;

(d) contravenes a provision of subsection (9),

shall be guilty of an offence and liable on conviction—

(i) in the case of a contravention contemplated in paragraph (a), (b) or (c), to a fine not exceeding R500 or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment;

(ii) in the case of a contravention contemplated in paragraph (d), to a fine not exceeding R1 500 or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

(12) The provisions of this section shall be without prejudice to the power of any authority to institute an investigation into any alleged contravention of, or failure to comply with, any provision of this Act.".

Substitution of section 52 of Act 56 of 1974.

6. The following section is hereby substituted for section 52 of the principal Act:

"Medical practitioners and dentists may dispense medicines.

52. (1) (a) Every medical practitioner or dentist whose name has been entered in the register contemplated in subsection (2) shall, on such conditions as the council may determine in general or in a particular case, be entitled to personally compound or dispense medicines prescribed by himself or by any other medical practitioner or dentist with whom he is in partnership or with whom he is associated as principal or assistant or *locum tenens*, for use by a patient under treatment of such medical practitioner or dentist or of such other medical practitioner or dentist: Provided that he shall not be entitled to keep an open shop or pharmacy.

(b) The council may, on such conditions at it may determine, exempt any medical practitioner or dentist from the requirement of registration contemplated in paragraph (a), and may, after an investigation, withdraw such exemption.

(2) The registrar shall keep a register in which he shall enter, at the direction of the council, the name and such other particulars as the council may determine of a medical practitioner or dentist—

(a) who within three months after the commencement of the Medical, Dental and Supplementary Health Service Professions Amendment Act, 1984, submits proof to the satisfaction of the registrar that at such commencement he compounded or dispensed medicine as contemplated in subsection (1) *(a)* in the practice of his profession; or

(b) who informs the registrar in the prescribed manner of his intention to compound or dispense medicine in the practice of his profession as contemplated in subsection (1) *(a)*.

(3) The council may, after an investigation, direct that the name of any person be removed from the register contemplated in subsection (2), or prohibit him for a specified period from making use of the right contemplated in subsection (1).

(4) The council may determine fees to be paid for the entering of a name in the register contemplated in subsection (2).".

Substitution of section 52A of Act 56 of 1974, as inserted by section 17 of Act 36 of 1977.

7. The following section is hereby substituted for section 52A of the principal Act:

"Authority for supply in certain circumstances of certain medicines by certain registered persons in accordance with directions of medical practitioner.

52A. The **[Secretary for Health]** council may, if **[he]** it is of the opinion that the consulting rooms of a medical practitioner contemplated in section 52 (1) *(a)* are not situated within a reasonable distance of a retail pharmacy, grant authority, subject to such conditions as **[he]** it may deem fit to impose, for the supply by any person who is in the employment of such medical practitioner and who is registered **[or enrolled]** as a nurse under the Nursing Act, **[1957 (Act No. 69 of 1957)]** 1978 (Act No. 50 of 1978), of any medicine mentioned in Schedule 1, 2, 3 or 4 to the Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965), to any person under the treatment of such medical practitioner: Provided that such supply shall take place in accordance with the directions of such medical practitioner.".

Repeal of section 53A of Act 56 of 1974, as inserted by section 10 of Act 52 of 1978 and amended by section 8 of Act 43 of 1980 and section 1 of Act 66 of 1981.

8. Section 53A of the principal Act is hereby repealed.

Amendment of section 61 of Act 56 of 1974, as amended by section 10 of Act 33 of 1976, section 18 of Act 36 of 1977, section 9 of Act 43 of 1980 and section 4 of Act 38 of 1982.

9. Section 61 of the principal Act is hereby amended by the deletion of subsection (2A).

Short title and commencement.

10. This Act shall be called the Medical, Dental and Supplementary Health Service Professions Amendment Act, 1984, and shall come into operation on a date fixed by the State President by proclamation in the *Gazette*.

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