

SAMA INSIDER

FEBRUARY 2014



**A doctor's journey
through Gaza**

**Why doctors are
not punching bags**

**Dispensing licences
become permanent**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

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Nelson Mandela

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EDITOR'S NOTE FEBRUARY 2014



Conrad Strydom
Editor: *SAMA INSIDER*

Helping the helpless

It doesn't take the average medical graduate long before they realise how much the real world differs from medical school. Within the space of a few short months, they are plucked from an often self-congratulatory atmosphere of academic prestige and late nights hunched over Grant's Atlas of Anatomy and dropped in a high-pressure environment of 18-hour shifts where the slightest mistake could lose someone their life. There are as many horror stories as there are doctors: plugging arteries with one's fingers, performing surgeries on the floor due to a lack of beds or not being relieved for 48 hours.

After such a nightmarish day at work, it is no wonder many doctors feel their salaries are small compensation for the trauma they have had to endure, and some choose to forego compensation altogether. There has been a surge of interest in medical volunteer organisations lately, with many doctors devoting their time to treating disadvantaged persons at home and abroad. We take a look at one doctor's recollections of her time among the war-wounded in Gaza on pages 6 and 7.

We also check in with the SAMA Trade Union's General Secretary, Dr Mahlane Pahlane, who writes about the national doctor-bashing mentality on pages 8 and 9, while former SAMA chairman Dr Norman Mabasa keeps members informed about dispensing licences on pages 16 and 17.

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Design: Health & Medical Publishing Group (HMPG)

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Nossob Street,
Erasmuskloof Ext 3, Pretoria

Published by the Health & Medical Publishing Group (HMPG)
www.hmpg.co.za | publishing@hmpg.co.za | Printed by FA Print

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End-of-life decisions – some ethical considerations



Prof. Ames Dhai, President, SAMA

My first duty as President was to represent SAMA a day after my inauguration on the television programme 'Rights and Recourse'. The agenda was a debate on legalising euthanasia and four of us participated in the show. Two were vociferous on the merits of legally allowing such a practice. The other was a pastor who tenaciously advocated the sanctity of life. My responses were informed by ethical analysis and drew from international and local guidelines and codes.

The issue of euthanasia resurfaced in South Africa after Professor Sean Davison, an academic from the Western Cape, faced a charge in New Zealand of attempting to murder, in 2006, his terminally ill mother. His High Court trial ended late in 2011 with the Court withdrawing the attempted murder charge and Davison pleading guilty to a lesser charge of procuring and inciting his mother's death. Dignity South Africa, an organisation founded by Davison on his return to South Africa, has lobbied for assisted suicide to be legalised in the country.

From the international perspective, I drew on four sets of guidelines from the World Medical Association (WMA) which we as SAMA members subscribe to. They are:

- The WMA Declaration of Venice on Terminal Illness (adopted by the 35th WMA Assembly, Venice Italy October 1983 and revised by the 57th WMA Assembly in SA, October 2006);
- WMA Declaration on End-of-Life Medical Care (adopted by the 62nd WMA Assembly in Montevideo, Uruguay, October 2011);
- WMA Declaration on Euthanasia (adopted by the 38th WMA Assembly, Madrid, Spain in October 1987 and reaffirmed by the 170th WMA Council in Divonne-les-Bains, France May 2005; and

- WMA Resolution on Euthanasia (adopted by the 53rd WMA Assembly, Washington, USA, October 2002 and reaffirmed with minor revision by the 194th WMA Council in Bali, Indonesia, April 2013).

The Declaration of Venice recognises the fact that complex ethical issues will arise when dealing with end-of-life care and therefore questions regarding euthanasia and physician-assisted suicide inevitably surface. However, the WMA 'condemns' both these acts as unethical. It states that while advances in medical science have improved the ability of physicians to address many issues associated with end-of-life care, the latter is an area of medicine that has not received the attention it deserves. The dying process must be recognised as integral to a person's life and hence dying is integral to living. The primary responsibilities of the physician are to assist the patient in maintaining an optimal quality of life by addressing their psychosocial needs and controlling their symptoms so that they remain comfortable and retain their dignity until the very end. Alleviating suffering by appropriate clinical pain management is of paramount importance. The value of palliative care is underscored throughout the Declaration. In addition, the rights of patients with regard to advance directives and the designation of substitute decision-makers in the event that they are unable to communicate should there not be an advance directive are acknowledged as valuable components to their care.

In the WMA Declaration on End-of-Life Medical Care, the value of palliative care is highlighted as an essential component of good medical care. Good communication, respecting patient autonomy, adequate record keeping for continuity of care and medico-legal needs and the importance of acknowledging the family and emotional environment of the patient are all stressed. In addition, guidance is given for the very advanced stages of physical illness where symptoms may be refractory to standard therapy. Palliative sedation to unconsciousness is recommended in such cases as an extraordinary measure. In this situation, the patient and physician must agree that the clinical situation is intolerable. Palliative sedation must never be used without the patient's agreement where the patient is mentally competent. Furthermore, palliative sedation cannot be used to intentionally cause a patient's death.

The WMA Declaration on Euthanasia states: "Euthanasia, that is the act of deliberately ending

the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness." On the issue of physician-assisted suicide, the WMA Statement of September 1992 stresses that this action is unethical. However, it gives emphasis to the right to decline medical treatment as a basic right of the patient and states that the physician would not be acting unethically even where respecting such a wish would result in the patient's death. In its 2013 Resolution the WMA, while noting that the practice of active euthanasia with physician assistance is adopted into law in some countries, emphasised that the practice was in conflict with the basic ethical principles of medical practice and that physicians should refrain from participating in such activities.

Under South African law euthanasia is not legal and is considered to be murder. The End of Life Decisions Bill, which, if passed as an Act would have legalised euthanasia, was tabled in parliament in 2000 but has not progressed any further. With regard to ethical guidelines for the professions, the HPCSA's Booklet 12 on *Guidelines for the withdrawing or withholding of treatment* states that the HPCSA finds euthanasia, or the wilful act of causing the death of a patient, by a practitioner unacceptable. While there seems to be a lack of clarity among some members in the legal fraternity regarding the acceptability of the Living Will, the HPCSA gives credence to this document when it states that patients should be given the opportunity and encouraged to indicate their wishes regarding further treatment and to place in writing their directives for future care in possible critical circumstances. It further states that an appropriately drafted living will may be used for this purpose. This places an obligation on practitioners to follow the directives and wishes of the patient as contained in the living will. Failing to do so, would be tantamount to disrespecting the patient's choices and autonomy.

During the television programme, it became clear that the massive strides made in the discipline of palliative care are not understood and appreciated by many. Living life in dignity right to the very end is a reality. The answer should perhaps be that more energy and focus be directed to improving access to high-quality palliative care.

Healthcare in besieged Gaza

Aayesha J Soni, Vice Chairperson, Media Review Network

The views expressed in this article are not necessarily those of the South African Medical Association. It is published as an example of what doctors may experience while performing volunteer medical work.

As a final-year medical student at the University of the Witwatersrand in South Africa, going into Gaza on a humanitarian mission and seeing the healthcare system in Gaza was my prime objective. I had read that Gaza's hospitals are at 'zero stock levels' for 178 of 480 essential medications, with another 69 at low stock. Of 700 essential medical supplies, 190 are at 'zero stock levels' and another 70 at low stock. I was expecting to be faced with a dire situation in terms of the medical and healthcare situation.

