

Supersession: Collegiality to the rescue

SADJ MAY 2024, Vol. 79 No.4 p215-219

MI Makoea¹, ML Machete², T Bapela³, PD Motloba⁴

BACKGROUND

An extensive search of the literature shows a huge dearth in scholarly opinion on supersession. The debates surrounding supersession have evoked deep emotions and polarised the cadres of oral health. Allegations of practitioners completing dental treatment on a patient without consulting the original dentists are rife. We speculate that this concept is unknown, poorly explained and understood, hence the difficulty to implement it in different clinical scenarios. A random survey of oral health professionals was undertaken to canvass views, opinions and understandings of the concept and application of supersession. The findings indicate a multiplicity of viewpoints and understandings of supersession. Additionally, Rule No 10 of the HPCSA was considered to be unclear, “murky” and less instructive on how to avoid supersession. For these reasons, practitioners tend to act out of sync with the expected provisions from the regulator. It is hence the objective of this paper to provide very clear criteria and a roadmap in dealing with alleged supersession.

EXPLORING RULE NO 10 OF THE HPCSA: SUPERSESSION

1. Unpacking the legislative expression of Rule No 10

Definitions of supersession

Supersession and supersession are homophones often and erroneously used interchangeably, despite their distinct meanings and contextual applications. Fundamentally, these words involve the replacement of one thing by another. Supersession is a term commonly encountered and used in fields such as law, philosophy and theology. It describes the act of replacing one law, philosophy or

doctrine with another. In such cases, the new law or theory may eventually render the older law or doctrine obsolete. Supersession has a more specific meaning, referring to the act of replacing one thing with something that is considered superior or more advanced. Supersession is not gradual, but abrupt and less tolerant of engagement with the status quo, as it seeks to displace or take the place of something or someone completely. For example, the innovation may replace, supersede or supplant the older technology, rendering it obsolete.

The definition of supersession in health care is based primarily on Rule No 10 of the HPCSA, which states that “a practitioner shall not supersede or take over a patient from another practitioner if he or she is aware that such patient is in the active treatment of another practitioner”.^{1,2} This legal pronouncement bestows rights while also imposing limitations on the same rights under specific conditions. The above regulation permits the taking over of a patient from another practitioner but imposes conditions under which the takeover can happen. Therefore, the conduct becomes supersession only when the limitations are infringed. Most notable is the use of the negatively worded expression “shall not” which imposes an absolute and mandatory obligation to refrain from doing something. It is not uncommon for legislation to forbid rather than permit. Other definitions of supersession exist, providing different impositions and prohibitions. For example, the Department of Trade, Industry & Competition provides that “should a practitioner take over the care of a patient, such practitioner has an obligation to inform the erstwhile practitioner, prior to proceeding with any treatment, or such take over”.³ This definition does not forbid or restrict takeover but imposes conditions to be satisfied for the takeover.

Similarly, McQuoid-Mason emphasises two conditions that are necessary for supersession to occur. According to McQuoid-Mason, supersession is the “practice of taking over the patient of another doctor without informing the other practitioner in situations where the patient has not terminated the other healthcare provider’s services”.⁴ The similarities, differences and points of emphasis in the definitions of supersession above highlight the nuances and complexity of this concept. To fully understand the legal expression of Rule No 10 and the definitions above, we invoke George Coode’s system.⁵ This formulation divides the language of the written law into performative and deontic declarations, which confer and describe the obligations or permissions respectively. Coode’s system further simplifies a legal sentence by suggesting four parts: (i) the case or the circumstance in which the legal action applies (ii) the legal subject, which details the person to whom rights and obligations are conferred; (iii) the legal action, rights and obligations conferred; and (iv) the condition, which details what must be done for the legal action to arise.

