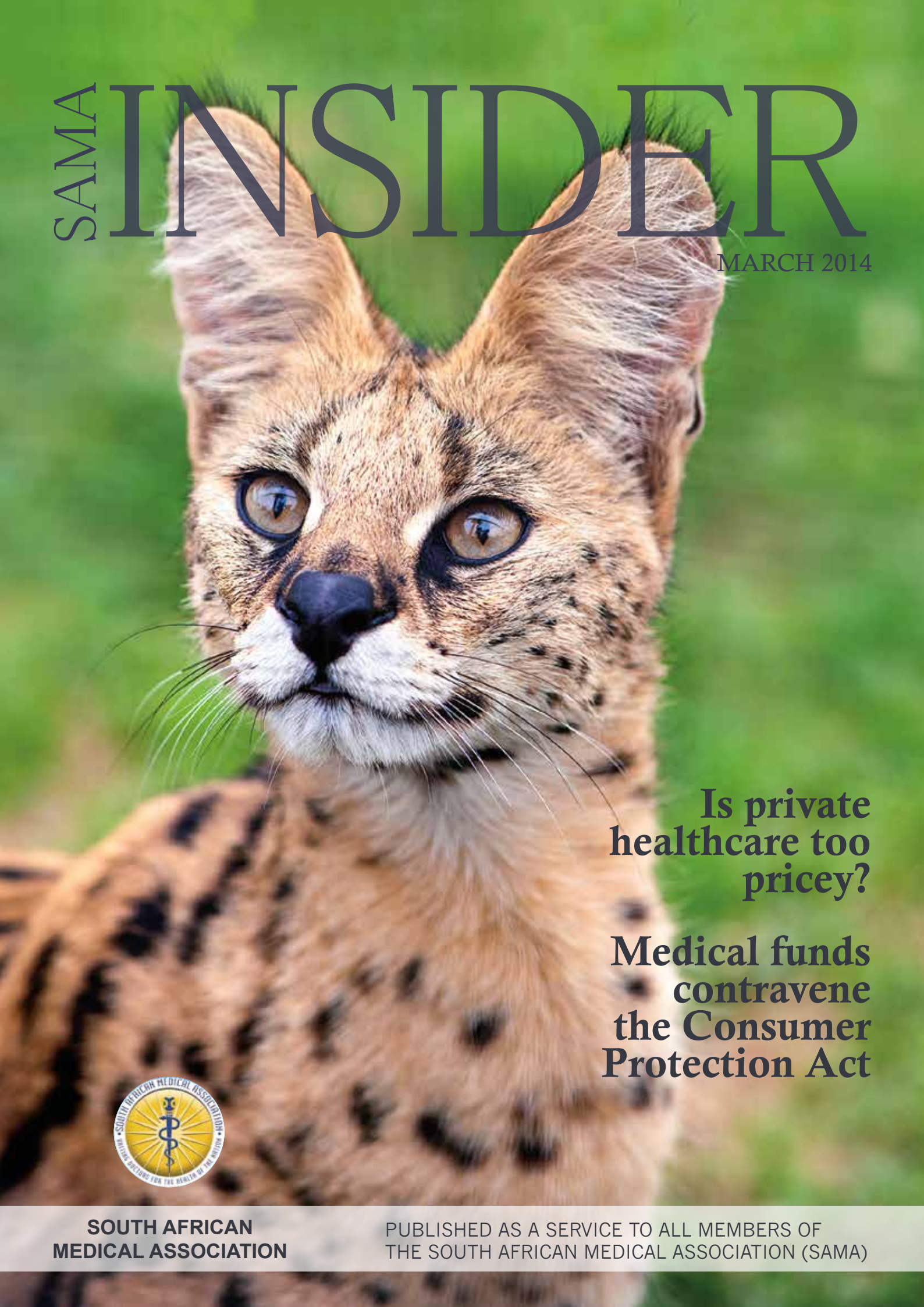


SAMA INSIDER

MARCH 2014

Is private healthcare too pricey?

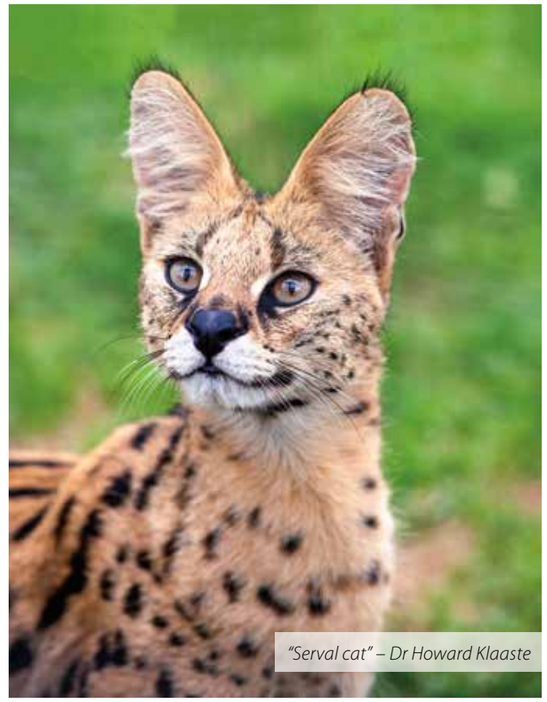
Medical funds contravene the Consumer Protection Act

SOUTH AFRICAN MEDICAL ASSOCIATION

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

CONTENTS

MARCH 2014



"Serval cat" – Dr Howard Klaaste

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EDITOR'S NOTE

MARCH 2014

Conrad Strydom
Editor: *SAMA INSIDER*

Sacred or profane?

Much is made, even in modern times, of a doctor's obligation to the Hippocratic Oath. While the ethical aspects of the oath are rightfully treated as the crux of this ancient Greek text, there is another side to it that deserves as much attention – its spirituality. In the minds of ancient Greeks there was little division between the everyday world and the world beyond it; indeed, the opening line of the Hippocratic Oath invokes the gods Apollo, Asclepius, Hygieia and Panacea.