I visited and spent the day at the largest hospital in Gaza – the Al-Shifa hospital. Whenever faced with a disaster of mass scale this is the prime spot where all the casualties are brought. We were warmly welcomed, in what became known as unique Gazan hospitality, by the director general of Al-Shifa hospital Dr Nasr. He began telling us about general conditions in the hospital and the operations carried out, highlighting the general and everyday struggles faced by the hospital. Al-Shifa hospital had carried out its first heart transplant – a remarkable achievement for a population cut off from all supplies, including medical access. Their surgeons had carried out various open heart surgeries; with the electricity being cut no less than six times during one of these operations. Amazingly the operation was still a success! The will of the doctors in Gaza was evidently no different from that of the people of Gaza – they were determined to be successful, no matter the challenges.

Walking around the corridors of the hospital, I was reminded of the healthcare system back in South Africa, except for the fact that Al-Shifa was considerably cleaner than the teaching hospitals I have worked at in South Africa. We were told how, during an Israeli attack, the number of patients brought into the emergency department would be so overwhelming that patients would lie in the corridors waiting to be treated. Considering the Emergency Department only had 11 beds, this was a reasonable expectation. I commented on the fact that Al-Shifa appeared very similar to our hospitals back home. Dr Nasr immediately pointed out a very relevant fact – South Africa is not under constant attack and does not have to deal with the military casualties inflicted upon



The South African delegation arrives in Gaza

the civilian population by the fourth largest army in the world, Israel.

During both onslaughts on the people of Gaza, during 2008/9 and 2012, white phosphorous – a chemical weapon illegal under international law – was indiscriminately used against the population of Gaza by Israel. Its effects are still seen today, as there has been a significant rise in the number of congenital heart diseases among babies in Gaza as a direct result of the white phosphorous. Also, this chemical substance has the ability to remain on trees and in the soil of the land for months after it is released – posing a constant threat to the people of Gaza who might come into contact with it on a daily basis. It has the potential to burn through skin on immediate contact. These chemical weapons are no different to those used in Syria but the reaction of the international community was baffling and astonishing.

The (1949) Fourth Geneva Convention has two protocols that afford special protection to medical personnel and humanitarian staff. These are enshrined in articles 14-24. The Convention also guarantees respect for the freedom of movement of medical personnel, and ensures they be granted all necessary material facilities for them to perform their duties, including removal of victims, attending to and transferring injured and sick civilians, pregnant women, and children who require vaccinations. Palestinian medical personnel indicate that during the reporting period (27



A young child in Gaza

December 2008 – 13 January 2009) Israel killed medical personnel, including two doctors, while they were on duty and attempting to evacuate the dead and wounded in the Gaza Strip. Investigations carried out by the Palestinian Centre for Human Rights (PCHR) indicate Israel targeted the medical personnel despite the fact they were wearing clothing that clearly identified them. In addition, during the reporting period, Israel also killed one truck driver working for the UN Work and Relief Agency (UNRWA) while he was transporting humanitarian aid near Beit Hanoun in the northern Gaza Strip. A second truck driver was seriously injured in the same incident. UNRWA subsequently suspended its entire



The pier at Gaza seaport

Gaza Strip operations for 24 hours, stating that Israel had targeted its staff despite the fact that its vehicles are clearly distinguished by blue UN flags, and UNRWA had secured prior coordination with Israel concerning the exact location and movements of its staff.

It became quickly apparent to me that the healthcare workers in Gaza put their lives in danger in a more serious manner than any other



The exterior of Al-Shifa Hospital, the largest and busiest healthcare facility in Gaza

healthcare workers across the globe. By taking an active decision to be on duty for the civilian population of Gaza during an attack, they were knowingly jeopardising their own lives. Yet with every single doctor we met it became apparent that this was a sacrifice they would be willing to make over and over again. Dr Nasr told us something profound as we were escorted around the hospital and even spent time in

the ICU department. He said: "We have decided to live". The people of Gaza have not given up. They have refused to succumb to the inhumane treatment they are subjected to daily from the Israeli siege and closure of the Rafah border by the Egyptian military. The people of Gaza have an enduring desire to live, no matter what and it is this courage in their hearts that will soon afford them their freedom!

Volunteer for a good cause

In today's increasingly profit-driven health sector, many doctors are becoming disillusioned with the contrast between the actual world of medicine and the lofty ideals of the Hippocratic Oath. Even conservative and outdated research indicates that doctors are nearly twice as likely to commit suicide than members of the general population. Rates of chronic depression and stress-related disorders are also markedly high among physicians, and understandably so – a constant exposure to pain and death on the one hand and cynical money-making on the other is hardly conducive to mental equilibrium.

For this reason, many doctors have decided to volunteer their time to worthy causes at home and abroad, often via a gamut of volunteer medical organisations such as Médecins Sans Frontières (MSF, aka Doctors without Borders) or our very own Gift of the Givers. MSF has long been known for their intervention work in some of the world's most dangerous warzones, including Sudan, Syria, Lebanon, Somalia, Guatemala and Yemen. They focus on providing humanitarian assistance in warzones, migrant and refugee health, emergency disaster response, treating

malnutrition and providing access to essential medicines. If you are interested, send an email to their Johannesburg office: active-recruitment@joburg.msf.org.

Pietermaritzburg-based charity organisation Gift of the Givers (GotG) was founded in 1992 by physician (and SAMA member) Dr Imtiaz Sooliman as a disaster response NGO. It is no exaggeration to say that, since then, they have become one of the world's most respected relief organisations. Operations in Bosnia, Syria, Japan, Yemen, Mozambique, Afghanistan and 24 other countries have resulted in 84 international accolades and no less than four South African Presidential honours. To sign up for duty with GotG, contact info@giftofthegivers.org or your nearest GotG office.

Another noteworthy organisation is the South African Red Cross Society, which has been commended for its role in the fight against HIV/AIDS in this country. You can contact their Hatfield office on 012 342 8610/12.

Although volunteering for some of the organisations can involve a very real element of danger, medical professionals who have volunteered their time – and risked their lives – for the benefit of their fellow man return with a sense of purpose and fulfilment not often

encountered in everyday medical practice. Most can unanimously endorse the power of this transformative experience, so do yourself a favour and consider volunteer work at least once in your career.



Gift of the Givers
FOUNDATION



Doctors are not punching bags

Dr Mahlane Pahlane, General Secretary, SAMA Trade Union



experiences and examples to substantiate this daily harsh reality for most doctors:

- You are only important and special in your ego and your dreams; in real life most people do not even recognise your value and hard work.
- Doctors – you are suffering from self-hatred and a syndrome of learned helplessness, you don't have any strategic and effective way of dealing with serious challenges to yourself and especially your profession.
- Everyone is making a lot of money out of your hard work except you; the pharmaceutical representative you disrespect has better perks than you, the car salesperson you are shouting at makes more money than you, the private hospital you work for makes more money and gives you the crumbs. The sad thing is that lawyers have even made a career and business out of your mistakes.
- In the financial scheme of things, you are mainly treated by the banks with some respect not because of your current high financial status, but mainly because the bank hopes that in the future you may make enough money to have a private banker. We may also venture to inform you that a plumber, electrician or a car mechanic charges you more money than you make in a month for the job they do for you in minutes or hours.