Authors’ information

1. MI Makoea, LLB (Unisa), B.Dent Ther (Medunsa), Lecturer, Dental Therapy Section, Department of Community Dentistry, Sefako Makgatho Health Sciences University, Ga-Rankuwa, South Africa
ORCID: 0000-0003-6902-4364
2. ML Machete, BDS (UL), MDS (SMU), Registrar (MDent), Department of Community Dentistry, School of Oral Health Sciences, Sefako Makgatho Health Sciences University, Ga-Rankuwa, South Africa
ORCID: 0000-0002-0218-8428
3. TM Bapela, BDS (Medunsa), Department of Community Dentistry, School of Oral Health Sciences, Sefako Makgatho Health Sciences University, Ga-Rankuwa, South Africa
ORCID: 0009-0000-9397-2527
4. PD Motloba: MDent (Comm Dent) (Medunsa), MBL (Unisa), Head, Department of Community Dentistry, School of Oral Health Sciences, Sefako Makgatho Health Sciences University, Ga-Rankuwa, South Africa
ORCID: 0000-0003-1379-7576

Corresponding author

Name: MI Makoea
Email: moalosisimakoea@gmail.com

Author’s contribution

1. MI Makoea – conceptualisation, writing and final review (25%)
2. ML Machete – conceptualisation, writing and final review (25%)
3. T Bapela – conceptualisation, writing and final review (25%)
4. PD Motloba – conceptualisation, writing and final review (25%)

Application of Coode's system to Rule No 10 about supersession

Applying Coode's system framework to Rule No 10 raises critical questions which, in our view, are the crux of the debate about supersession. Clear, unambiguous clarification of these questions is a prerequisite to understanding and interpretation of the rule.

The case: supplant behaviour, supersession or taking over of a patient has occurred (averred or definite).

Legal subject: (1st) practitioner from whom the patient was taken over by the 2nd practitioner.

Legal action: lodging a complaint with the regulator (HPCSA) by 1st practitioner.

The conditions to be satisfied: (i) the patient is receiving active treatment; or (ii) the patient has not terminated treatment, (iii) the 2nd practitioner is aware of the nature of the treatment.

The multiplicity of definitions of supersession are instructive in providing clarity to the concept. However, the primary reference in understanding supersession should be based on Rule No 10 of the HPCSA.

2. Decoding the definitional elements of Rule No 10, of the HPCSA

The essence of supersession is intricately immersed in the following conditions as defined by George Coode: (i) active treatment; (ii) practitioner's awareness; and/or (iii) taking reasonable action. We provide below a clarification of the elements.

The concept of active treatment in dentistry

What is active treatment in the context of oral and dental care?

An extensive search of the literature did not yield any comprehensive definition of active treatment. However, according to the Thesaurus, the word "active" is defined as "effective", "functioning", "progressive", "efficacious", "in force" and so on. While treatment means any intervention given to the patients seeking relief from dental and oral health challenges. Therefore, active treatment can be defined as an ongoing, effective intervention aimed at providing efficacious outcomes. On the contrary, passive treatment would be treatment that is unlikely to produce effective results for the patient because it is not progressing or has stalled. We are safe to assume that the beginning of active treatment follows any intervention given to a patient to address the ailments diagnosed by the practitioner. The intervention may include consultation, counselling, medication, surgery or any other intervention. The treatment can be scheduled for a specific period or in perpetuity, depending on how the patient responds to the treatment. Yet, treatment must end at some point. Either the patient recovers, or treatment is considered ineffective, in which case a new regime must be given as a continuation or beginning of new treatment. For the sake of this paper, a change in treatment for the same ailment is still ongoing treatment. In cases where the patients recover from the ailment, it is good clinical practice for the practitioner to have a final, closing consultation with the patient to counsel them about self-care and future consultations should the need arise. This critical final engagement with the patient marks the end of active treatment by the practitioner. Active treatment could be based on a single intervention for a complaint or the entire treatment plan.

Does active treatment encompass the entire "planned" treatment or is it based on procedures?

Dental treatment is based on individual procedures which form part of a planned treatment for the patient. For example, a patient might need management of an active infection before rehabilitation. The planned treatment will invariably include scaling, polishing and root planning to manage periodontal problems. Additionally, direct restorations might be indicated to arrest ongoing dental caries. Lastly, orthodontic and/or full prosthodontic mouth rehabilitation will be provided to complete the planned treatment. It is critical for practitioners to complete individual procedures in pursuit of finalising the planned treatment. Extraneous factors often hamper the completion of treatment plans within the scheduled timeframe. Hence the importance of completing procedures rather than a treatment plan. Imagine an orthodontic patient whose appliances have not been activated in more than six months. Can a treating orthodontist claim that the patient is on active treatment? Or can he be charged with patient abandonment and neglect? Prima facie, such a patient is not on active treatment; instead, the orthodontist has failed in their duties to complete the procedure and has neglected the patient. Other factors, such as compensation, do not form part of the supersession. Unfortunately, many practitioners tend to invoke finances and the failure of patients to compensate as a defence for stalling or terminating treatment.