The point is that the Greeks did not view the practice of medicine merely as an act of physical labour but as a sacred duty, connected to higher principles of compassion and charity. However, it is not always evident that these concepts have translated into the 21st century economy. While the great majority of doctors do care greatly about their patients, it would be very disingenuous to say that exploitation never occurs or that – for some at least – the house in Constantia is not more important than Patient X's cirrhosis. We examine the continuing spate of interest in private practice costs (and whether doctors charge too much) on pages 5 and 6.

Last month saw the publication of an article about a South African doctor's visit to Gaza that many viewed as controversial. The article, which was not solicited by SAMA, has attracted a lot of response. In the interests of representing a fair, balanced view of the situation in Gaza, we are publishing a response by the South African Jewish Board of Deputies on pages 11 and 12.

There is also a wonderful exposé of some questionable practices by medical aid schemes on pages 16 and 17. Written by a High Court advocate, the article deals with the way schemes withhold crucial information from patients and whether or not this breaches the Consumer Protection Act – a powder keg of note that both doctors and patients should be aware of.

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Private healthcare – too expensive?

Conrad Strydom

Only 20% of the South African population can afford to use private healthcare, yet the sector contains 80% of the country's doctors. Conversely, 80% of the population is stuck with 20% of the doctors – overworked, underpaid public servants who often lack the equipment or medicines to treat their patients properly. Besides being a great example of the so-called 'Pareto principle' (also known as the 80-20 rule), these simple facts also highlight the tremendous inequalities that exist in South African society. One imagines it is for reasons like this that the World Bank has consistently labelled South Africa one of the most unequal countries in the world.

"Doctors must tailor their costs so that their services are affordable to patients in their area"

The 80-20 distribution of South African healthcare is always going to be a contentious issue in a society that – at least on paper – values greater social equity, and has in fact attracted a great deal of attention from decision makers outside of the medical industry. The recent announcement of a formal Competition Commission inquiry into private healthcare costs is only the latest in a long line of red flags raised by regulatory and civil society bodies. In fact, the prime motivating factor for the country's National Health Insurance (NHI) scheme is the unequal distribution of medical services among the public. Ultimately, the question doctors must ask themselves is whether all this attention is warranted. In a nutshell, are private doctors greedy?

What is greed?

The exact definition of greed is unfortunately rather nebulous. This is both a blessing to people who are genuinely greedy, since it provides them with the defence 'What is greed?', and a curse to those who wish to regulate greed-driven enterprises. The recent price regulatory overtures by the Department of Health and the Competition Commission have defined the industry as greedy because it is unaffordable to the vast majority of citizens. According to acting Competition Commission chair Tembinkosi Bonakele, the goal of the commission's enquiry into private health is to find indications of "... price increases and expenditures that tend to be above inflation in the private healthcare sector".

So how do doctors determine their tariffs? Remarkably, it is often a rather straightforward process. Let us assume Patient A goes to Doctor B for a check-up that lasts an hour. Doctor B requires a guideline according to which he can bill Patient A. Prior to 2004, he would have had a choice between a guideline structure drawn up by the Board of Healthcare Funders (BHF) or one drawn up by SAMA. In 2004 a Competition Commission ruling created a single tariff structure called the National Health Reference Price List (NHRPL), which is now known simply as the RPL, so that is what Doctor B will be using as a baseline to determine his fee.

Doctor B will first have to determine how much the consultation has cost him. He has to pay his staff and pay his rent, for example, and both of these amounts can be fractured into an hourly rate. Then he has to calculate his take-home pay rate, which is entirely at his discretion, but has to be justifiable according to industry regulations. He then divides this amount, which is his practice cost (salary plus expenses), against the amount of hours he spent on the consultation (taking into account that doctors are calculated as having an average of 46 working weeks a year).

This is the amount a doctor will charge. Any additional costs are at the doctor's discretion, though medical aids can refuse to pay these. It is overcharging at this point that has arguably led to the public perception that doctors are greedy. Research by Discovery Health indicates that although 45% of specialists charged fees at NHRPL rates, an estimated 5% were charging over 300%. Keep in mind that specialist procedures are expensive by definition, so even a rate that is 100% of NHRPL will appear intimidating to the average patient.

However, according to Dr Meshack Mbokota chairman of SAMA's Specialist Private Practice Committee, the issue is more complex than a statistical overview of prices can suggest. "First of all, patients are only in a position to say that somebody is overcharging if there is a norm to compare their charges to," Dr Mbokota said, "and since the Competition Commission effectively ruled in 2004 that no one can fix the price of medical care anymore, there are no industry norms." According to Dr Mbokota, the fact that government is not regulating the healthcare industry has left patients and doctors with no frame of reference. "The notion that doctors are overcharging is therefore preposterous since there is no reference structure to measure their rates against."

Regulation

With the recent advent of the Competition Commission's new enquiry into public healthcare, the introduction of price regulation and guideline tariffs has again become a distinct possibility. According to Sha'ista Goga, an economist with Acacia Economics, there are very good reasons why this should be the case.

"The notion that doctors are overcharging is preposterous since there is no reference structure to measure their rates against"

"The main reason why prices should be regulated," Goga said, "is because healthcare is not normal goods like food or clothing. It is a highly specialised field. The patient desperately needs to know the details of the care they are going to receive, but these are usually too complicated for them to understand. As a result, a situation arises that economists refer to as 'information asymmetry'. In instances like this, the government has a responsibility to ensure that patients are provided with guidelines that can redress this imbalance."