If doctors really were essential workers their requests for equipment would not fall on deaf ears

- Most doctors do not even have a restroom or a kitchen at their workplace; compare this with the five-star facilities in the management buildings in the same hospitals.
- Simple and cheap things like shaded parking are a luxury to the doctors; money

would rather be wasted on obsolete technological systems or equipment.

- The call rooms for most hospitals are inhabitable; dirty, poor hygiene, breaking furniture and a lack of very basic things such as a study table, a fridge or even a fan. This is in stark contrast to the big flat screens in the boardrooms, or even in labour wards where no one is interested in watching TV.
- There is no danger allowance for doctors despite their work being a daily flirting with diseases and death itself; how many doctors have been assaulted, raped or even killed while on duty without any compensation? How many doctors have contracted TB while at work without any compensation?
- Doctors are allocated to institutions without consultation, thrown into departments by force, put on the call roster with indifference.
- Most doctors are thrown to the wolves when they relocate to new jobs, compare this with the relocation benefits given to other civil servants; people are given a travelling allowance and accommodated in hotels for months.
- Doctors are forced to work extra-overtime with no pay, and the new trend is to even cut down or completely abolish overtime for certain departments without any consultation or consideration.
- The general hatred of a doctor is visible, tangible and palpable from the hospital gate to the porch corner offices of management and even in the corridors of power. People only appreciate doctors when they or their loved ones need medical treatment, especially emergency medical care.

Let us compare this with the overtime forms administrators submit for doing work they were supposed to have done anyway during normal working hours. It is ridiculous to say certain specialities do not do much work at night, though it indeed will never be the same, but overtime work is overtime work regardless of the department. Why are people working in other departments, such as the mortuary, not subjected to the same treatment when it comes to overtime? No one will be punished for not doing work in the mortuary because there were so many dead bodies received for a particular night, but why should doctors be punished because there were not that many

patients on a particular call? We have never heard of any bomb squad members or fire-fighters losing their salaries because there was little or no actual work done by them during a particular period.

It is a great tragedy when even the politicians can carelessly label doctors “a bunch of tsotsis” with impunity. It gets excruciatingly painful when the reports from the regulatory body are sensationalised with headings such as “doctors are drunkards and drug addicts”. The brutal and painful truth is that a medical doctor is reduced to nobody, a non-essential worker and a punching bag. The biggest tragedy is when all these missiles directed at medical doctors and the medical profession itself are now targeting the very core of its existence; politicians interfering and management dictating to the doctors who, where, when and how to treat patients.

If doctors were essential workers then their requests for life saving equipments and medication would not fall on deaf ears

and blind eyes, in preference for non-value adding things such as landscaping. If indeed their worth in saving life was fairly considered then rewarding them handsomely for the work done would not be such a big problem?

The greatest tragedy comes when even the politicians can carelessly label doctors “a bunch of tsotsis” with impunity

There is an onslaught on the salaries of medical doctors; it is starting right under our noses. We ignore it at our own peril, or we will perish as

the entire medical profession. First it was the abolition of the RWOPS, then the issue of extra-overtime, and now it is on the commuted overtime itself. What is next? How many doctors can survive without their commuted overtime salaries? These abrupt and unilateral changes in the work and salary structure of medical doctors are unfair, disruptive, demoralising and downright provocative.

If you are not affected personally yet, it is a matter of time, soon you will be screaming for help. All of us need to have a reality check; we need each other more than we think, unity is power. Let us not fall into the divide and rule strategy of those plotting our demise. We cannot afford to do nothing. Leadership without strong membership on the ground is powerless. Let us start a bottom up crusade to champion the interests and rights of doctors. An injury to one doctor should be an injury to the entire medical profession. If we achieve this, we can reverse all the ill and prevent future bigger ills threatening our noble profession.

Steve Biko Centre awarded prestigious titles

The Steve Biko Centre for Bioethics was recently awarded World Medical Association Cooperating Centre status and appointed to the South African Unit of the UNESCO International Network in Bioethics.

These accolades come at a time when the director of the Centre, Professor Ames Dhai, has been working relentlessly with the World Medical Association (WMA) on the revision of the Declaration of Helsinki, a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data. Two prominent international awards such as these are evidence that the Centre is recognised for its excellent academic standards both locally and globally.

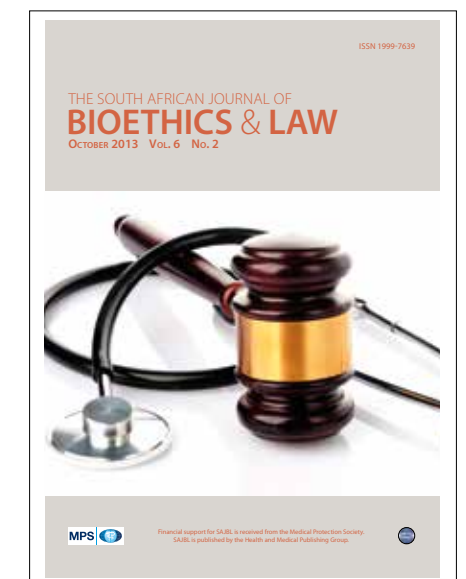
The central role that the South African Medical Association (SAMA) has played in the Centre's WMA achievement must be highlighted. SAMA recognised the expertise in the Steve Biko Centre and both facilitated and funded the Centre's participation in the Working Group of the Declaration of Helsinki. This is a clear example of the important role SAMA plays in supporting academia.

The Steve Biko Centre for Bioethics at Wits is the fifth centre to be given WMA Cooperating Centre status, joining the Centre for Global Health and Medical Diplomacy at the University of North Florida on Medical Leadership and Medical Diplomacy; the Centre for Study of International Medical Policies and Practices at George-Mason University in Fairfax, Virginia, USA on Microbial resistance and development of public health policy; the Institute of Ethics and History of Medicine at the University of Tübingen in Germany; and the Institut de droit de la santé at the University of Neuchâtel in Switzerland.

“Over the past one and a half years Professor Dhai has participated in the World Medical Association's revision of the Declaration of Helsinki. As such the WMA has come to recognise the contribution that she can make to their work,” says Professor Mkhululi Lukhele, Head of the School of Clinical Medicine in the Wits Faculty of Health Sciences.

“Being a WMA Cooperating Centre will add substantially to the international and national profile of the Centre and it is a great compliment to the Centre, the country and the continent for what it stands for and what it does in the medical world. It is quite an

achievement and one I am extremely proud of,” says Professor Dhai.



The Steve Biko Centre publishes the South African Journal of Bioethics and Law, a bi-annual, peer-reviewed journal that covers matters related to ethics, law and human rights. You can download the journal (open access) via the journal website: <http://www.sajbl.org.za>

Social networks important for seriously ill children

Just Footprints Foundation

The most frequent concern expressed by children who are being treated for cancer is disappointment in missing activities and time with friends. This is of greater concern for them than treatment procedures or side effects.

This research finding, by USA-based SeriousFun Children's Network (formerly Association of Hole in the Wall Camps), underlines the experience of the Just Footprints Foundation, a South African organisation that provides camping experiences for children with serious health and life challenges. Just Footprints camps are modelled on those of SeriousFun Children's Network.

Just Footprints Chairperson, Leoné Jooste, says that children who are undergoing treatment for serious illnesses often miss out on school and social events because of the time spent receiving treatment, and recovering from its side effects.

