The South African Medical and Dental Council:
A Suitable Case for Treatment

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Health professionals have a large degree of power in that they deal with people in their most vulnerable and needy situations. That power must be balanced with responsibility and a code of ethics, because there is a difference between what CAN be done and what SHOULD be done. Health professionals are, in part, controlled by the laws of the land, but, to a very large extent, they are self-governing. This is often explained as being necessary to allow their conduct to be independently devoted to the genuine good of their patients, and not to be subject to political controls.

Tragically, in South Africa, the South African Medical and Dental Council (SAMDC) has, for years, shown gross and consistent political and racial bias in its control of the health professions.

No Promotion of Health

The first duty of the Council, according to its governing act, is "to assist in the promotion of the health of the population of the Republic". As we shall see, it has never yet taken effective enough action to carry out this duty, while many of its decisions have, in fact, damaged the health of the population. Though the Act does not refer exclusively to the white population, the Council has not shown an understanding of or interest in the health needs and views of the great majority of the population. Furthermore, it has never advised the Minister of Health against the many ideological follies which have ruined South African health care, despite the fact that this is one of its functions.

A primary duty of medical and health professional councils is to exercise responsible control of medical and health sciences education, to ensure that the country's medical and other health sciences graduates meet the highest relevant standards, so as to be able to meet the nation's health care needs with technically competent and humane care.

Inappropriate Standards

However, their consistent decisions to define excellence exclusively in terms of the medicine practised by super-specialists in very expensive hospitals with very expensive equipment have been damaging to health care. A system of training that has so reliably ignored the real needs of Southern Africa, while so effectively meeting the needs of the First World to which 50% or more of their graduates have fled, cannot be called excellent.

True excellence lies in doing what needs to be done, as well as it can be done, and wherever it needs to be done. Why can't the Council and the academics it represents see the actual excellence in the practice of effective minimal-technology progressive primary and rural health care? Medicine that is not devoted to the needs of all of society is never excellent, however glittering its practitioners and their shiny technical toys.

At no time has the Council ever seriously tackled this problem, despite being the only body in the nation with the power to do so.

Inconsistent Approach to Overseas Graduates

Related to this task, the SAMDC was entrusted with assessing the training of overseas graduates in the health professions, to decide whether they have appropriate skills to be worthy of registration to work in this country. For many years, this task, too, was managed with blistering negligence. As apartheid prevented numerous able black South African students from attending our medical schools, such students could only hope to qualify in the health professions if they could train overseas.

The SAMDC's system of recognising overseas qualifications was based primarily on political considerations, ignorance of educational standards, and racial bias. Without any reliable system of visiting and inspecting overseas schools, or their curricula or examinations, and without collaborating with the equivalent Councils in other countries, the SAMDC devised a bizarre classification, dividing the world into three classes.

Graduates from countries in category A could be registered promptly without examination. Graduates in category B needed to pass a feeble English language test, and a "Legal/ethical" examination, which consis-

South African doctors about to sit for exams to qualify to practice in the US. How many have left the country? *Photo: The Star*

tently ignored the entire field of medical ethics (see below), but stuck to partly obsolete medical etiquette, with questions about the maximum permissible size of a doctor's brass name plate! Category C consisted of all other countries, whose graduates had to pass a more complex examination, dealing with all pre-clinical and clinical subjects, but very inefficiently.

Britain, Australia and Canada were placed in the first category. Countries in Europe were excluded from the privileged list, but there were two exceptions which were given special privileges, namely Belgium and the Netherlands, despite the fact that all countries in the European Economic Community are recognised as having absolutely equivalent degrees. There is not a scrap of evidence that the standards of training in Belgium and the Netherlands are any higher than, for example, Scandinavian countries or Germany, but their graduates almost speak Afrikaans.

Although the regulations specifically require the Council to be assured that foreign graduates are able to speak English, not Afrikaans, the Council ignored this requirement. Malaysia was on the A list, for reasons no one could explain, but Singapore was not. Canada was on the A list, but

the United States was not, although the standards of these two countries are identical. Thus, a graduate of Harvard University was required by the SAMDC to take an English Language test, while a French-speaking graduate of a Canadian school like Laval had no need to do so!

