MDPCZ/85/14

Medical & Dental Practitioners Council of Zimbabwe
Disciplinary Bulletin

Volume 1

MDPCZ Disciplinary Bulletin JULY 2014

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Background

In terms of Section 112 of the Health Professions Act (Chapter 27:19) any allegations which might be a subject of an inquiry by the Disciplinary Committee of Council is investigated by the Executive Committee (EXCOM) through the Preliminary Inquiries Committee (PIC).

The PIC is a Committee whose majority of members are senior members of the profession who are not members of the Council, from both the medical and dental professions. Only after exhaustive investigations which include interviews will a case be referred to the EXCOM.

EXCOM is comprised of Chairpersons of Committees of Council who will review recommendations and may refer the cases back to PIC for further investigation if not satisfied with the evidence and findings of the PIC.

The Disciplinary Committee is comprised of a Chairman who is a member of the Council and members of the same profession are appointed by EXCOM. Expert witnesses who are senior members of the same profession are called to give evidence on how a reasonable practitioner of the same experience, status and education would have conducted themselves given the same circumstances (reasonable man's test). It is important to note that a practitioner is judged by his own peers (concept of self regulation). Members should be aware that it is not Council per ser which judges them but members of the same profession and standing as themselves who make the determination on disciplinary cases. Council only enforces that determination made by the Disciplinary Committee.

Practitioners have a right to appeal and the first point of call is the Health Professions Authority which should be within 30 days ***Section 22 of the Health Professions Act (Chapter 27:19) refers***. If not satisfied the practitioner can appeal to the Administrative Court, High Court and the Supreme Court in that order.

Council has been advised by its Legal Advisors that the Court deals with such matters in terms of Section 128 of the Health Professions Act (Chapter 27:19). Thus the Courts will deliberate at issues based on evidence which would have been given by expert witnesses during the inquiries. Courts do not have technically competent individuals on medical issues therefore senior members of the same profession will be called to assist to come up with decisions. Usually the Council decision is confirmed.

It is worth to note that lawyers are in business. The practitioners impoverish themselves and enrich the lawyers. As part of the function of Council to guide the doctors, advice can be sought from Council on how to proceed when seized with a disciplinary matter.

Introduction

All patients are entitled to good standards of practice and care from their doctors. Essential elements from this are expertise, altruism and professionalism

"Commitment to maintain high standards and serve the public, trust and life long learning. Responsible for maintaining medical knowledge all clinical skills and team skills necessary for provision of quality care and honesty" (***Prof Ron Patterson – Auckland New Zealand)*** When patients say they have a good doctor they mean a doctor they can trust.

"Goodness is equated with:-

- Integrity,
- Safety
- Up to date medical knowledge,
- Diagnostic skills,
- Ability to form a good relationship with the patient.
- Good doctors are clinically expert,
- Kind
- Courteous,
- Empathetic and
- Caring. "

(Prof Ron Patterson – Auckland New Zealand)

This Bulletin publishes some of the cases that appeared before the Disciplinary Committee of the Medical and Dental Practitioners Council (MDPCZ). The names of the practitioners have been removed but there are based on real cases.

COUNCIL VISION

To be the referenced regulatory authority in promoting excellence in standards of health care, education and ethics.

MISSION

To promote the health of the public through licensing education, regulation and supervision of the Medical and Dental Professions

MOTTO

Promoting the health of the population of Zimbabwe through guiding the Medical and Dental Professions.

VALUES

Ethics
Professionalism
Justice
Continuous Quality Improvement

Case 1

Dr "A" a General Practitioner appeared before a Disciplinary Committee on an allegation of incompetently managing a patient during delivery of her baby at his surgery in that:-

1. Dr A referred the patient to a Central Hospital without indicating that he had attempted a vacuum extraction thereby not fully disclosing what had taken place whilst the patient was under his care.

2. The facilities at his surgery were not adequate for a vacuum extraction procedure to be done or attempted.

3. The condition of the patient at the time that he attempted to perform a vacuum extraction on the patient did not meet the minimum standard required in practice.