Umunyana Rugege of activist group Section 27 agrees: "There is a definite need for tariff guidelines, especially since after

2004 there has been a lack of transparency for patients. The South African Constitution treats access to healthcare as a human right. For private healthcare to be accessible to the public, it must first become a transparent process, and that is why tariff guidelines are a good idea." Rugege also pointed out that the industry is already regulated to an extent since technically the Health Professions Council of South Africa can determine guidelines on overcharging in terms of a provision in the Health Professions Act.

A complex issue

It must be kept in mind that six years of medical school costs roughly R1.4 million, leaving many doctors crippled by debt from the outset of their careers. The financial burden on doctors is therefore much higher than that experienced by the vast majority of professionals, and doctors increasingly have to contend with the growing threat of medical malpractice suits – a threat which has increased by an average of 500% over the last five years – which necessitates very expensive practice insurance coverage.

Goga concedes that price regulation is a complex task. "Certainly, no one should be in favour of lowering prices ridiculously, nor should doctors subsidise people who can't afford care." Practice costs are also extremely difficult to pin down, since a practice in Sandton, for example, will have much higher costs than a practice in Beaufort West, and as a result it is not helpful to determine averages between the two.

Werner Swanepoel of Medical Practice Consulting identifies a number of factors that complicate charging tariffs based on averages. "Since South African doctors cannot set the price of supply when they enter into contracts with medical schemes, the principles of supply and demand costing do not apply here. We are still a developing country and the vast majority of people in our country do not earn comparable salaries, since we have a 25.2% unemployment rate."

Fair value

Central to the question of whether or not doctors are overcharging is the concept of a 'fair value'. According to Swanepoel, the concept of a fair value derives from the Health Professions Act and implies that health professionals should behave with discretion when charging fees. "A fair value should not be below the cost to deliver a service and where tariffs are offered to healthcare professionals that result in a loss, additional fees should be recovered from the patient to support the business." At the same time, Swanepoel says, "Charging exorbitant mark-ups that do not reflect the level of skill or risk of the procedure does not constitute a fair value."

In South Africa, the average income of patients over large geographical areas can vary tremendously, further complicating any attempt to find average values that can regulate private healthcare prices. "You must remember that a private healthcare practice is a business," Swanepoel said. "It has direct and indirect costs. Healthcare professionals must be allowed the freedom to tailor their costs in such a way that it makes their services affordable to patients in their area of practice."

"For private healthcare to be accessible to the public, it must become a transparent process, and that is why tariff guidelines are a good idea"

Additionally, there are concerns that pricing on the basis of cost, which is being suggested by some regulators, effectively provides no incentives for efficiency. This particular complaint has been a recurring feature of the UK's National Health Service, one of the models that South Africa's NHI programme is trying to emulate.

According to Goga, these concerns about pricing according to cost are "... a prime reason why the debate must move beyond price towards a focus on efficiency and quality." The solution according to Swanepoel is quite simply for private doctors to start running their practices as businesses. Doctors need to be able to negotiate with medical schemes in a way that allows them to calculate a profit on the delivery of the procedure and should be in a position to refuse tariffs that are not viable. "Every private doctor needs to draw up a dynamic budget from actual financial data taken from their practice. This will give them an accurate picture of the true cost of procedures in their area."

However, the fact remains that the general public takes a negative view of the cost of private healthcare. As long as this situation exists, regulations and guideline tariffs will be among the solutions offered by regulatory bodies and civil society, and doctors can best prepare for this by keeping their own house in order.

The South African Medical Association's Code of Conduct for doctors states:

- When determining professional fees, consider the financial position of the patient and discuss the financial implications of treatment options.
- Respect the rights of patients, including the right to informed consent, which includes discussion and information relating to their condition so as to assist informed decision-making.
- Ensure that undue pressure from third parties does not influence patient management.
- Patients enter into a contract with a doctor and not with their medical schemes. Patients remain responsible for payment of their doctor's account. Schemes usually settle accounts within 30 days after receipt of a claim.
- A doctor or his/her staff can give estimated costs for further treatment, but precise amounts can only be given after the actual service has been rendered.
- A doctor may not ask for an 'up front' payment before a service is rendered. This is only allowed in certain cases of cosmetic or corrective surgery where the patient has been informed about this arrangement beforehand. Some medical schemes require patients to pay a levy when visiting a doctor. This is not regarded as advanced payment.
- Patients are advised to negotiate fees with all the members of the surgical team when going for an operation. They should be made aware that all of the members of the team (surgeon, assistant anaesthesiologist, etc.) can charge medical scheme benefits individually.

Regular performance management required

Advocate Mpotlana Daniel Madiba

The SAMA Trade Union has been dealing with a sizeable number of queries, grievances and disputes relating to government departments' failure and/or refusal to grant qualifying members pay and/or grade progression. The advent of the Occupational Specific Dispensation (OSD), and more particularly Resolutions three of 2009 and one of 2010, both of the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC), introduced a system where a medical professional is no longer required, in certain instances, to apply for a vacant post in order to progress to a post of a higher rank. For example, a Medical Officer grade one does not require for a grade two post to become vacant before he/she may progress to such a post, but rather a grade one officer simply needs to satisfy performance management requirements to progress to a higher grade.

The OSD Resolution three of the PHSDSBC provides as one of its objectives that they intend to introduce an occupational specific remuneration and career progression dispensation for medical officers and specialists. Furthermore, the OSD aims to provide for career path opportunities based on competencies, experience and performance. Therefore in order to obtain both pay and grade progression, a medical doctor must have performed at least satisfactorily in a specific performance management cycle.

In practice, an officer needs to ensure that a performance instrument is developed and agreed upon (performance contracts) with his/her supervisor at the beginning of the performance management cycle (1 April – 31 March). Upon agreement on the performance standard, the parties will sign a performance agreement in line with the institutional and Health Department goals and priorities. The performance management assessments or reviews will take place regularly, usually on a quarterly basis, in order to establish whether the agreed standards are met, and when they are not met necessary remedial action is introduced.