When is a specific dental procedure or treatment completed?

When does dental treatment begin and end? Generally, a procedure is completed once a patient has been recalled following the intervention. This consultation allows for the practitioner and patient to share the notes and review the treatment, how the patient is progressing and any other related issues. If the expected patient and practitioner outcomes have been achieved, the patient is discharged to practice self-care. If not, changes and adjustments are made to the planned treatment, and the patient is followed up until they settle into their new and restored dental status. Though uncommon in practice, it is good clinical practice for a patient to return to the practitioner following an extraction, restorations, scaling and polish, or after delivery of a prosthesis or even surgery. Due to unrelated and compelling social, economic and health system issues, most patients never report for their recalls, nor do practitioners insist on recall as part of treatment.

What about emergency dental treatment?

A patient consults a dentist due to a complicated crown fracture and pulpal exposure. The dentist performed emergency root canal treatment (ERCT) and restoration on the tooth. The patient was discharged and never went back to the dentist to complete the treatment. Three months later, the patient consulted another dentist with definite signs of pulp necrosis and infection of the root canal system. The patient was treated and advised to return to complete the treatment. Does the emergency dental treatment constitute a complete intervention? Is the second practitioner supplant in providing care without informing the first practitioner? While it is preferable for the patient to visit the first practitioner for further care, Section 5 of the National Health Act imposes an absolute obligation on the second practitioner to treat and not abandon any patient presenting with a dental emergency. Therefore, dental emergencies, as per the National Health Act and Section 27(3) of the Constitution,

are not a necessary condition for supersession. In the case of ERCT, there cannot be an expectation from the first practitioner; consequently, the second practitioner will not be “taking over” the patient from “another” since the patient will not be in “active treatment”. In other words, emergency treatment cannot be classified as active treatment as per Rule 10 of the HPCSA.

SUMMARY

Active treatment involves ongoing, effective intervention based largely on the procedure(s) undertaken by practitioners, inclusive of recall. It is incumbent on the practitioner to inform the patient about these processes, including their responsibility in completing the treatment. Except for dental emergencies, dentists must take reasonable steps to liaise with other practitioners before treating any patient.

Can a practitioner be unaware of a patient's active treatment?

Is it possible, permissible or justifiable for a practitioner to be unaware of continuing patient treatment? It is very unlikely for a practitioner to be unaware of an ongoing patient's dental treatment. We argue that a good rapport with the patient is the first step in fully managing any patient. Intimate and personal information is shared when the patient trusts their dentist. Lack of trust and confidence can result in patients withholding critical information, thereby compromising patient care. A full and comprehensive medical and dental history and clinical assessment are prerequisites for any dental treatment planning. Meticulous records allow dentists to reach a proper diagnosis and document historical and current conditions. It is therefore possible, but not permissible or justifiable, for a practitioner to be unaware of ongoing dental treatment. If in doubt, previous practitioners should be contacted to provide further clarification and information. It might not be justifiable or reasonable for a dentist to be unaware of a patient's active treatment.

THE NOTION OF REASONABLE(NESS) IN RULE No 10

According to Rule No 10: A practitioner shall not supersede or take over a patient from another practitioner if he or she is aware that such patient is in active treatment of another practitioner, unless

he or she takes reasonable steps to inform the other practitioner that he or she has taken over the patient at such patient's request.

What does the expression “reasonable” steps mean?