4. The patient was not at the minimum 8cm dilation required for such a procedure to be done.

5. The foetal head was still high and therefore he should not have performed the procedure. He had indicated that the foetal head was at 5/5 therefore not ready for vacuum extraction.

6. Despite there being indications of cephalo pelvic disproportion Dr A proceeded with the vacuum extraction which he should not have done.

7.The bladder of the patient was not empty when he did the vacuum extraction.

Findings

i. The doctor did not disclose in his referral letter to a Central Hospital that he had attempted 3 failed vacuum extractions on a patient who was 4 cm dilated with the head at 5/5 above bream.

ii. From the Preliminary Inquiries Committee (PIC) report it was clear that he admitted having performed some procedure on the patient.

iii. A vacuum extraction should not be performed in an environment where one cannot perform a caesarean section immediately upon failure of such a procedure.

iii. The records presented showed that he failed to correctly report his own observations.

iii. His assessment of the patient was inconsistent at one time he says it was 8cm as shown in PIC report. He later says perhaps the patient was not fully dilated.

iii. Dr A appears to lack understanding of obstetric concepts. This is particular to the issue of maceration. Expert witness said one can never have maceration in a live foetus something Dr A disputed.

Dr A denied ever applying a cup to the baby physically. He said the cup was applied to the mother physically. He further submitted that he has been in practice for 36 years when doctors at Central Hospitals were failing. He maintained that he had done nothing wrong.

On the evidence before the Committee Dr A was found guilty of disgraceful conduct in that :-

1. He assessed a patient inaccurately.

2. He attempted a vacuum extraction inappropriately.

3. He concealed or did not disclose correct facts in his letter of referral.

In mitigation Dr A maintained that he did nothing wrong. There was no evidence on the head of the baby. The use of vacuum was normal by his training. The judgment must be less as there was no evidence that there was use of a vacuum.

In aggravation it was submitted that:

1. Council had a duty to protect the public.

2. This was a second time Dr A has been before the Disciplinary Committee on a similar case of mismanagement on a maternity case.

3. A sanction that he orients in maternity at a Central Hospital was given which he did not fulfil.

Case 1 Continued

4. Dr A lacks appreciation of the gravity of the matter and as such there appears to be no amount of correction or learning that will make him appreciate the gravity. The prosecution urged the Disciplinary Committee to place Dr A in position that he will not attend to obstetric patients or pregnant mothers.

Judgement

Dr A was found guilty of malpractice

Sentence

"After considering the mitigating factors as well as the aggravating factors the panel imposed the following Penalty".

1. You are removed from the Register of the Medical and Dental Practitioners Council. Such removal is however suspended for three (3) years on conditions that you do not commit a similar offence".
2. You are barred from Obstetrics practice until you have been certified by two Obstetrician and Gynaecologists who will be supervising you for a period of not less than twelve (12) months at a Central Hospital with reports after every three (3) months";
3. You are ordered to pay a fine of $300.00"; (This is the maximum penalty possible.
4. You will not be issued with a Certificate of Good Standing (CGS) for a period of 12 months"
5. You are ordered to pay the costs of this inquiry within a period of three (3) months".
6. You are ordered to sign an acknowledgement of debt form.

Dr A appealed to the HPA and the Council's decision was upheld. The appeals Committee felt Council had been too lenient with this doctor.

LESSONS LEARNT

GOOD CLINICAL CARE AND PROVIDING GOOD STANDARDS OF PRACTICE ARE FUNDAMENTAL DUTIES OF A DOCTOR. PATIENTS MUST BE ABLE TO TRUST THEIR DOCTOR WITH THEIR LIVES AND WELL BEING.

TO JUSTIFY THAT TRUST THE PROFESSION HAS A DUTY TO MAINTAIN GOOD STANDARDS OF PRACTICE AND CARE AND SHOW RESPECT FOR HUMAN LIFE.

