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You're stepping on my turf!

It was the season when yet another batch of ritual circumcisions go wrong. The avoidable deaths and disfigurement of many young men prompted a debate in the then South African Medical and Dental Council. Should circumcisions be left to people who are untrained in hygiene and the surgical basics of a procedure on an anatomical structure in which so much male ego is invested? Considerations included the paucity of medical personnel, particularly in the rural areas, and resistance on the part of the communities and their traditional circumcision practitioners to interference by the health professions because of deep-seated cultural beliefs. One solution proposed was to train nurses to do circumcisions, as they were in more plentiful supply and their skill in other aspects of health care meant that not much further training would be required. The nursing representative on the Medical and Dental Council, however, was quick to object on the grounds that circumcision was not in the scope of practice of nurses. I had not expected this response, as it is more usual for professions to try to expand their scopes of practice. Nurses were also already being trained to practise at high levels of expertise in areas such as obstetrics, paediatrics and intensive care. There was also the question of who was to pay for the procedures. As the debate was getting somewhat heated, I tried to lighten it somewhat by enquiring whether there was not perhaps too much concern about making money out of tips?

The circumcision episode illustrated the eternal battle for acquisition of an increased scope of practice by those wishing to enhance the status of their profession, and the vigorous defence to keep them out by others who perceive this as a threat to their turf. To enable anyone to move up various education ladders, including the professions, the South Africa Qualifications Authority (SAQA) in its initial ideological zeal tried to impose a system of 'unit standards' on all education in the country. The theory was that by acquiring a unit standard here and another one there, one could theoretically eventually cobble together a bunch of unit standards that would make up a degree or its equivalent. But how, for instance, could one compare the anatomy and physiology done by a first-aid practitioner with that of a doctor? Fortunately wisdom eventually prevailed and it was understood and accepted that professional qualifications, such as those in health care, were 'whole qualifications' and could not be broken down into small readily transportable bits.

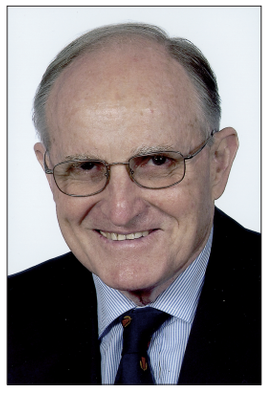
The Health Professions Council of South Africa (HPCSA) is generally not prescriptive about the scopes of practice of the various health professions under its control. Its stated objectives are to protect the public and to guide the professions. It therefore requires that any health professional applying any procedure should have had adequate training to be able to do so effectively and safely. And it is in interpreting and applying this principle that many of the turf battles are fought.

A radiological colleague, long since deceased, was one of the pioneers of gastroscopy in South Africa, in the days of large rigid scopes. Today's optical systems and thinner and flexible instruments have vastly improved diagnostic capacity and safety. Well-trained physicians and surgeons in gastroenterology now do most gastroscopies and colonoscopies, and to my knowledge no radiologist does them.

With the advent of the initially vastly expensive computed tomography scanners and magnetic resonance imaging there were attempts to limit their installation and use because of costs. However, their costs have come down, their diagnostic capacity has much improved, expensive invasive procedures can be avoided by their use, and the length of hospital stays is reduced. Such 'big ticket' items are now typically owned by radiologists and by hospitals, but what about smaller, less costly items such as mammography, bone densitometry and diagnostic ultrasound apparatus? Two papers in this journal[1,2] make a case for mammography and diagnostic ultrasound to be recognised for use by appropriately trained personnel other than radiologists.

Given adequate training, who does any procedure is ethically neutral. Academic hospitals also have turf battles over procedures and practices which are often ego driven. But the real problems arise in the private sector pay-per-procedure environment. Doctors may buy items of equipment, such as for mammography or diagnostic ultrasound, with the stated intention of improving their practice capacity. But financial matters may end up the prime consideration, as there is firstly a need to recoup a significant financial outlay, and secondly the temptation to turn it into a cash cow. In this setting there is a further moral hazard in that the patients who undergo the procedures are self-referred – unlike the patients seen by a radiologist, who is dependent upon referral from others.

The thousands of smaller procedures done unnecessarily and for the wrong reason may be a more important contributor to rapidly rising health care costs than the big items.



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2. Bruijns SR, Engelbrecht D, Lubinga W, Wells M, Wallis LA. Penetrating the acoustic shadows: Emergency ultrasound in South African emergency departments. *S Afr Med J* 2008; 98: 932-934.