Rules, legal instruments and case law are replete with the notion of reasonable(ness). It suffices to say that every stage of judicial reasoning is laced with the notion of reasonable(ness).^{6,7} Whether it is the determination of facts, qualification or interpretation of rules, the notion of reasonable(ness) is reminiscent of similar notions such as equity, fairness, justice, adequate, averageness, welfare maximisation, normality and good to ideal.⁶⁻⁸ Yet again, the notion of reasonable is profoundly ambiguous and should be treated as such. The International Court of Justice in its ruling stated that “what is reasonable and equitable in any given case must depend on circumstances”.¹⁰ This means the court could not ascertain the meaning of reasonable(ness), since it depended on circumstances. At the same time, the court could draw a formulation to judge what is reasonable given the circumstances of a particular case. It appears, therefore, that the notion of reasonable(ness) is both definable

and undefinable or an indication of an agreement or a lack of agreement. Nonetheless, reasonable(ness) remains the standard of review used to determine the constitutionality or lawfulness of an act or rule. Reasonable(ness) serves to judge whether an act or rule is justifiable vis-à-vis the desired outcomes and the constitutional rights to be protected. This substantive model of reasonable(ness) assumes a causal link between a legitimate objective sought and the behaviour that one seeks to establish as reasonable. Given the explanation above, what criteria would be considered in assessing whether the behaviour of the practitioner (steps or measures taken) is “reasonable” or “adequate”?

- The extent to which the measures taken were deliberate, concrete and targeted towards the fulfilment of objectives. In other words, were the steps taken rational and justifiable?
- Were the channels of communication used appropriate and deliberate?
- In contacting the other practitioner, were the steps followed fair and equitable?
- Whether the practitioner exercised his discretion in a nondiscriminatory and nonarbitrary manner? In other words, the steps taken did not limit or violate the rights of the practitioner and the patient.
- Whether the steps taken considered the prevailing circumstances of the other practitioner.
- The time frame in which the steps were taken is acceptable.

Application of reasonable(ness) to Rule No 10 of the HPCSA

The analysis of reasonable(ness) must be cautious beyond mere technical and dogmatic approaches. Instead, a more pluralistic view must embrace legal, philosophical and sociological approaches in the quest to develop a broader view of reasonable(ness). The character of reasonable(ness) is thus best assessed or predicted by interrogating what is relevantly average and ideal together, rather than by average and ideal alone. This viewpoint presents a spectrum from the “average” to the “ideal or prescriptive”.^{7,8} This means judgment will be based on what is common and expected to what superlatively maximises welfare, and entrenches professional values, is virtuous, ethical and respects rights. In our case, analysing whether a practitioner took reasonable steps should include a combination of the following factors:

- Did the practitioner act like an average dentist would act, or like an ideal practitioner ought to act?
- Did the action of the practitioner result in benefit for the patient? Were the cost benefit or efficiency considerations met?
- Did the action cause harm to the practitioner or the profession?
- Did the practitioner, on average, act appropriately in all respects?
- Did the practitioner act like a person who cherishes or pursues high and noble principles, purpose or goals? Idealism constitutes the extreme end of reasonable(ness).

To the best of our knowledge the notion of reasonable(ness) has not been tested in dental practice. Extensive research is necessary to provide case law and precedence on the interpretation of reasonable(ness) in allegations of supersession.

The interactions between practitioners as a moral necessity.

We argue that the 2nd practitioner is not legally or morally

obligated to contact the 1st practitioner as a matter of compliance. In fact, there is no mutual reason or requirement for the 2nd practitioner to inform the first that “your” patient is seeking treatment at my establishment. Beneficence and nonmaleficence create the moral necessity for the practitioners to interact in the best interest of the patient. As indicated in Rule No 10, the objective of communication between the practitioners is to ensure that the treating practitioner is well informed about the patient’s diagnosis, prognosis and treatment. The 2nd practitioner does not require permission to treat but needs adequate clinical information to provide the best care. Practitioners ought to recognise that the absolute reason for engagement is to ensure the continuity of care and the best clinical outcomes for the patient, nothing else. This need to interact is underpinned first by the principle of medical beneficence,^{9,10} the moral obligation of the practitioner to act for the benefit of the patient. Second, nonmaleficence,^{11,12} or the obligation not to cause harm, pain, suffering, offend or deprive of a good life. Third, the promotion of a patient’s overall health and wellbeing.¹³