Good clinical care must include:-

1. **An adequate assessment of the patient's condition based on the history and symptoms and if necessary an appropriate examination.**
2. **Recognise and work within your limits of professional competence.**
3. **Taking suitable and prompt action when necessary.**
4. **Referring the patient to another practitioner when indicated.**
5. **Willing to consult other colleagues.**

This is a case where the doctor admitted a patient at 6.00am at a private maternity hospital in early labour. She was about 3cm dilated according to the doctor's assessment and head was 5/5 above bream. Five hours later she had another pelvic examination which showed that she was now 5cm. The labour was slow. During the whole labour record the foetal heart was recorded as grade 1.

The doctor attempted vacuum extraction 3 times without success on a patient who was now 5 cm with head 5/5 above bream. The doctor did not assess the patient correctly, failed to recognize the limits of his professional competence.

Dr A failed to recognise that the labour was not progressing. He also failed to timeously refer the patient to a Central Hospital for specialist care. He also did not keep proper records on his assessment and observation.

In providing care doctors should always keep clear accurate, legible and contemporaneous patient records

Case 2

Dr B a Specialist Physician appeared before a Disciplinary Committee on an allegation of poor standard of practice. Dr B saw a patient Ms x who was complaining of weakness and breathlessness after walking, bathing her baby and after exertion. She also complained of lack of sleep due to difficult in breathing. Dr B received thyroid function tests and blood tests results which clearly showed a diagnosis of hyperthyroidism.

Dr B proceeded to prescribe Thyroxin drugs (the exact opposite of the treatment that was required.) after taking the prescribed drugs Mrs X started feeling weaker than before, she could not sleep and she experienced difficulties in breathing, she lost appetite, could not walk, her hair fell off, legs became swollen amongst other things.

Mrs X sought a second opinion from another Physician where she improved significantly and returned to work after the current treatment.

Findings

1. Dr B made the right diagnosis in his assessment of Mrs X.
2. Dr B prescribed Thyroxine in error
3. Dr B sincerely apologised for the error
4. Dr B said he had not been feeling well at the time he saw the patient
5. Dr B should have referred the patient to a colleague as he had not been well.
6. Dr B had not wasted the Committee's time.

On his own admission and on the evidence before the Committee, he was found guilty of improper conduct.

Submissions In Mitigation

1. Pleaded guilty and apologised
2. On the day in question he was not feeling well.
3. Had the patient come back for review after noting that she was not improving he would have corrected the error.
4. He was a first offender and asked for the Committee's leniency.
5. He had now engaged a junior doctor to work with him

The Disciplinary Committee ordered that:-

1. He pays the costs of this inquiry.
2. He will have an endorsement of his Certificate of Good Standing (CGS) for a period of six (6) months".
3. He be referred to the Health Committee of Council which assesses practitioners with health problems with a view to rehabilitate them. Impairment means a psychological or medical condition which may interfere with safe practice of medicine. The Health Committee assess such cases and may place a contract of surveillance which will be possible at that time"
4. He was ordered to sign an acknowledgement of debt form.

LESSONS LEARNT

PATIENTS MUST BE ABLE TO TRUST THEIR DOCTORS WITH THEIR LIVES AND WELL BEING. TO JUSTIFY THAT TRUST THE PROFESSION HAS A DUTY TO MAINTAIN GOOD STANDARDS OF PRACTICE.

1. **Dr B failed to exercise reasonable care expected from a Specialist in the management of Mrs X.**
2. **Mrs X subsequently received restorative treatment from another Specialist.**
3. **Dr B acted negligently and caused harm to the patient by prescribing wrong drugs.**
4. **Dr B should have realized that he was not well and referred the patient to another Specialist.**

Case 2 Continued

WHEN PATIENTS SAY THEY HAVE A GOOD DOCTOR THEY MEAN A DOCTOR WHOM THEY EQUATE WITH GOODNESS, INTEGRITY, SAFETY, UP TO DATE MEDICAL KNOWLEDGE AND GOOD DIAGNOSTIC SKILLS AND CLINICAL EXPERTISE.

This is a case where a 32 year old lady had just delivered a baby. She had a history of severe breathlessness at night, as well as paroxysmal nocturnal dysponea. She was experiencing frequent hot flashes and pronounced insomnia. She had frequent and constant diarrhoea. The patient had been seen at a Private Clinic Casualty where the Casualty Officer advised the patient that the difficulty in breathing was due to a goitre causing tracheal compression.