"This leaves them feeling isolated from their peers, which in turn leads to loneliness and depression.

"Our aim at Just Footprints Foundation is to create a fun-filled time for these children, in which they are surrounded by other children with similar life challenges. Our camps provide many opportunities for children to receive and give each other social support, whether through counselling by volunteers, or through the friendships with their peers on camps," she adds.

Ms Jooste said that the experience of the Just Footprints camps correlated with those of SeriousFun Children's Network camps in the USA, in that children and families view camps as an important context in which children build strong networks of social support and feel socially connected to peers, counsellors and adults.

SeriousFun Children's Network research involved a survey of and interviews with families of children who attended camps organised by the USA organisation.

"Social support at camp was associated with increased feelings of self-esteem and self-worth, positive emotions and the use of effective coping mechanisms. Interactions with peers, older children and adults provided opportunities for campers to feel socially connected to networks of social support. Moreover, children viewed older campers and counsellors as role models. Having role models gave children an opportunity to see



others coping with and adapting to many of the same struggles they faced, and helped them to think about what they may encounter as they grow older.

"Role models also provided children with models for how to cope with the stresses and challenges related to serious medical illness. These relationships also provided children with hope for the future as well as more appreciation for their own experiences, and increased their gratitude and sympathy for those who were suffering from more severe illnesses."

The research also highlighted the opportunity that camps provide for children to increase their sense of independence and experience a healthy separation from their families.

"Children with serious medical illness spend a significant amount of time in close contact with their families and, for many, this was their first experience away from home for such a lengthy period of time (not including hospital stays). Although the separation was initially difficult for most children, feedback indicates that their sense of independence and self-confidence increased during this separation."

Since the founding of Just Footprints Foundation in 2008, nearly 1500 children

have been given the experience of a lifetime, at no cost to the children, through 32 camps in three provinces.

The five-day camp programmes are designed to leave an indelible footprint on the lives of the children attending them. For most of them, the challenges they face have all but stripped them of the opportunity to be just children, to experience all the fun and sheer joy of life that should be part of childhood.

Many of them are fighting a heroic battle with a serious illness. Some of them may need the help of assistive devices. Others may need to be always close to medical attention. Still others may be living with HIV and a strict regime of medication. Or they may be part of a sibling-headed household for which every day is a battle to survive in a hostile world.

A sparkling time is in store for the children on our camps as their days are filled with the joy of childhood. Whether through the creativity of an arts and crafts workshop, the challenge of a specially-designed obstacle course, the discovery of the natural world, the fascination of story-telling, the bonding of team work – everything is geared towards making this a special and memorable time for each child.

SEDASA congratulates first group of AHMP candidates

Dr Kallie Spenser, SEDASA

The Senior Doctors Association of South Africa (SEDASA) would like to congratulate the first group of graduates to complete the Advanced Health Management Programme (AHMP) which is co-certified by the Yale School of Public Health and the Foundation for Professional Development (FPD). This is an intensive management development short course (it takes one year to complete) that is tailor-made for African healthcare executives and professionals in the public or not-for-profit sector.

This course has been customised for health managers working in the field of HIV/AIDS and is designed to take into account the time constraints of managers who work full-time. The programme is designed to develop the participants' strategic management

capabilities by broadening their views of their roles in the HIV sector and developing key managerial competencies required to successfully manage in such an environment.

With the onset of the National Health Insurance, SEDASA encourages the position of healthcare managers to be filled by doctors. Courses like these educate and empower doctors to successfully perform these functions. This group of students were the product of a successful partnership between the SEDASA (Senior Employed Doctors Association of South Africa) and FPD.

According to SEDASA Chairperson, Dr Zameer Brey: "These doctors represent the first step in a long journey and commitment to empowering health care managers in South Africa. We believe that healthcare should be managed by those who understand it

well and are able to create environments that encourage patient and staff wellbeing simultaneously."

We would proudly like to congratulate the following SEDASA members who have graduated from this programme:

- Dr F Chinyanga: Dr Chinyanga is passionate about hospital management and health systems, with a desire to become a health systems specialist.
- Dr S Joubert: Dr Joubert is a specialist physician at Kimberley Hospital.
- Dr M Obida: Dr Obida works at Tshilidzini Regional Hospital as a Family Medicine specialist.
- Dr E Orisake: Dr Orisake currently works at Ngwelezana Hospital.
- Dr S Peters: Dr Peters works at Mahatma Gandhi Memorial Hospital in Phoenix.

FPD Business School – training tomorrow's leaders



The Business School has been a part of the FPD journey for the past 15 years, reaching new heights every year in establishing a footprint of training excellence.

We pride ourselves on choosing faculties based on their exceptional skills, experience and ability to continuously research, explore and apply new and dynamic practices in the classroom.

We also enable independent learning through our distance courses as well as the self-study aspect of our combination courses. Our workshops are facilitated in a problem-based and integrated approach through case studies and role-play.

The Business School emphasises trans-lating management and theory into practical

workplace skills. This is ensured through our educational approach, our panel of national and international subject expert faculty and our willingness to customise training programmes for our market.

Enrol now for an inspiring experience that will renew your leadership potential and strategic direction in life! Courses include the ever-popular Certificate in Practice Management (CPM), aimed at practice managers and health professionals in private practice or who plan to go into private practice, the Diploma in Advanced Health Management (DAHM) aimed at individuals who hold management positions in the healthcare environment and the Certificate in Risk Assessment and Management (CRAM) aimed at healthcare managers and hospital case managers.

There are also plenty of short courses available. Often these courses comprise a self-study module coupled with a one or two day interactive workshop. Available short courses include courses on corporate governance, HR management, marketing and communications, personal effectiveness,

project management, strategic planning, conference organisation, resource mobilisation and donor relations, B-BBEE, clinical issues in health risk assessment and diversity management.

Every course the FPD Business School offers is aimed at improving the leadership ability of healthcare providers and increasing the efficiency of the organisations they serve. The FPD is registered with the Department of Education as a Private Institution of Higher Learning under the Higher Education Act of 1997, so you know you are getting a recognised, quality education whenever you sign up for one of these courses.

Since 1998, no less than 233 000 students have received qualifications through the FPD. In 2013 alone 32 525 students enrolled for courses. With such a track record, it is no wonder that medical doctors, nurses, educators, law counsellors and healthcare managers all view the FPD as their training institution of choice.

For more information, phone 012 816 9000/9099 or email: lanavdm@foundation.co.za.

SAMA Trade Union calls for ‘stay in school and succeed’ campaign

Dr Phophi Ramathuba, *President, SAMA Trade Union*

The South African Medical Association Trade Union calls for all school-going children in general, and township and rural school children in particular, to stay in school and make a success of their schooling. We call upon all stakeholders to make Nelson Mandela's legacy and values on education a reality as he strongly believed that "education is the great engine of personal development. It is through education that a daughter of a peasant can become a doctor, that the son of a mine worker can become the head of the mine, and that the child of farm workers can become the president of a great nation. It is what we make out of what we have, not what we are given, that separates one person from another".

We are indeed fully aware that the only way we became doctors and managed to escape abject poverty was through education. It is our collective national duty that we create

opportunities for all children to have access to quality education. As professionals and adults, we need to help young people deal with challenges that prevent them from getting a high quality education:

- The high 30% teenage pregnancy rate;
- The high dropout rate of about 12% in Grade 11-12, with even a more alarming dropout rate of 46% in tertiary institutions;
- The social and health ills such as HIV orphans, child-headed households and extreme poverty.