The medical officers/specialists who at the end of a performance management cycle and after the four regular assessments are found to have performed at a satisfactory level in terms of the agreed performance standards will be entitled to a pay progression in terms of the OSD. In the event that an officer/specialist is already on the highest notch of a specific grade, he/she will be entitled to a grade progression.

Members are strongly urged to ensure that they, together with their supervisors, develop and conclude performance management instruments at the beginning of each performance management cycle in order to avoid difficulties and disputes at the end of the cycle.

For more information contact:
SAMA TRADE UNION
012 481 2090/92
labour@samedical.org

Coming soon: SAMA/MPS photography competition

Zukiswa Nomnganga

Our 2013 photography competition was a success, with entries beautifully capturing the theme, 'A Day in the Life of a Doctor'. We hope this year will be no different.

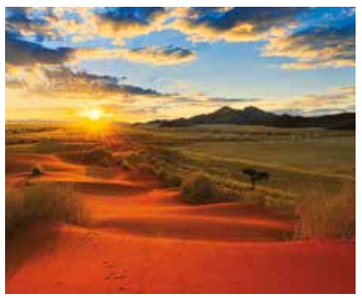
Members were asked to take photographs of their time spent in hospitals, in their private practices, saving lives in theatre and especially those special moments and experiences shared with their patients, fellow doctors and nurses.

This year we would like to continue with the same theme, adding a category on the community health programmes that our doctors are often involved in but rarely recognised or captured. The photographs will be used in future SAMA and MPS publications and journals. The following categories will be adhered to:

- Work environment
- Emotions
- Community health.

We urge you to start recognising photo opportunities and that perfect angle for a winning entry. More details will follow soon via email and the SAMA/MPS websites.

For further info, please contact Zukiswa Nomnganga at SAMA Head Office on 012 481 2052 or *zukiswan@samedical.org*



The SAMA/MPS photography competition has been a huge success in the past, giving doctors a chance to display a talent unrelated to medicine

HPC interrogates policy shifts

Bernard Mutsago, *SAMA Health Policy Researcher*

South Africa is experiencing an unprecedented episode of major change in the national healthcare sector in the post-apartheid era. Of late, the country has become incredibly bloated from an explosion of national health policy and legislative developments aimed at facilitating transformation of the health sector. Doubtless, a lot of the current policy hustle and bustle in South Africa relates to National Health Insurance (NHI) and the associated public health, primary care and preventive focus of government policies.

In any country anywhere, for any policy transformation to be successful, a robust policy debate involving key stakeholders – who must be engaged in an inclusive and participatory manner to ensure that the policy propositions are transparent, feasible and enjoy the support of the policy and local communities – is requisite.

This is where the chipping in of powerful bodies like SAMA becomes necessary to gauge what is deliverable and what is not, and to make recommendations. The Health Policy Committee (HPC) is the arm of SAMA responsible for fostering dialogue and analysis of health policy issues relevant to the welfare of doctors. The committee meets at least three times a year. Recently, in February, the HPC held its first meeting of the year, graced by the presence of the SAMA chairperson, and dealt with some of the major policy issues currently facing the country. It must be mentioned that the work of the HPC straddles both SAMA's private and public sector doctor issues, details of which are left to the respective standing committees to tackle in depth.

Topmost on the agenda of the HPC is, of course, the NHI. The existence of a SAMA national task team, co-ordinated by the HPC, which is looking into the NHI roll-out activities countrywide, is testament to the unwavering commitment of SAMA to make a contribution to the reshaping of our healthcare system. The task team is the technical engine geared to analyse the proposals of the mysterious, perpetually 'soon coming' White Paper when it is released. The current business of the task team, comprising a skilled panel of SAMA doctors scattered in various NHI pilot districts and SAMA branches across the country, is to monitor developments in all pilot sites; to actively seek participation in pilot structures, processes and decisions; and to diagnose successes and challenges while championing the interests of the medical profession and the patients.

The HPC regrets the sad fact that government's negotiations with doctors on NHI have been fraught with complex challenges, particularly regarding the role of doctors in the NHI and associated contracting arrangements.

The HPC also debated the pertinent subject of the government proposal for immunisation of schoolgirls (9 –13 years) against the human papillomavirus (HPV) with effect from early 2014. The HPC's reaction is that the public good of the programme is obvious, but does the state health system have the capacity to deliver, given the current shortage of healthcare staff such as nurses and doctors? Also, the cost per single dose is quite prohibitive for the state (in the range of R500 – R750 a dose), while the ethical question of possible confusion and resistance by parents and society to the immunisation of juveniles with a vaccine that is associated with prevention of sexually transmitted diseases must not be ignored.

Another priority issue considered by the HPC was quality of care. In the healthcare environment, quantifying and improving the quality of healthcare becomes an increasingly important objective. The recent HPC gathering concurred with the SAMA chairperson's observation that SAMA needs to engage in quality of care developments in the country, especially in the wake of the recent inauguration of the Board for the Office of Health Standards and Compliance (OHSC). The chairperson urged all SAMA committees to engage on this all-important subject. While South Africa's doctors support the broad objective of a universal healthcare system, the persistent poor service quality, doctor shortage, and other inefficiencies of the public health sector need to be corrected first, otherwise successful implementation of the NHI will be hampered.

The HPC also noted with concern the Lancet article[1] and associated recent media reports about worrying XDR-TB patterns in South Africa. The HPC notes that the trouble is not just with XDR-TB but all forms of TB. Drug resistance is a major challenge. The HPC, which has representation at the South African National AIDS Council under the umbrella of SAMA, undertook to seek dialogue between SAMA and relevant role players in TB care to find solutions.