She was referred to a General Surgeon on call who determined that the diagnosis was acute thyrotoxisis required a medical rather than surgical treatment. The patient was later seen by a Specialist Physician Dr B who advised that she had an overactive thyroid gland and was commenced on thyroxine, completely the opposite to the treatment that was required, an anti thyroid drug.

This was not an emergency case hence Dr B should have referred the patient to a colleague.

Case 3

Dr C a post Intern doctor undertaking General Medical Experience (GME) year in a Provincial Hospital appeared before the Disciplinary Committee on an allegation of improper conduct. On 29 September 2012 at around 10.00pm Dr C was called to see a patient the late Mr T who was brought in by the Police reported to have been hit by a car and sustained injuries on the right hand shoulder which was off the socket and bruises all over the body.

Dr C examined the patient and noted that the patient had multiple swellings on the scalp, had lacerations that had been sutured, chest was resonant to percussion and there was equal air entry. The abdomen was soft and non tender. His level of consciousness, verbal was 1, motor was 1, eye opening was 1, Dr C put Glascion Score at 3/15. The CNS was not moving any limbs.

Dr C made an impression of severe head injuries and admitted the patient in the emergency ward. Around 2.00am Dr C was called to see the patient who had deteriorated. He certified him dead at 2.00am and indicated the cause of death as severe head injury. The allegation was that Dr C improperly examined the patient in that:-

1. He examined the patient whilst he was putting on his clothes.

2. He did not ensure that a post mortem was done since this is a legal requirement.

3. He failed to take x-rays of the patient who had been involved in a car accident.

4. He failed to follow the requirement of a patient whose death was not natural by proceeding to sign the BD12.

5. He failed to examine the pupils of a patient who had head injuries and refer the patient to a Nuero-Surgeon immediately.

Findings

1. The examination carried out by Dr C was inadequate and was performed in a way below the expected standards. He examined the patient while putting on his clothes.
2. Dr C failed to carry out the important investigations such as chest and skull x-rays.
3. He failed to refer the patient to a nuero-surgeons
4. He did not ensure that a post mortem was done.
5. He failed to note the dislocated shoulder.

On his own admission and evidence before the Committee Dr C was found guilty of unethical conduct.

Submission in Mitigation

1. The incident occurred during my first year post internship.
2. I am a first offender on a government salary.
3. My failure to ensure that a post mortem was done was due to the assumption that the Police would take the body to Harare for post mortem.
4. On the particular day I had attended to numerous accidents and this could have lead to clouding of judgment.

Judgement

Dr C was found guilty of improper conduct

Sentence

The Committee gave the following judgement:-

1. You are suspended from practice for a period of six (6) months. This sentence is suspended for a period of one (1) year.
2. You are ordered to pay a fine of $300.00 within a period of three (3) months from the date of the inquiry.

Case 3 Continued

3. You are ordered to pay the costs of this inquiry within a period of three (3) months.

4. You are also ordered to make a presentation on 'Management of Trauma cases and the issue of post mortem reports'. You are required to give a copy of the presentation to Council. This presentation to be done within a period of three (3) months at Provincial CME meetings. You are also required to inform Council of the date of the presentation."

5. You are cautioned for a period of two (2) year.

6. You will not be issued with a Certificate of Good Standing or it will be endorsed for a period of one (1) year.

7. You are ordered to sign an acknowledgment of debt form.

LESSONS LEARNT

Good Clinical Care includes:-

1. **Adequate assessment of the patient's condition based on the history, symptoms and appropriate examination.**

2. **Providing or arranging investigations and treatment.**

3. **Taking suitable and prompt action when necessary.**

In this case the doctor failed to take adequate assessment of the patient given the history of the patient. The doctor examined the patient whilst putting on their clothes. He failed to arrange for investigations, chest and skull x-rays. Dr C also failed to refer the patient for further management at a Central Hospital.

He also failed to recognise the need to have a post mortem done on a case whose death was unnatural. Thus the doctor did not provide the care expected. The lack of experience was noted by the Disciplinary Committee but that did not absolve the doctor from his omission as he would have consulted Senior Colleagues of the same station.