We invite all doctors to visit their nearest schools and offer their services and time. We call upon all doctors to adopt at least one school and provide mentorship, career guidance and health education. There is currently a tremendous shortage of workers in the healthcare sector and doctors should encourage school learners to strive for

“[Doctors] need to help young people deal with challenges that prevent them from getting a high quality education”

careers in this sector, whether as nurses, doctors, researchers, administrators or allied service workers. We further expand this noble call to all other professionals and organisations that share the same ideals and hope to work together for a more significant and positive impact on our education system.

Pay your annual HPCSA fees

SAMA Legal and Governance Department

The Health Professions Council of SA (HPCSA) published Board Notice 1 of 2014 in the Government Gazette on 3 January 2014 and intends to prescribe the annual fees payable by registered practitioners as set out in the schedule. The amount of the annual fee payable for 2014 by medical practitioners is R1 318 and that for

medical practitioners as specialists is R1 343.

The schedule of all annual fees payable to the HPCSA is available on the Council's website under <http://www.hpcsa.co.za> > Fees > Annual fees.

The annual fees payable by persons registering with the Council for the first time, in terms of the Health Professions Act 1974,

will be a pro rata amount of the applicable annual fee and will be calculated according to the month of registration after the due date for payment of annual fees.

We wish to remind members of the South African Medical Association that the annual fees payable by persons registered with the Council is due and payable with effect from 1 April 2014.

New online service eases Compensation Fund claims

Department of Labour



In an effort to improve service delivery, the Compensation Fund introduced a number of new online services in December 2013.

This enables both employers and medical service providers to hand in COIDA-related claims online in an attempt to get rid of the phenomenal backlog of current claims and shorten the time it takes for claims to be processed.

It allows users to request, print or determine the validity of 'good standing' letters; report injuries on duty; check on the

status of their claims and upload medical reports and bills.

To gain access to these services, go to <http://www.labour.gov.za/DOL/services> and create a user account.

If you have difficulty accessing these services, phone 0860 105 350 or email cfcaseinput@labour.gov.za.

Farewell to acting PPD chief, Dr Jacques Botha

SAMA Private Practice Department



We regret to announce that Dr Jacques Botha left SAMA on 3 January 2014. Jacques started working at SAMA on 1 September 2011 and became the youngest-ever acting head of the Private Practice Department at SAMA in April 2013.

After completing his studies at Tuks in 2006, Jacques became an Exco member of the Junior Doctors Association of South Africa (JUDASA) and the honorary secretary of SAMA's Western Cape branch in 2010. He was appointed Strategic Account Manager in SAMA's Private Practice Department in 2010. Jacques is very eager to continue the work he started at SAMA in his subsequent career: "In all future endeavours I will continue to strive to improve the lives of medical professionals."

He is fondly thought of by those who served under him in the Private Practice

Department. According to Glenda de Beer, the new acting head of the department: "During his time at SAMA and lately as acting head of the Private Practice Department, Jacques always aimed to please. He always walked the extra mile when you asked him to assist you with something. He was even willing to help in matters that were not work-related."

"He endeavoured to keep Private Practice alive and was always looking for new ways to make the lives of medical doctors easier. In his time at SAMA, he implemented or assisted in implementing many projects for the benefit of SAMA members. We in the Private Practice Department will miss him dearly and wish him the best for the future."

SAMA wishes Jacques all the best in his career ahead and hopes that he will achieve many moments of happiness, success and achievement.

Member profile: Dr Meshack Mbokota



firsthand knowledge of the difficulties that specialists face. We asked him for his take on these challenges and the general direction of private practice in South Africa.

What are the biggest challenges facing specialists today?

Undoubtedly, the biggest challenge is the current confusion about tariffs. This is an explosive situation that has been caused by the fact that we, the South African Medical Association, are no longer allowed to publish tariffs in the Doctor's Billing Manual we publish annually. Instead, a situation has developed where the HPCSA is trying to implement a new set of guideline tariffs without consulting us. This is indeed a great pity. Another thing that troubles us is the fact that there is no explicit mention of the role of specialists in private practice in the NHI Green Paper. We remain hopeful that this situation will be remedied in the White paper, which should be arriving anytime soon.

What are your thoughts about the looming NHI programme?

Actually I am quite optimistic, for the simple fact that it is the duty of doctors to fight for

the provision of health services to the general population, not only those who can afford it. The NHI will completely level our society in terms of healthcare – rich and poor alike will have access to the same level of basic care, and this is indeed a wonderful thing. Also, if this programme is properly implemented, it will mean that we can finally switch our system from a curative one, which only focuses on symptoms, to a preventative one that will stop diseases from occurring.

What concerns you most about South African healthcare?

The fact that we have an increasing burden of diseases, particularly lifestyle diseases such as diabetes, that are exerting tremendous pressure on our health system. I am also worried about both government and private funding of healthcare. It seems to me that medical fund managers hardly ever remunerate doctors properly, especially in private practice, where the cost of running a practice is never covered in payouts. In the end the patient suffers, since the doctors are forced to raise their prices to cover their practice fees. This causes a lot of confusion in the market.

Risk Management in medical practice and hospitals

Negligence is a legal concept. It does not mean neglect or wilful misconduct, but a failure to attain a reasonable standard of care. Any doctor can make an error of judgment. Some are legally defensible, others are not; what is important is whether the management can be defended by a responsible body of professional opinion. In cases of negligence, the only remedy available in law is financial compensation: damages are paid to restore claimants to the position they would have been in had the negligent act not occurred. Before damages are payable, however, the claimant must prove all three of the following: a) they were owed a duty of care; b) there was a breach of that duty of care; c) damage was suffered as a result.

Adopt accepted practice

Accepted practice is easy to define in some areas – prescribing in accordance with the recommendations of the South African Medicines Formulary is an obvious example. Increasingly, proper practice has to be based on evidence (i.e., determined by systematic methods based on literature review, critical appraisal, multidisciplinary consultation and grading of recommendations by strength of evidence).

Accepted methods of investigation and treatment are often described by clinical guidelines. Such evidence-based guidelines improve the quality of clinical decisions, help replace outdated practices, and provide benchmarks for clinical audit. Guidelines are not directives, so in theory you may choose to exercise your discretion by deciding not to follow a particular guideline. In reality, however, you should only deviate from the accepted practice embodied in the guidelines if you have very good reasons for doing so. If your judgment is called into question, you will have to demonstrate why you were justified in not complying with the guidelines. Conversely, if you follow respectable clinical guidelines and base your decisions on evidence, you will be in a very strong position if a complaint is made against you.

Act within your limitations

Although you are not expected to be infallible, the law expects that, as a doctor, you exercise a reasonable standard of skill and care at all times. As a general rule, you

should not undertake tasks that are beyond your competence. The exception is if you find yourself in a situation where a patient will die or sustain severe and permanent injury without urgent intervention and you are the only (or most experienced) doctor available. Ideally, you should ensure that sufficient help and equipment are available for any procedure you undertake, and for the management of all foreseeable complications.