Also under the HPC's focus are key public health policy issues affecting South Africa, for which the HPC has drafted a handful of SAMA discussion documents. These have recently been reviewed by the SAMA Board of Directors and have been posted on the SAMA website for SAMA members to make their inputs (deadline 7 March) before the 2014 SAMA National Council can adopt the documents as SAMA official position statements. The draft documents are on:

- Restriction of alcohol use and marketing
- Restriction of smoking in public places
- Violence in the health sector by patients and those close to them
- Climate change and health.

Shortly, the HPC, in co-operation with the SAMA Policy and Research Department, will begin to compile the next batch of draft SAMA policies on a wide range of issues, taking their cue from the World Medical Association policies.

[1] *Long-term outcomes of patients with extensively drug-resistant tuberculosis in South Africa: a cohort study; Lancet: Published Online, 17 January 2014*

SAMA and SAPPF join forces to fix coding

A historic meeting took place on Saturday 1 February between the South African Medical Association (SAMA) and the South African Private Practitioners Forum (SAPPF). It was the first meeting between the two bodies since 2004. The event, which took place in the Southern Sun Intercontinental Hotel at OR Tambo airport in Johannesburg, was co-chaired by Dr Chris Archer of SAPPF and Dr Meshack Mbokoto of SAMA's Specialists in Private Practice Committee (SPPC).

SAMA and the SAPPF participated in a joint coding meeting at OR Tambo airport

The purpose of the meeting was to establish a joint SAMA/SAPPF committee that will meet to develop new codes and descriptors for the medical industry. There was general consensus among attendees that the current coding situation in South Africa is in need of an overhaul.

Some of the major gripes were that current codes do not match today's medical environment and that there is a lack of consensus among industry role players about the proper content of codes. According to Dr Archer, the current situation is "chaotic" and "like the Wild West", with few new doctors having any practical knowledge of coding. It was decided that the joint coding committee would have to establish itself as the final authority on coding. The committee will not review old codes but will instead focus on overseeing and generating new codes in response to eventualities such as technological advances.

Coding requests will be accepted, but only via recognised medical representative groups such as the SPPC, GPPC, SAPPF or similar bodies.

SAMA chairman Dr Mzukisi Grootboom was at pains to explain to the committee members that the time had come to let go of divisions in the private practice environment. "This is not about politics," Dr Grootboom said, "it is about bringing practitioners together for the good of the profession." He also emphasised that a committee such as the one being formed by SAMA and the SAPPF would entrench the notion of doctors' independence, something which is under threat in the corporate and regulated world of private practice.

Call for input on new ER/24-hour facility coding structure

SAMA Private Practice Department

SAMA is aware that the current procedural coding structure does not provide for adequate coding in the emergency rooms (ER) environment.

ER practice has changed tremendously over the past few years, due to the emergence of ER/24-hour facilities in hospitals. Here the doctors render a service but sign a rental agreement with the particular hospital. These contracts do not specify what the rental costs include, except that the doctors may not supply their own equipment or use their own support staff.

As SAMA is not able to update the Medical Doctors' Coding Manual without requests from doctors involved in this area, we rely heavily on information from these doctors to ensure that our coding structures are up to date. Your input is needed to enable us to create an ER/24-hour facility coding structure appropriate for use in these facilities.

Therefore, SAMA's Private Practice Department invites all interested doctors to provide us with information relevant to the ER/24-hour situation. After we have collated this information, we will arrange a workshop where this problem can be discussed and resolved.

We will need the following information:

- Level of classification of the unit.
- Who performs examinations, for example inserting drips or performing ECGs or dipstick tests? This excludes the taking of the history, the physical examination of the patient and the decision to initiate treatment by the doctor on duty.
- Who handles the supervision of patients? Is it performed face-to-face by the doctor for the whole period, or by the hospital staff under the supervision of the doctor on duty?
- Who supplies the materials – such as sterile trays, dipsticks, drip sets, etc. – used in the unit?
- Who owns and maintains the equipment?
- Who provides the staff and is there any agreement on who should pay staff salaries?
- Please provide a brief summary on the type of contract signed by the doctors.
- What does the 'facility fee', payable by patients, include?
- Please include any general suggestions on what a new ER/24-hour facilities coding structure should cover – both needs and wants.

SAMA will highly appreciate your contribution to this process, as we strive to do our best to assist doctors working in the ER/24-hour facility environment.

Please send your input to Leonie Maritz at *coding@samedical.org* before 17 March 2014.

Gaza, Israel and medical care – the real story

David Saks, *Associate Director, SA Jewish Board of Deputies*

This is a response to an article in the February issue of *SAMA Insider* entitled 'Healthcare in besieged Gaza'. The views expressed in this article are not necessarily those of the South African Medical Association.

In June 2005, a young Palestinian woman named Wafa Samir Bas was arrested attempting to smuggle an explosives belt through the Erez crossing between Gaza and Israel. Interviewed on Israeli television afterwards, she said that her intention had been to carry out a suicide attack with the aim of killing as many Israelis, particularly young people, as possible. One thing made this case different from the hundreds of other instances where Palestinians – men, women and children – had been dispatched to immolate themselves as a weapon against the Israeli population. For the previous several months, Bas had been receiving treatment in Israel's Soroka Medical Centre in Beersheba, having suffered massive burns in a cooking accident. It emerged that the Fatah al-Aqsa Martyrs Brigade had instructed her to use her personal medical authorisation documents to carry out a suicide attack in Israel.

This is not the only instance of Islamist extremists using Israel's willingness to provide medical assistance to Palestinians as an opportunity to carry out terror attacks. The previous December, for example, a Hamas agent with forged documents claiming to be a cancer patient in need of medical treatment was arrested en route to carrying out such an attack. That same month, another al-Aqsa Martyrs Brigade operative was caught with false papers indicating that he needed to enter Israel for hospital treatment. His intention had been to plant a bomb on the railway tracks near Netanya.