This was a case were the relatives thought their relative died under unclear circumstances. The patient was hit by a car and was admitted to a Provincial Hospital around 2200 hours. He was attended by the doctor and later died around 2.00am. the relatives alleged inconsistencies in that the patient was examined putting on his track jacked and had a satchel to his back. His shoes were on lying in the resuscitation room.

This case clearly shows that although they are lay members of the public, they can see when a patient is poorly assessed and treated by the profession

Case 4

Dr D appeared before the Disciplinary Committee on an allegation of mismanagement of a patient in that he was presented with a patient whose ankle was fractured.

1. The patient had an unstable fracture which Dr D attended to by instructing that a plaster of Paris (POP) be applied by a Physiotherapist who was not trained for such procedures.

2. The patient was diabetic and should have been managed taking his condition into consideration.

3. The patient should have been referred to see a Specialist soon after seeing Dr D and not six weeks later as Dr D indicated,

4. Ideally the patient should not have been discharged and should have been observed before being sent to see a specialist.

5. The record keeping standards and referral process was poor evidenced by the fact that there was no referral note given to the patient after patient had been attended to.

Dr D pleaded not guilty to all the charges.

Findings

1. Dr D examined the patient and advised him to have an x-ray.

2. The patient had a bimalleolar fracture.

3. A POP was applied and some analgesic was prescribed for the pain.

4. The Doctor failed to document the instruction to the patient to come back the following morning to see a specialist.

5. Evidence by the expert witness Specialist Orthorpaedic Surgeon revealed that incorrect management was instituted.

Dr D admitted to poor record keeping.

On the evidence before the Committee Dr D was found guilty of improper conduct on count 5 which is the poor record keeping and referral process.

Submissions in Mitigation

1. I am a first offender to appear before a Disciplinary Committee

2. I do not have any Court conviction in connection to my profession.

3. My profession is my only source of income which I rely on.

In aggravation the Council legal Practitioner submitted that the practitioner had more than 26 years of experience. The breakdown in communication was not the type of error expected of someone of his experience.

Sentence

The Chairman gave the judgment as follows:

1. You are reprimanded that a man of your experience should not be seen to be managing a patient in the manner in which you managed the patient

2. You are ordered to undergo re-training in a structured casualty where there is a supervisor to be supervising you in your care of Orthopeadic patients for a period of three (3) months at a Central Hospital. During this period you will not e allowed to do locums at a Private Hospital, you could do those locums at the institution that you are in training.

3. You are ordered to pay a fine of $100.00 which is payable to the Medical and Dental Practitioners Council".

4. You are ordered to pay the costs which were incidental to this inquiry within a period of six (6) months.

Case 4 Continued

5. You are ordered to sign an acknowledgement of debt form and return it to Council within a period of two (2) weeks from the date of receipt.

6. You are cautioned for a period of twelve (12) months. If you commits a similar offence within this period it will be taken as an aggravating factor".

7. You will not be issued with a certificate of good standing for a period of twelve (12) months, if issued the certificate of good standing will be endorsed. The period of the endorsement of the Certificate of Good Standing will end on 26 September 2014".

8. The fine and the costs of inquiry should be paid within a period of six (6) months".

LESSONS LEARNT

GOOD COMMUNICATION BETWEEN PATIENTS AND DOCTORS IS ESSENTIAL IN EFFECTIVE CARE AND RELATIONSHIP TRUST. THIS INCLUDES, GIVING PATIENTS' INFORMATION ABOUT THEIR CONDITION TREATMENT AND PROGNOSIS IN A WAY THEY CAN UNDERSTAND INCLUDING PRESCRIBED DRUGS AND FOLLOW UPS, SHARING INFORMATION ABOUT THEIR CONDITION.

This is a case where a patient was injured at work and was referred to a private hospital. He was seen by the Casualty Officer Dr D who ordered x-ray and made the correct diagnosis of bimalleolar fracture. He ordered that Plaster of Paris be applied and claims he advised the patient to return the following day for Specialist review. This information was not documented anywhere. The patient went to see a Specialist Orthorpaedic Surgeon 6 weeks later claiming that it was the instruction of the Casualty Officer.