Keep up to date

Under the terms of your registration with the Health Professions Council, you are obliged to continually update your professional knowledge and skills. This usually means enrolling in some kind of formal learning programme on a subject relevant to your clinical practice in order to earn credits. It also requires that you keep abreast of developments in your field by regular reading of relevant journals and published guidelines. Successful CPD depends to a great extent on planning, and good planning is predicated on an accurate assessment of learning needs. Before you can assess your learning needs, however, you need to identify them – something that's not always that easy to do because it means finding out what you don't know or, as Maslow put it, your unconscious incompetence. Abraham Maslow published his model of the four stages of learning back in the 1940s, and it's still widely employed by educationalists. It's a simple model – two axes (unconscious – conscious and incompetent – competent) give rise to a matrix comprising four quadrants. In many respects, getting from the first stage – unconscious incompetence – to the second stage – conscious incompetence – is the most difficult transition because, by definition, we're not conscious of the deficits in our competence. Many of these deficits will naturally advance into the realm of conscious incompetence as you come face to face with them in your daily practice, or because you're made aware of new information through reading journals and talking to colleagues. Others, though, are harder to uncover and you will need to employ various techniques to identify your shortcomings. The best ways to find out where you're falling short are either to measure your performance against an accepted standard (auditing), or to get feedback from colleagues and

patients. Sources of information might be formal or informal, planned or unplanned, and although some might arise from solitary reflection, most require some form of feedback from colleagues, patients or others.

Take responsibility for your health

If you have an illness, disability or infection that may put patients at risk, you must seek medical advice and, if necessary, stop or reduce your practice. The safety of your patients should be your prime concern. If you do not already have one, register with a family doctor; apart from simple and obvious conditions such as common colds or sore throats, you should not rely on self-diagnosis and treatment. Your GP will be able to provide a better sense of perspective than you can, and if he/she thinks you are not fit to work you should respect his/her opinion.

Check equipment

Be fully conversant with any equipment you use – ensure that it has been properly serviced and is in working order before beginning any procedure. This advice applies not only to complex machinery and software, but also to simple components such as tubing. Several deaths have been reported due to foreign bodies occluding anaesthetic tubing, for example. Had the patency of the tubing been properly checked beforehand, the deaths could have been avoided.

Other things to consider are: ensuring that you have replacements, such as batteries and bulbs, available if needed, the cleanliness of the equipment or instrument, whether you know what to do if a crucial piece of equipment – such as a dialysis machine or a ventilator – fails and whether emergency equipment (e.g., a mask and bag) is available, knowing the whereabouts of back-up equipment, whether you've been taught how to use the equipment and know how to run operational checks or troubleshoot common problems.

Delegate appropriately

In the context of multidisciplinary and cross-agency teamwork, it can be difficult to distinguish between delegation and shared responsibility. The question is really one of accountability and clarity about who is responsible for each aspect of a patient's care. As a member of a clinical team, you

will have ongoing responsibilities for the care of patients, some of which you might delegate to staff who do not belong to a registered professional organisation. In these circumstances you would be held accountable for the actions of those staff members, so you must satisfy yourself that they are competent to take on the duties you are delegating to them and supervise them if necessary. The matter is a little different when you delegate to a professional colleague. You would not be held accountable for the actions of another registered professional, but you would still be expected to delegate appropriately (i.e., to a colleague with relevant training and skills) and to have provided them with sufficient information to carry out the task assigned to them. If a colleague delegates tasks to you, make sure that you are properly briefed and if the task lies outside your expertise, say so.

Keep comprehensive up-to-date records

The medical record is an essential component of patient care. A good medical record will contain all the information one clinician needs to take over where another left off – or, to put it another way, to allow a clinician to reconstruct a consultation or patient contact without relying on memory. It should, therefore, provide all the information a newcomer to the care team would need to know about a patient and their treatment plan. If you ever need to alter the notes at a later date, make it clear that you are introducing a retrospective correction. Any alteration to paper records should be clearly dated and signed. Do not obliterate the original entry – just run a line through it. Never try to rewrite notes at a later date. Do not delete entries in computer records, but add annotations to them if necessary (and date and initial them if the software doesn't do it automatically). Do not write derogatory statements or criticisms about patients, colleagues or others; be as objective and factual as you can in making your notes. If you record any history provided by someone other than the patient, make sure you include the source – e.g., "Has been 'confused lately' (daughter)". Remember, patients have a legal right of access to their records, which can also be scrutinised by the courts.

Be aware of the potential for medication errors

Medication errors account for a high level of complaints, claims and adverse incidents.

The World Health Organisation estimates that patients suffer adverse events related to the administration of medication in approximately 1% of all hospital admissions. The underlying causes include:

- "inadequate knowledge of patients and their clinical conditions
- inadequate knowledge of the medications
- calculation errors
- illegible handwriting on the prescriptions
- confusion regarding the name of the medication
- poor history taking."

Many of these can be avoided by being conscious of the most risky aspects of prescribing, calculating doses and administering drugs. A good starting point for reducing your own risk of committing a prescribing error is to follow the guidance set out by the Department of Health (see – avoiding prescribing errors below).

Negligence is a legal concept. It does not mean neglect or wilful misconduct, but a failure to attain a reasonable standard of care.

Avoiding prescribing errors

"Drugs should be prescribed only when they are necessary for treatment following a clear diagnosis. Not all patients or conditions need a prescription for drugs. In certain conditions simple advice and non-drug treatment may be more suitable. "In all cases carefully consider the expected benefit of a prescribed medication against potential risks. This is important during pregnancy where the risk to both mother and foetus must be considered.

"All prescriptions should:

- be written legibly in ink by the prescriber with the full name and address of the patient, and signed with the date on the prescription form;

- have contact details of the prescriber e.g., name and telephone number.

"In all prescription writing the following should be noted:

- the name of the drug or preparation should be written in full using the generic name; and
- no abbreviations should be used due to the risk of misinterpretation. Avoid the Greek mu: write mcg as an abbreviation for micrograms
- Avoid unnecessary use of decimal points and only use where decimal points are unavoidable. A zero should be written in front of the decimal point where there is no other figure, e.g. 2 mg not 2.0 mg or 0.5 ml and not .5 ml
- Frequency. Avoid Greek and Roman frequency abbreviations which cause considerable confusion – qid, qod, tds, tid, etc. Instead either state the frequency in terms of hours (e.g. 8 hourly) or times per day in numerals (e.g. 3x/d)

State the treatment regimen in full i.e:

- drug name and strength
- dose or dosage
- dose frequency
- duration of treatment e.g. amoxicillin 250 mg eight hourly for five days
- In the case of 'as required' a minimum dose interval should be specified, e.g. every 4 hours as required
- Most monthly outpatient prescriptions for chronic medication are for 28 days; check that the patient will be able to access a repeat before the 28 days are up
- After writing a script, check that you have stated the dose, dose units, route, frequency, and duration for each item. Consider whether the number of items is too great to be practical for the patient, and check that there are no redundant items or potentially important drug interactions. Check that the prescription is dated and that the patient's name and folder number are on the prescription card. Only then sign the prescription, and as well as signing provide some other way for the pharmacy staff to identify you if there are problems (print your name, use a stamp, or use a prescriber number from your institution's pharmacy)."

Acknowledgement: The above article forms part of the MPS risk management booklets and has been published with consent from the MPS.