These are just some of the cases where Israel's humanitarian provision of medical treatment to Palestinians has been exploited in order to kill and maim its citizens. Under the circumstances, it is to be wondered at that Israel chooses to provide such assistance at all, yet they continued to do so. To an extent the assistance is barely recognised, if acknowledged at all, by the world at large.

One would expect any balanced and reasoned analysis of healthcare in Gaza to make some mention of these obviously very relevant facts. Not the slightest allusion to them, however, can be found in the article 'Healthcare in besieged Gaza' by Aayesha Soni (*SAMA Insider*, February 2014). This is hardly surprising. The writer is vice-chairperson of the Media Review Network, a hard-line Islamist lobby group whose primary purpose is to demonise the State of Israel at every possible opportunity.

Gaza residents being transferred for medical treatment in Israel through the Erez Crossing

While only a summary can be given here of the kind of medical assistance provided by Israel both to Gaza and to the West Bank, the bare facts are impressive enough. In 2008, the number of Palestinians who received health permits allowing them to enter Israel and receive treatment in Israeli hospitals and clinics was 144 838. That figure has steadily increased, reaching just under 220 000 in 2012. Among those who received treatment are the brother-in-law of Gaza Prime Minister Ismail Haniyah, and a teenager who was injured when a rocket destined to be fired at Israel exploded in its launching pad. Many Israelis, in fact, complain bitterly, and not without cause, that the heavy tax burden they must bear is being used to provide succour to those intent on killing them!

In many cases, treatment is provided free of charge. Such is the case with the Peres Peace Centre's 'Save a Child's Heart' programme, where children with heart problems receive free medical attention and surgery; 45% of those who have received such care are Palestinian. Other Peres Centre initiatives include programmes for training Palestinian doctors. The training of Palestinian medical personnel, including doctors, nurses and paramedics, also forms a key component of the medical department of COGAT, a military unit responsible for implementing the Israeli government's policy in the West Bank.

None of this, of course, merits a mention in Aayesha Soni's article. At least some response is also called for regarding her contention that the people of Gaza are being subjected to a 'siege'. As hardly needs be spelled out, a siege is when one party is trapped in a certain area while a second party on the outside tries to force its way in. In the case of Gaza, the complete opposite is true. Israel has no desire to get into Gaza but rather seeks to keep out those who seek to harm Israel. For the past eight years and more, Gaza's Hamas-led regime has been waging a ceaseless campaign of violence against the Israeli people. Israel's military withdrawal from Gaza in mid-2005 did not end hostilities. Instead, Gaza has become a platform for Islamist radicals to launch one attack after another against the hated 'Zionist Entity'. It has included launching thousands of missile attacks against such Israeli towns as S'derot. Another tactic has been to tunnel under the security fence along the Israel-Gaza border with a view to smuggling in militants to carry out terror attacks and kidnappings. Israeli troops discovered one such tunnel last year, a massive affair stretching over a kilometre into Israel. Who, in fact, is besieging whom?

The situation in Gaza is undeniably an unhappy one. Under the dictatorial rule of Hamas, the territory has been in a more or less continual state of war with Israel. The aim of Hamas is what it has always been – to pursue the destruction of the State of Israel, the annihilation or expulsion of its Jewish

inhabitants and the restoration of the land to Islamic rule. If Gaza's people desire to live normal, undisrupted lives, then the solution is in their hands. Simply put, it means giving up on their obsession of destroying Israel and ending their frankly deranged campaigns of indiscriminate violence against it. What is more, anyone who truly has the welfare of Gaza's population at heart would say as much. Activists like Soni are routinely silent in the face of the Palestinians' self-destructive behaviour while raucously denouncing Israel for the counter-measures it adopts in response. This suggests that what really motivates them is not any genuine sense of compassion for the Palestinians but an implacable hatred for Israel, a country whose very existence is regarded as an unendurable affront.

Coding: General Modifiers 0004 and 0007

SAMA Private Practice Department

The following is taken from SAMA's coding training manual *Coding: Critical and Undervalued*. These coding rules ensure that billing information is accurate and that all parties in a typical medical transaction – doctor, patient and medical scheme – are treated fairly. The following codes have been updated to reflect the current practice environment.

Modifier 0004		
AM	0004	**Procedures performed in own procedure rooms:** (a) Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). (b) A fee according to modifier 0004 may only be charged when an operation or procedure has a value greater than 30,00 units allocated to a single item. (c) Please note: Only the medical doctor owning/renting the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms. (d) Please note that modifier 0004 may not be used in conjunction with modifiers 0074 and 0075
	Extra information on Modifier 0004	Section G has been removed from the MDCM as the information contained in this list was grossly outdated. Modern techniques have changed to such an extent that procedures that would have been done in theatre are now done in procedure rooms or in the doctor's consulting rooms.

Example: Endoscopies were never performed in the consulting rooms in the past. When the doctor was prepared to take the risk of performing the procedure in his/her rooms, modifier 0004 could be added to item 1653 – total colonoscopy

However, currently endoscopic procedures, such as colonoscopies and upper gastro-intestinal endoscopies, are performed in the doctor's rooms with the doctor's own equipment; modifier 0004 will therefore not be applied to the account. Modifier 0074 – own equipment, and modifier 0075 – own procedure room, will compensate for the extra expense incurred.

Modifier 0007		
AM	0007	(a) Use of own monitoring equipment in the rooms: Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation – 15,00 clinical procedure units irrespective of the number of items of equipment provided. (b) Use of own equipment in hospital theatre or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital – 15,00 clinical procedure units irrespective of the number of items of equipment provided.

Additional information:

- Modifier 0007 **is not appropriate** for only operating a pulse oximeter or for reading the results.
- Modifier 0007 **is appropriate** for use of monitoring equipment in rooms when procedures are done **under intravenous sedation**.
- Modifier 0007 **is applicable** to doctors for the use of own instruments used in performing procedures in theatre, when these instruments are not supplied by the facility.
- Modifier 0007 may not be used in conjunction with modifier 0074.