On presentation to the specialist the fracture was in an unsatisfactory position. He took the patient to reconstructive theatre for a plate and screw fixation. The further delay was due to financial constrains. There was a delayed healing as the patient was diabetic. The healing was further delayed by sepsis on the operation site.

As alluded to by the late Professor Nyapadi and Professor G Felto in their book Law & Medicine in Zimbabwe "Poor communication is often a recipe for medical disaster and often leads to damage claims for negligence. Poor clinical notes as a result of inadequate recording led to the medical disasters where the patient ended up developing complications".

Case 5

Dr E appeared before the Disciplinary Committee on an allegation of improper conduct or disgraceful conduct in that Dr E operated on a workmate (the patient) at a District Hospital who demised during the procedure. The patient came to Dr E complaining of a painful lump in her shoulder 3-4 months before the operation was done. Dr E had agreed with the patient 3 weeks prior to the date of the operation that he would personally perform the procedure on the patient. During the procedure Dr E was assisted by a **General Hand**. About 10 minutes into the procedure the patient began to hallucinate. She jumped off the operating table and began to convulse. The patient became unconscious and attempts to resuscitate her did not succeed. The signs and symptoms described as presented by the patient were consistent with systematic effect of lignocaine reaction that took place during the procedure. It was therefore alleged that Dr E's conduct was improper and / or disgraceful and / or unethical in that:

1. The patient was a friend and a colleague of Dr E and as such it was not good practice to treat the patient to this extent.

2. The procedure was done without the assistance of the nurse anaesthetist and scrub nurse despite the fact that both of them being on duty on the day of the procedure.

3. Dr E was assisted by an unregistered person, being a general hand, during the procedure.

4. Dr E attended to the patient who had come straight from home to the theatre. The patient was not clerked and there are no records of the patient even in the accounts department of the hospital. There were no preop observations.

5. No preoperative assessment was done and / or recorded

6. Dr E indicated that he attended to the patient about 3-4 months prior to the operation, yet no medical records could be found for the patient at the hospital.

7. Only a clinical examination of the patient was done and there was no further investigation.

8. The management of the patient was poor before and during the procedure.

9. The case was an elective case and not an emergency and therefore Dr E could have waited and managed the patient properly especially given that he had made the appointment to operate on the patient 3 weeks before the actual date.

10. By attending to the patient after hours, operating on the said patient as she had come directly from home, not having the required staff complement and not having any records Dr E acted below the standard required in this circumstance.

On evidence before the Committee and on his own admission Dr E was found guilty of unethical conduct to all the above 10 charges.

Submissions in Mitigation

1. I have spent 16 years practising in the very remote part of the country.

2. Over the past 16 years I have worked without any relief.

3. I have not enjoyed the privileges enjoyed by my colleagues as I have not been promoted.

4. I work long hours and this might have impaired my senses of judgement.

5. I have a wife and seven children to look after and have a lot of social problems.

Sentence

1. You pay a fine of $200.00 within three (3) months to the Medical and Dental Practitioners Council of Zimbabwe.

2. You pay the costs related to this Disciplinary Inquiry within three (3) months. The Registrar of the Medical and Dental Practitioners Council would advise him of the amount of the cost of the Disciplinary Inquiry".

Case 5 - Continued

3. You undergo orientation and retraining at a Central Hospital under the supervision of identified specialists, for a period of twelve (12) months on four monthly rotations in, Anaesthetics, Surgery and Medicine with reports at the end of each rotation. He was allowed to do limited private practice during the period of retraining".

4. You are cautioned for a period of 2 years.

5. You will not be issued with a Certificate of Good Standing or it will be endorsed for a period of two (2) years. This period ends on 28 October 2015".

6. You are ordered to sign an acknowledgement of debt form.

LESSONS LEARNT

Good Clinical care must include:-

- **An adequate assessment of the patient's condition.**
- **Referring a patient to another practitioner when indicated.**
- **Recognising and working with one's limits of professional competence.**
- **Maintain professional relationships with patients.**
- **Acting in the best interest of the patient. "Do NO HARM to the patient."**

This is a classical case where due to the doctor's conduct; harm was done to the patient. The patient was not assessed. The doctor asked a General Hand to put the patient to sleep.