Dispensing doctors breathe a sigh of relief as all dispensing licences are now permanent

Dr Norman Mabasa, *Chairman, National Convention on Dispensing*



of licensing in the first place. The course came at a price. All hell broke loose. There were approximately 7 000 dispensing doctors at the time and the course cost an average of R2 400 per head. At least R17m was amassed in one fell swoop. Talk of modern-day tenders (or a lotto win *noga!*).

Other paraphernalia formed part of the process and I mention a few below:

- You were to advertise for 30 days before you applied and required to attach a copy of that advert to your application form – many of which got lost and you battled to reconstruct your story. Newspapers charged between R400 and R500 x 7 000 medical practitioners excluding nurses both in public and private sectors. Newspapers even issued adverts offering to advertise dispensing licence applications. This was one of the biggest tenders which will go down in history as the worst exploitation of health professionals by the DoH.
- You were to motivate to convince the Director-General (DG) why you think you must be given a dispensing licence. In fact some doctors compiled ‘mini-bibles’ to try and compile a convincing story on why they wanted to dispense. Others even appointed law firms to do it professionally (I am serious here).
- You also had to compile a list of all dispensers, including pharmacists, other professionals in your area and give the distances from your intended dispensing rooms. Anybody could object to your application. Pharmacists even established an ‘objection website’ whereupon sighting your advert in the newspaper they would assault your application to convince the DG otherwise, and indeed such objections are rumoured to have been sent.
- You then had to give measurements of your building.

Once you had been through the whole rigmarole and got your licence you had to pay R800 annually to maintain your licence. Multiply that by 7 000 (now 10 000) medical practitioners.

You were to renew at the cost of R1 000 in the third year without forgetting your R800 ‘maintenance fee’ so the third year

would leave a dispensing doctor R1 800 poorer. On applying for renewal the original paraphernalia of adverts, motivations, objections, etc. applied.

The NCD took the Department to court and won their first victory in 2005 when the Constitutional Court declared the requirement that prevented them from dispensing within a 5 km radius from pharmacies, unconstitutional and invalid. In the following years, the NCD also won their fight against the publication of advertisements, the high annual licence fee and the low dispensing fees.

Enough about this historical nightmare.

I am happy to report that all that is now in the past after the NCD engaged the DoH and received a warm welcome, thanks to the Minister of Health, Dr Aaron Motsoaledi and the Director-General, Ms Precious Matsoso.

From this year, doctors with valid dispensing licences will no longer be obliged to renew them once obtained and these licences will remain valid indefinitely

Dispensing doctors have won the last of their battles to effectively nullify most of the requirements around dispensing licences in the much contested regulations of the Medicines and Related Substances Act that came into effect in 2003.

From this year, doctors with valid dispensing licences will no longer be obliged to renew them once obtained and these licences will remain valid indefinitely, provided the holder pays an annual R200 licence fee or until the licence is suspended or revoked by the Director-General of Health. This followed

an agreement reached between the National Convention on Dispensing (NCD) and the DoH after the publication of an amendment to the 2003 regulations in the Government Gazette on 14 October last year.

The scrapping of the three-year (now five-year) renewal requirement will effectively save the country’s 10 000 dispensing doctors a total of R10m as they had to pay R1 000 for each renewal. It will also bring an end to the frustrating administration process at the DoH that often delayed renewal notices, resulting in medical schemes not paying doctors for the medicines they dispensed after the expiry date of a licence.

There was initial confusion around the interpretation of the amended regulations, which required one more renewal before a permanent licence would be granted. However, in December the DoH accepted recommendations from the NCD that no further renewals will be required from doctors in possession of valid dispensing licences providing that they pay their annual fees. It was also agreed that the Department would issue revised licences with no expiry date

reflected to replace existing valid licences without the holders having to submit any further documentation.

The Department has been requested to send statements to all current licence holders reflecting outstanding fees or other amounts owing and give them six months to bring their accounts up to date. The NCD emphasised that no doctor should be penalised if the Department cannot provide proof that a statement was sent out. It also wants an online database set up of all dispensing doctors with valid licences, which will allow them to verify their details and ensure that they are informed about the Department’s requirements.

The Department sent a letter to the Board of Healthcare Funders (BHF) in December 2013 to notify medical schemes that the expiry date of all licences will be amended to 2028 and that a doctor’s licence can only be revoked if the BHF is advised by the Department to do so on the grounds of non-payment of the annual licence fee. This is to give the Department time to issue all current licence holders with permanent licences. This process

could take twelve months. When the licence regulations were implemented, the annual fee was set at R800 but this was reduced to R200 in 2009 following submissions by the NCD. We saved R6m per year.

The battle is not over yet. The NCD remains in existence to fight for the right of dispensing doctors to get a decent dispensing fee which we believe is currently not equitable. Doctors buy medicines from wholesalers at the same price as pharmacists and yet the gap in the dispensing fee is appalling.

The NCD has managed all of this because of doctors’ contributions which have enabled us to go to court and to pay our office expenses. The results are there for all of us to see. Doctors are still encouraged to support the office of the NCD financially as we still have to make sure there is no threat to our existence.

I wish to thank all members of the NCD committee who worked tirelessly to achieve this result and veteran activist, Dr Joe Maelane, for his background role.

To contribute or for any inquiries about NCD please contact Mrs Debbie Enslin on 082 955 1752.

Protection of Personal Information Act: What medical practitioners need to know

Rebecca Moeketsi, *SAMA Legal Advisor*

The Protection of Personal Information Act seeks to regulate the processing of personal information by both private and public bodies; in pursuant to the constitutional right to privacy entrenched in Section 14 of the constitution. The Act applies to the processing of personal information by or on behalf of a responsible party domiciled in South Africa or by using automated or non automated means in South Africa.

The Act confers the data subject (person to whom the information relates) with a number of rights where the processing of personal information is concerned i.e. the right to object to processing of personal information, to be notified of processing of personal information, to establish whether the responsible party holds information, to request correction, destruction or deletion of personal information, to refuse processing for direct marketing by unsolicited electronic communications, to complain to the

Regulator and institute civil proceedings where there has been a contravention of any provisions of the Act.

The Act defines ‘personal information’ as information relating to an identifiable, living, natural person, and where it is applicable, an identifiable, existing juristic person, including, but not limited to information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the person; information relating to the education or the medical, financial, criminal or employment history of the person; any identifying number, symbol, e-mail address, physical address, telephone number or other particular assignment to the person; the blood type or any other biometric information of the person; the personal opinions, views or preferences of the person; correspondence

sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence; the views or opinions of another individual about the person; and the name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person.

While ‘processing’ is defined as any operation or activity or any set of operations, whether or not by automatic means, concerning personal information, including the collection, receipt, recording, organisation, collation, storage, updating or modification, retrieval, alteration, consultation or use; dissemination by means of transmission, distribution or making available in any other form; or merging, linking, as well as blocking, degradation, erasure or destruction of information.

In light of the above there is no doubt that the application of the Act is wide enough and applies to all sectors and all information patterning to natural persons and/or juristic persons, except where processing is purely in the course personal or household use, where the information has been de-identified and cannot be re-identified, where processing is by a public body regarding national security or prevention and detection; by the Cabinet and Committees and Executive Council, where processing is for the purpose of investigation or proof of offenses, prosecution of offenders, execution of sentences or security measures, for exclusive journalistic purposes, relating to judicial functions of the court or exempted in terms of section 37.