Termination of dental treatment as a triumph of autonomy

The principle of autonomy guarantees the patient’s absolute agency which implies, *inter alia*, that the patient can terminate treatment at any point during care.¹⁴ However, certain safeguards such as competence, voluntariness and informed consent must be satisfied *apriori*. Once these conditions are met, the patient cannot be impeded from terminating their relationship with the treating practitioner. On the contrary, incompetent patients must be protected from making irrational decisions including the termination of care. In such cases, paternalism is justifiable, advisable and necessary. According to Rule No 11 of the HPCSA, a practitioner has a duty “not to impede his/her patients from obtaining an opinion from another practitioner or from being treated by another practitioner”.¹ Hence the debate over whether a practitioner can truly take over a patient from another practitioner or patients can consult whichever practitioners they choose. We believe that, within reasonable limits, the patient has the absolute and uncontested right to consult a practitioner of their choosing. The protection of the respect for autonomy in dental practice is the first step towards a dentist-patient relationship and shared decision-making.¹⁵

CONTRACTS, COMPENSATION AND SUPERSESSION

The consensus between the patient and practitioner about the nature of the service and commensurate compensation creates an obligation. This obligation becomes a valid legal contract once signed voluntarily by the consenting patient. This formalisation of the contract establishes rights, assigns responsibility and apportions accountability in case of a breach.^{16,17} Yet most contracts are implied or tacit, because patients arrive in dental practices and are summarily attended to without clear and valid agreements. It is therefore advisable for practitioners to conclude a valid and legally binding contract before commencing with treatment.¹⁷ The contract must include a clause that deals specifically with breach. Breaching of a contract may occur when (i) the patient unilaterally terminates treatment without agreement with the treating practitioner; or (ii) if the practitioner fails to

provide the expressly guaranteed care.¹⁸ Notwithstanding the latter, patients have uncontested moral agency to make unilateral decisions about their care, including the termination of treatment. However, such a decision does not absolve the patient from their contractual obligations or invalidate the contract. The patient is duty-bound to fulfill their contractual obligations and compensate the clinician for their service, especially financial debts. Similarly, the practitioner cannot impede the patient from seeking care from another practitioner. Instead, the clinician can invoke all manner of avenues to recover the monies owed for the service provided. However, practitioners often resort to (i) withholding continuity of care; (ii) refusing to provide records to the second practitioner; and (iii) alleging that supersession has occurred. The actions of the practitioners as described above also deviate from the contract and may be deemed unethical. Anecdotal evidence suggests a plausible correlation between alleged supersession, amount of unpaid dental bills, type of service provided and nature of practice. Interestingly, practitioners in the public sector are seldom accused of supersession compared to colleagues in the private sector. Why? It is possible that supersession is largely attributable to economics and other material interests that pervade the private sector. During our illustrious years of public service, there has not been any allegation of supersession; instead, private practitioners are willing to refer their patients to the public sector when patients’ dental benefits run out. Our study did not evaluate factors associated with the spade of the alleged supersession. While extensive research is critical in understanding the root cause of supersession, practitioners should always have a formalised valid contract to protect their financial interests in case of a breach.

COLLEGIALITY TO THE RESCUE

Supersession is a mere codification and an attempt by the HPCSA to regulate practitioner behaviour and enable the regulator to mete out sanctions and apportion responsibility in line with the law of delict. We contend that collegiality is a more profound and fundamental mechanism to inculcate communal values in the health profession.¹⁹ Collegiality is more than just being “gentlemanly” and “polite” towards another colleague.²⁰ Collegiality is a “special relationship among doctors based on a common pursuit for medical excellence and a desire to provide good patient care”.²¹ Collegiality is also characterised by “respect for one another’s professional abilities, a genuine humility to accept constructive criticism and learn from one another, and an eagerness to help and serve one another”.¹⁹⁻²¹ Regrettable factors such as heavy workload and pressure, and a highly competitive clinical environment have contributed to the pervasive uncollegial behaviour among oral health professionals.

Ultimately, interprofessional collegiality improves patient care and enhances clinical outcomes. No clinician can do “it alone”.^{22,23} Professionals should work closely with each other, having mutual respect for the knowledge, competence and skills that each brings to the provision of patient care.^{21,24} Collegiality is the best antidote for supersession. No form of regulation can eradicate uncollegial behaviour among colleagues. The values of mutual respect and cooperation should be encouraged and incorporated into the dental curriculum for future professionals.