This is a case where Dr E operated on a workmate who was a friend of Dr E. The patient had a lump on her shoulder. No investigations were done before the operation. No pre-operative assessment was done. Dr E found the patient on the table and with the assistance of General Hand who put the patient to sleep Dr E operated on the patient. Patient started hallucinating and jumped off the operating table. The doctor called the Nurse Anaesthetist who should have assisted the doctor in the first place. This was a private patient who was operated with the assistance of General Hand.

The patient developed signs and symptoms consistent with systematic effect of lignocaine reaction during the operation. Attempts to resuscitate the patient were not successful and the patient demised. The patient was not clerked and there were no records. This was not an emergency case. Harm was caused to the patient.

Case 6

Dr F a Specialist Radiotherapist and Oncologist appeared before the Disciplinary Committee on allegations of contravening the provisions of Medical Practitioners Professional Conduct Regulations published in Statutory Instrument 41 of 2004 and Section 135 of the Health Professions Act (Chapter 27:19) which prohibits advertising of professional services. Dr F published an article in a weekly tabloid in 2012 which talked about Cancer awareness which included the doctor's name, photograph and qualifications.

Dr F pleaded not guilty.

Findings

1. The article was in violation of the provisions of Section 135 of the Health Professions Act (Chapter 27:19) as well as the Medical Practitioners Professional Conduct Regulations which prohibit advertising of professional services. Dr F published the professional qualifications

2. The article clearly said 'For more information contact the Cancer Association of Zimbabwe' and the practitioner's picture was above those words as the endorser".

3. The Cancer Association's information was unendorsed, the publication could be interpreted to mean if the members of the public wanted more information about the doctor (endorser) they could contact Cancer Association".

4. There were two logos on the article to increase visibility of the organizations, Cancer Association of Zimbabwe and TM which is advertising. By inference the presence of the practitioner's picture and qualifications also increased her visibility"

On evidence before the Committee Dr F was found guilty of unethical conduct.

Submissions In Mitigation

My client is a first offender hence the Committee should be lenient.

Judgement

Dr F was found guilty of improper conduct.

Sentencing

The Chairman gave the sentence as follows:

1. The doctor is ordered to pay a fine of $300.00 within a month (30 days) to the Medical and Dental Practitioners Council of Zimbabwe".

2. "That you also pay the costs related to this Disciplinary Inquiry within three (3) months. The Registrar of the Medical and Dental Practitioners Council will advise you of the amount of the cost of the Disciplinary Inquiry".

3. The Certificate of Good Standing will be endorsed for a period of six (6) months.

Dr F appealed to the Health Professions Authority and lost the appeal.

LESSONS LEARNT

THIS IS A CLASSICAL CASE WHERE THERE WAS OVERWHELMING EVIDENCE OF A VIOLATION OF THE ACT AND REGULATIONS. THE DOCTOR ENDED UP ENRICHING THE LAWYER AND IMPOVERISHING THEMSELVES.

Advertising is prohibited. Doctors advertise through their deeds.

Whom to contact at Council

Registrar

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All correspondence should be addressed to the Registrar

Members from the Southern region of the country may now access Council services in Bulawayo at No 2 Robertson St, Parkview in Bulawayo. Contact Harriet Dhliwayo on 0777884162 or 09—72237/8.

MOVING

The Council's register must contain both your current mailing address and your primary practice address. At the back of the newsletter, a change of address form is provided to mail or fax in.

Your MAILING ADDRESS is the address you would prefer the Council use to communicate with you and may be different from your practice address. It is NOT available to the public, unless you decide to use your primary practice address as your mailing address. Your PRIMARY PRACTICE ADDRESS is available to the public.

Updated Information Form Registration No: .....

Surname ..... Name:.....

Mailing Address	Primary Practice / Alternative Address	Home Address
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Business Telephone..... Cell:..... Home .....

Email Address .....

Effective Date ..... Signature .....