Member profile: Dr Samkelo Jiyana

Dr Samkelo Jiyana is a member of the South African Registrars Association's (SARA) executive committee.

What has being a registrar meant to you?

It has meant a lot of personal sacrifices. I decided to specialise in the field of paediatrics after my community service year, while still working in rural Mount Frere at Madzikane Ka Zulu Memorial Hospital, where I was in charge of the paediatric ward. The satisfaction I got from working with those kids, as well as the nurses who were so enthusiastic, made me realise that paediatrics was the field I wanted to follow.

My time in Mount Frere was quite humbling. To go from getting blood results in 15 minutes to receiving them three days later was quite a shock to the system, but the prospect of helping children kept me motivated. I also wouldn't have specialised without the support of my parents. Not once did they ask me *"Yintoni le uyifundayo inde kangaka?"* ("What is it that you are studying that is taking so long?")

Do you ever feel like giving up while specialising?

I must admit the final stretch has been rough. To think that the past four years of hard work and studying will come down to a few papers and oral exams! It seems such a formidable task, at times even impossible. I did my fellowship at WSU's East London Hospitals complex. There were times during the rotation when senior doctor numbers were down and the wards full to the brim. Then you really felt like quitting. Luckily for me I got to work with an amazing bunch of people. When I got here everyone was on a first name basis, which is not a norm in Xhosa culture.

What are the major issues in South African healthcare?

The mortality rate for children under the age of five is nowhere near the Millennium Development Goals for 2015. Poverty stricken communities without education and proper services will continue to produce sick children and young mothers who are unemployed and uneducated. This is a recipe for disaster.

Have you learned anything from the kids in your care?

I remember at an early stage of my training, a child who was terminally ill was attended to by one of my colleagues every day. When the people from the Reach for a Dream Foundation came to ask him what his dream was, he said his dream was to own a pair of pyjamas. Even though some unwanted prompting was going on, all he wanted was pyjamas as he had never slept in pyjamas. This taught me to appreciate the simple things in life.

What are your research interests?

My research is on the use of oral rehydration solution in the home environment. As we all know, diarrhoeal disease is still a major role player in childhood mortality. I hope to publish a paper on this issue soon.

Member profile: Dr Gillian Boshomane

Dr Boshomane is a registrar in nuclear medicine at the Steve Biko Academic Hospital.

Nuclear medicine is a very cutting-edge field. Has South African healthcare embraced its potential?

There is a gradual but steadily growing awareness of the field among healthcare practitioners and the public. It is not a field that medical undergraduates rotate through, so most medical interns will not know about it unless they are in academic institutions. It is also not as well marketed as other disciplines and this prevents the real benefits of nuclear medicine being utilised. We are pioneering 'theranostics', which in essence means that our diagnostic and therapeutic modalities target disease specifically without affecting the normal tissue. This is cost-effective, has fewer adverse effects, is minimally invasive and reduces the amount of time patients spend in hospital.

How do you cope with life in public practice?

It is no secret that remuneration in the public sector is not as good as the pay in the private sector. At present my most significant pull factor to remain in the public sector is the opportunity to do research on a huge scale. I also have the opportunity to liaise with specialists who are churning out amazing research. The head of our unit at SBAH (Steve Biko Academic Hospital), Professor Sathekge, is a leader in his field. Also, one of our specialists, Dr Mariza Vorster, just completed her PhD. The support from senior specialists has been incredible and our team spirit is healthy. One must realise that there is synergy between public and private healthcare; the profit generated in private by corporations and individuals is used to sponsor research in academia. I have made a choice to be where I am today because I believe that for now this is where I will add the most value. I am also living my passion.

If you could change anything about South African doctors, what would it be?

Medicine is a demanding profession. Many South African doctors are sacrificing their families and more to keep the system functional. I believe that doctors in South Africa are not as united as they could be. We do not have a strong voice because we work in isolation. We do not get involved in key healthcare policy discussions and decisions and therefore are not in control of our destiny and profession. I would urge South African doctors to take pride in their work and to show value by engaging more with the administrators and having stronger and more united societies. Our strength lies in our unity, if we can achieve it.

UNIVERSITY OF OXFORD, ENGLAND

OXFORD NUFFIELD MEDICAL FELLOWSHIP 2014/15

Applications are invited for an award under the Scheme for Oxford Nuffield Medical Fellowships normally to be held in a department within the Medical Science Division of the University. This prestigious fellowship carries an allowance of £41,564 (plus any cost of living increases). This allowance is subject to United Kingdom tax. The Trustees will also pay direct, economy class return air fares for the appointee, his/her spouse and children up to the age of 18 years. A generous baggage allowance is also provided.

Applicants should have graduated from one of the universities listed below and should either hold a medical qualification or have appropriate research experience. There is no limit as to age or status.

The fellowship is tenable for two years in the first instance, with the possibility of an extension for a third year. Fellows are expected to return to South Africa at the end of the fellowship to continue to do work of a similar nature.

The award is available from 1 October 2014 or, subject to consultation with the University's Medical Sciences Office and the department concerned, from such other later date as may be agreed. The next round of Nuffield Medical Fellowship for South Africa will be in 2015/16.

Further information, including details of the research interests of those departments in which the fellowship may be held may be obtained from the Chairman of the Selection Committee and at website http://www.ox.ac.uk/divisions/medical_sciences.html

If the fellow requires a Visa to come to UK, a Tier 5 Temporary Worker Visa (http://www.admin.ox.ac.uk/personnel/permits/tier5/temporaryworkers/) will be sponsored by the University to allow the fellow to undertake Collaborative Research (only). Supplementary employment (such as clinical work) might be permitted only if the speciality is listed by the UKBA as a shortage occupation (Medical practitioners- 2211) – see http://www.ukba.homeoffice.gov.uk/sitecontent/documents/workingintheuk/shortageoccupationlistnov11.pdf Please note that the Visa regulations are constantly updated by the UK Border Agency.