CONCLUSION

Taking over a patient is not *prima facie* supersession. Based on Rule No 10, the following conditions are necessary and jointly sufficient for suppression to occur: (i) the practitioner takes over a patient from the other; (ii) the patient is in active treatment; (iii) the patient has not terminated treatment; (iv) the practitioner is aware of ongoing active treatment; (v) the second practitioner did not take “reasonable” steps to contact the first practitioner. How these conditions are applied in practice remains a serious challenge. The failure by a patient to settle outstanding financial debts is a breach of contract, but not a sufficient or necessary condition for supersession. A practitioner may not refuse to provide medical information to colleagues on the ground of financial breach. A review of alleged cases on supersession by the HPCSA could provide valuable insights on how this rule is implemented.

REFERENCES

- Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974, 4 August 2006 amended 2009 and 2010
- Govan P. (2016). Supersession. South African Dental Journal. 2016; 71(8): 370-1
- South Africa. Department of Trade and Industry. Competition Act, 2009 (Act No. 89 of 1998). (Notice for an application for exemption. Government Gazette No. 32253
- McQuoid-Mason D, Dada M. A-Z of Medical Law, 1st ed. Cape Town: Juta and Company Ltd, 2011
- Coode G. On Legislative Expression: or the Language of the Written Law. Law Library. 1848; 60(1):1833-60
- Fletcher GP. The Right and the Reasonable. Harvard Law Review. 1985;98(5): 949-82
- Corten O. The Notion of “Reasonable” in International Law: Legal Discourse, Reason and Contradictions. International and Comparative Law Quarterly. 1999;48(3):613-625. doi:10.1017/S0020589300063454
- Griffey B. The ‘Reasonableness’ Test: Assessing Violations of State Obligations under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights. Human Rights Law Review. 2011;11(2): 275-327
- Avant LC, Swetz KM. (2020). Revisiting beneficence: what is a ‘Benefit’, and by what criteria? The American Journal of Bioethics. 2020;20(3):75-7
- Crisp R. The duty to do the best for one’s patient. Journal of Medical Ethics. 2015; 41(3): 220-3
- Omonzejele PF. Obligation of non-maleficence: moral dilemma in physician-patient relationship. Journal of Medicine and Biomedical Research. 2005;4(1):22-30
- Motloba PD. (2019). Non-maleficence – a disremembered moral obligation. South African Dental Journal. 2019;74(1): 40-42
- Kilbride MK, Joffe S. The new age of patient autonomy: implications for the patient-physician relationship. JAMA. 2018;320(19): 1973-4
- Bester JC. Beneficence, Interests, and Wellbeing in Medicine: What It Means to Provide Benefit to Patients. Am J Bioeth. 2020;20(3):53-62. doi: 10.1080/15265161.2020.1714793
- Srivastav S. Essentials of a Valid Contract. Indian Journal of Law and Legal Research. 2021;3(3):1
- Van Dokkum, N. Hospital consent forms. Stellenbosch L. Rev. 1997;7: 249
- Eisenberg MA. Why there is no law of relational contracts. Nw. UL Rev. 1999;94:805
- Mangiardi JR, Pellegrino ED. Collegiality: what is it? Bull New York Acad Med J Urban Heal. 1992; 68: 292-6
- Bess J. Collegiality: toward a clarification of meaning and function. Higher Education: Handbook of Theory and Research. Volume III. Agathon Press. 1992: 1-36
- Betzler M, Lösckke J. Collegial relationships. Ethical Theory Moral Pract. 2021; 24: 213-229
- Loh LC. Collegiality: a fix for our current crisis. Can Fam Physician. 2023;69(2):146. doi: 10.46747/cfp.6902146
- Barros PP, Brouwer WBF, Thomson S et al. Competition among health care providers: helpful or harmful? Eur J Heal Econ. 2016; 17: 229-233
- Attwood CA, Wellik KE. Cooperation. Clinical Journal of Oncology Nursing. 2012;16(5): 487-90. doi.org. 10.1188/12.CJON.487-490
- Ng IK, Tan SM, Law LS et al. Spotlighting ‘Medical Collegiality’. JR Coll Physicians Edinb. 2023;30:14782715231221833. doi: 10.1177/14782715231221833

Online CPD in 6 Easy Steps



The Continuing Professional Development (CPD) section provides for twenty general questions and five ethics questions. The section provides members with a valuable source of CPD points whilst also achieving the objective of CPD, to assure continuing education. The importance of continuing professional development should not be underestimated, it is a career-long obligation for practicing professionals.