Zimbabwe's graduates were recognised with A list status only if they graduated prior to 1 January 1985. What disaster happened on that day to plunge Zimbabwe's standards into disrepute? India's graduates also fell from grace when India began to take a stronger anti-apartheid stance. Israeli graduates were once on the C list until Israeli political and military co-operation with South Africa increased. They were promptly promoted to the privileged A list. There was, however, never any evidence of changes in educational and clinical standards.

The examination was disgracefully chaotic: you might be told the paper would include so many hundred multiple choice questions on a specified range of topics and, on arriving in the hall, find it consisted of only 5 essay questions, on other topics. There was a very high failure rate.

The Council adopted a policy that anyone who failed the exam twice would be barred from ever being fully registered to practice in South Africa. At one stage, this even applied to those who merely failed to sit it a second time at the very next sitting. We discovered cases of this cruel rule

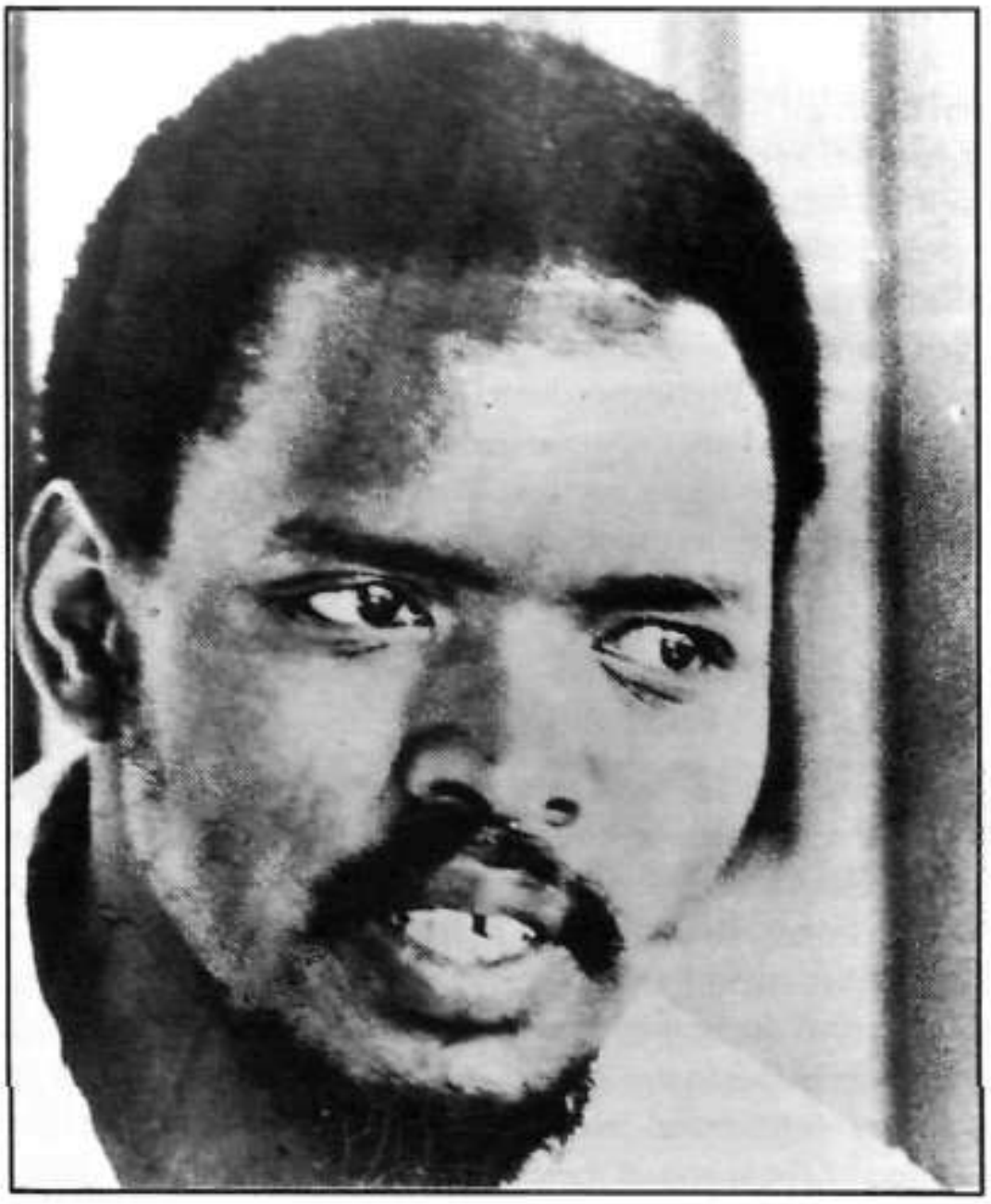
being applied to a woman who could not sit the exam as she was giving birth that day, and to another black doctor who was undergoing an operation at the time of the exam. The Council wrote to tell him that he could now not ever be fully registered, but it did ask him to "get well soon".