According to Section 10(1) Personal information may only be processed if the data subject consents to the processing; where processing is necessary to carry out actions for the conclusion or performance of a contract to which the data subject is party; where processing complies with an obligation imposed by law on the responsible party; where processing protects a legitimate interest of the data subject; is necessary for the proper performance of a public law duty by a public body; or is necessary for pursuing the legitimate interests of the responsible party or of a third party to whom the information is supplied. Subsection 2 gives the data subject a right to object, at any time, on reasonable grounds relating to his, her or its particular situation, in the prescribed manner, to the processing of personal information, unless otherwise provided for in national legislation. If a data subject has objected to the processing of personal information in terms of Subsection 2, then the responsible party may no longer process the personal information.

Section 25 prohibits the processing of personal information concerning a child who is subject to parental control in terms of the law; or data subject's religious or philosophical beliefs, race or ethnic origin, trade union membership, political opinions, health, sexual life or criminal behaviour.

The only exception to the general prohibition against processing personal information concerning a child (a natural person under 18 years of age who is not legally competent) is where the consent of a competent person to take any action or decision regarding any matter concerning the child is obtained.

In terms of Section 30 the prohibition on processing personal information concerning



a data subject's health or sexual life, as referred to in Section 25, does not apply to the processing by medical professionals, healthcare institutions or facilities or social services, if such processing is necessary for the proper treatment and care of the data subject, or for the administration of the institution or professional practice concerned. Processing by insurance companies, medical aid scheme administrators and managed healthcare organisations is also not prohibited, if such processing is necessary for assessing the risk to be insured by the insurance company or covered by the medical aid scheme and the data subject has not objected to the processing; the performance of an insurance or medical aid agreement; or the enforcement of any contractual rights and obligations.

It is important to take note that personal information processed in the manner provided for in Section 30 is subject to an obligation of confidentiality and may only be disclosed as required by the law and only to authorised third parties.

The above therefore means that personal information may only be processed by responsible parties subject to an obligation of confidentiality by virtue of office, employment, profession or legal provision, or established by a written agreement between the responsible party and the data subject and where no such agreement and / obligation exists the responsible party must still treat the information as confidential.

Personal information concerning inherited characteristics may not be processed in respect of a data subject from whom the information concerned has been obtained, unless a serious medical interest prevails; or the processing is necessary for the purpose of scientific research or statistics.

Where Section 30 does not apply, processing of prohibited personal information may only take place with the consent of the data subject or as provided for in Section 10(1). Sections 26-32 provides for further exceptions to the provisions of Section 25.

It is important to note that a private or public body is responsible for the security and integrity of personal health information collected by it. Security measures need to be in place if a third party will process information on the responsible party's behalf. Personal health information must be collected directly from a person unless consent to collateral collection has been obtained or the information is derived from a public record.

Information may not be retained for longer than is necessary to fulfil the original purpose for collection, except with the data subject's consent or where retention of records is required by law. Records may be retained where the responsible party requires it for purposes of its lawful functions. Personal information must be destroyed or at least de-identified as soon as practicable once the purpose for collection is fulfilled and the responsible party is no longer authorised / or obliged to retain the record by law.

Where the processing of personal health information is outsourced to third parties, the responsible party must ensure that the conditions of lawful processing are complied with and that agreements with third parties require them to comply with the relevant conditions of lawful processing i.e. confidentiality clauses must be incorporated in such agreements. Unauthorised processing of personal health information constitutes an offence.

All private and public bodies affected by the Act have a year to comply from the day when the Act came into effect i.e. 26 November 2013.

Penetrating the eyeball

The Medical Protection Society shares a case report from their case files

Ms J, a 36-year-old banker with myopia, consulted Dr R, an ophthalmologist, with a one week history of pain and blurring of vision in the left eye. Dr R diagnosed anterior uveitis and prescribed corticosteroid eye drops, and proceeded to give a sub-tenon's injection of 0.5 ml depomedrol under local anaesthesia in the lower outer corner of the left eye.

The patient felt minor pain with the local anaesthetic injection but felt excruciating pain with the depomedrol injection. Within seconds a black spot blocked the central vision in the left eye. The spot expanded rapidly until the vision was completely lost. Dr R continued injecting till the full dose was given. On examining the left eye Dr R found that the eye was filled with fluid – he arranged a follow-up consultation the next day.

Ms J called later that afternoon to ask if she could see Dr R immediately but was advised to return the next day. Ms J chose to see another ophthalmologist who diagnosed a localised retinal detachment and referred her to a retinal surgeon, who performed surgery eight hours later.

The retinal detachment was caused by two needle punctures penetrating the eyeball and injecting depomedrol into the eye instead of the intended sub-tenon's space. She underwent surgery to repair the retinal detachment and remove the intraocular drug but complete removal of the steroid was not possible.

Postoperatively, the retina was flat, but scattered retinal haemorrhage and macular nerve fibre layer oedema was noted. About three weeks later, Ms J developed an inferior retinal detachment, epiretinal membrane and retinal necrosis. She underwent further surgery to remove the epiretinal scar membrane and correct the retinal detachment. Her intraocular pressure was raised postoperatively but was controlled with medical treatment.

The iritis subsided, the intraocular pressure normalised and the remaining subretinal steroid dissipated completely within three months. Her final visual acuity was hand movement in the left eye and 6/6 in the right eye. The left eye remained painful and uncomfortable. Ms J had difficulty with near work and computer work, suffered eye strain and easy fatigue in the right eye



and experienced frequent headaches and imbalance when walking downstairs.

She was assessed as having 20% impairment of vision and 20% impairment of the whole person, with 50% loss of capacity. She also developed depression and was under the care of a psychiatrist. She returned to work six months later but, due to mental distress and intense eye pain, she had to work part-time in a less intense position, and with a lower salary.

Ms J made a complaint and a civil claim. The claim was indefensible and was settled for a substantial sum.

Learning points:

- Ample guidance is available through professional bodies and the scientific literature on the management of common eye conditions. Periocular corticosteroid is not indicated for uncomplicated anterior uveitis. Where topical corticosteroids are ineffective, a sub-conjunctival injection of a short acting corticosteroid may be considered. Dr R chose the wrong primary method of treatment, the wrong injectable drug and the wrong route of injecting the drug.
- Periocular injections carry a risk of globe penetration that is much higher in myopic eyes. The records showed no evidence of discussion of indication, risks or alter-

natives. No written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. Guidance on the principles of taking informed consent is available in a number of different countries.

Dr R failed to discontinue the injection when the patient had severe pain and loss of vision. Even though the globe had been injured, the extent of damage may have been reduced had he stopped immediately. Immediate exclusion of a penetration either by ultrasound or by clinical examination is mandatory when patient symptoms suggest globe penetration. Failure to do this established a breach in the duty of care. Early diagnosis and referral for emergency intervention may have reduced the extent of the irreversible damage.

Adverse outcomes and complications are part of a doctor's working life. Responding to these events in a timely manner, showing respect, being open and communicating honestly help to reduce the impact of these events on both the patient's wellbeing as well as the doctor's professionalism. A patient can withdraw consent at any time during the procedure. When pain is not what you expect, it is good practice to stop and reconsider your treatment.

THE SOUTH AFRICAN MEDICAL ASSOCIATION



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In an effort to improve the quality of service SAMA provides to its members, we would like you to complete this readership survey and return it to us via fax, postage or email. Doctors who participate will be entered into a lucky draw and could win a luxury executive gift hamper worth over R500!

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