Yet, these very same doctors who failed the exam, which appeared designed to fail them, were generally allowed to work under a special restricted registration. This limited them to a particular job, severely disadvantaged as to conditions and pay, and subject to losing their registration by the superintendent. They were restricted to working exclusively with black patients. The SAMDC never explained why, if these doctors were considered too ignorant and badly qualified to be allowed to practice freely on white patients or in private practice, they were considered nonetheless sufficiently qualified to limit their practice to black patients at government hospitals, who lacked any alternative. This was unethical and discriminatory practice.

Unethical conduct

The other area of primary responsibility for medical and health professional councils is the promotion and maintenance of high ethical standards of behaviour. Instead, it has often seemed as if the SAMDC was determined to promote and protect unethical conduct, so long as such conduct served the purposes of grand apartheid. The Council has a long history of finding no fault with many doctors whose professionally unethical conduct disturbed their colleagues. Doctors who refused to treat black patients, even when the patients died as a result of neglect, were not considered to merit severe disciplinary measures. In 1988, Dr Leon Venter was suspended for 3 months after being found to have acted unprofessionally when he refused to treat a patient who subsequently died from an asthma attack. Dr Venter's suspension was, in turn, suspended. Doctors who have behaved questionably with regard to political detainees have been found not to have acted improperly.

In the case of Dr. Benjamin Tucker, one of the doctors who examined Steve Biko while in detention in 1977, action was taken by the SAMDC only years after the incident, under intense local and international pressure. Tucker examined Steve Biko on two occasions and found no grounds for medical or hospital treatment. He was eventually found guilty of disgraceful conduct and suspended for 6 years, and it was only in 1985 that



Only after intense local and international pressure did the SAMDC do anything about the Biko case. *Photo: The Star*

he was taken off the medical roll. His suspension ended in October 1991.

Although South Africa is a signatory of major international conventions of medical ethics such as the Declaration of Tokyo, the Council has failed to enforce the requirements of such civilised standards. The Council has, in fact erred at an even more basic level. The practice of apartheid medicine was always irredeemably unethical. To design, plan and administer racially discriminatory health services was and still is unethical medical conduct, according to the most ancient laws of medical ethics. Yet, the SAMDC never in any way found fault with the racially discriminatory and unequal provision of health care, although it has the power to

stop such practices immediately.

Furthermore, the Council has failed to protect those doctors who have been harassed for acting ethically in opposing racist practices. In the 1980s, when Dr. Wendy Orr was working in the Area District Surgeon's office in Port Elizabeth, she raised the issue that detainees were being badly treated. She was immediately stopped from seeing detainees and she resigned soon thereafter.

The Council has also not objectively examined the ethical standards of its own conduct. Presidents have had significant relationships with major private health sector companies, while the Council needed to make decisions relevant to those sectors. The Council has also failed to act energetically when given proof that they have registered wholly unqualified "doctors", while such "doctors" continued to practice.

Conclusion

The time is long overdue for a total restructuring of the SAMDC and its related committees which control most health professionals in this country (apart from nurses). The recent appointment of a couple of token African and Indian members, who in no way represent anyone but themselves, and in no way represented views significantly different from those of the government, was no improvement. Only consistent pressure from the Overseas Medical Graduates Association (OMEGA), eventually combining with other democratic health workers organisations, has begun to remedy some of the worst of these faults.

It is more than time for a full public inquiry into the structure and functions of the SAMDC, and of its conduct and management in recent decades - for the sake of the health of the nation.

Dr. Michael A. Simpson was the elected president of OMEGA. OMEGA has now merged with other progressive health and welfare organisations to form the South African Health and Social Services Organisation (SAHSSO). He sits on the NEC of SAHSSO.