Participating Universities
University of Cape Town, University of Limpopo, University of KwaZulu-Natal, University of the Free State, University of Pretoria, University of Stellenbosch, University of the Witwatersrand.

Further information may be obtained from Ms Faiza Pearce at Faiza.pearce@uct.ac.za. Details of the research interests of those departments in which the fellowship may be held may be obtained at the website http://www.ox.ac.uk/divisions/medical_sciences.html

Candidates must provide a letter describing their plans and proposed work at Oxford University (prior contact with suitable academic hosts at Oxford University is highly recommended), as well as a full *curriculum vitae* and the names of at least three contactable referees should be sent, only via e-mail to Ms Faiza Pearce at faiza.pearce@uct.ac.za **by no later than 31 May 2014.**

Practice management – a note on delays and queues

Dr Gustaaf Wolvaardt, *MB ChB (Pret), MMed (Pret), FCP (SA), AMP (MBS), PGCHE (Pret)*
Managing Director, Foundation for Professional Development

An old business rule is that queues and delays at one business create an opportunity for a competitor to acquire their customers. Medical practices are unfortunately not immune to this threat. Research shows that the speed with which businesses respond when delays occur is critically important to a customer's ultimate satisfaction, and yet the single most commonly cited source of frustration expressed by customers was delays and long queues.

This aspect of customer service is often ignored in health practices, whether public or private, and can seriously undermine patients' perceptions of the quality of care they are receiving. FPD has been doing patient satisfaction surveys at public sector clinics, supported by FPD, over a number of years and frustration with long waiting times is consistently the number one complaint.

I use the word customer deliberately as we are living in an age where patients are acting more and more like activist customers rather than grateful patients and are increasingly using social media to share their opinion on the quality of care they receive from specific doctors. Their perceptions are unfortunately shaped not just by their interaction with the medical practitioner but rather by the total experience at a practice. In the final analysis, how they are treated by front office staff at the practice plays a major role in shaping their opinion. Just google 'list of worst/best doctors' if you doubt me. In New York these perceptions culminate in an annual publication of the worst 100 doctors in the city.

Factors such as how they are spoken to, the friendliness of support staff, the promptness with which phones are answered and the pleasantness of the waiting room experience all play a role in creating positive and negative perceptions.

Owing to the nature of medical practice, situations where patients may have to wait are unavoidable, but how you manage the situation will make all the difference to how the patient experiences and more importantly talks, Facebooks and tweets about your practice.

Given that patients are often unwell or stressed when visiting your practice, unhappiness will in all likelihood be expressed loudly and dramatically. Typical behaviour of unhappy customers includes exaggerating the situation (I've been waiting here for hours now!) or oversimplifying what needs to happen (You must make my medical aid pay for this procedure!'). Some may make unrealistic demands (If you don't get it to me in the next ten minutes, I'll go somewhere else), or suggest unrealistic solutions (Why don't you just fire your receptionist!).

The fact that these scenes usually play out in your reception area, does not help your business. At best, the competency of the practice is undermined with other patients in the waiting room; at worst, the practice loses patients.

The *practice management tips series* is written for the medical practitioner as the business owner rather than for the practice manager. The reality is that as the owner it is your responsibility to identify, anticipate and manage problems. This may sound obvious, but it never ceases to amaze me how out of touch many practitioners are with what is happening outside of their consulting rooms.

So what can you do to manage this problem? We would recommend a pragmatic approach that includes the following steps:

Step 1: Identify the extent of this problem in your practice. Do some very basic customer research by asking a few key questions such as: How often does this occur every day? What is the cycle time for your patients on average, i.e. how long does it take for them to transit through your practice from arriving at reception until they leave? Have someone track patients for a few days recording their time in, time out and then compare this with their scheduled appointment times. Track the number of patients who are not seen on time and quantify the problem. Try to work out if you have a big or small problem. Remember the old management saying: "if you do not measure it you cannot manage it". Delays are often caused by: poorly designed systems, overworked or apathetic staff, work not done right the first time, and so on. A little investigative work will probably find the root causes of delays reasonably quickly.

Step 2: As prevention is always better than cure, address these problems as soon as they are identified. A smoothly running practice will minimise the waiting times when delays inevitably occur. Once you understand the problem, identify what you can do to reduce cycle times and develop strategies for staff to implement when delays develop.

Step 3: Make sure that your staff are trained on customer relations. The friendliness and helpfulness of your staff will go a long way to soothing upset patients. Front-office staff also need to be trained on how to deal with delays and queues. When delays and subsequent queues develop, here are some ideas on how to manage them:

- Be proactive when it comes to communicating with patients. An apology if combined with an explanation will usually suffice.
- If possible, patients should be informed on how long the delay will be and what you are currently doing to sort out the problem.
- Remember that in any situation where patients have to wait their turn, they will keep track of where they are in the queue and who is before and after them. In this situation it is imperative to not allow latecomers to jump the queue without an extremely good explanation being provided to waiting patients. Most patients will accept an emergency case being fast tracked, but will have little sympathy if you give preference to a VIP.
- It is also important to ensure that patients who are in the queue are kept informed how far they are from the top of the list and how long it will take before they leave the practice.
- Another possible strategy is to engage patients in activities that will help speed them through the subsequent consultation. Identify potential preliminary work which may save time later such as having their vitals done. Apart from saving time later it also serves a symbolic purpose as it shows them that you understand the need to make up time.
- Have your staff enquire from patients who experience delays what impact this will have on the rest of their day and offer your help in sorting out the knock-on effect. Can the practice make a call on their behalf? Or would they like to reschedule their appointment?

In conclusion, delays and queues are unavoidable in medical practice. But once you have a system in place for identifying them and reacting when they occur, you can mitigate the negative consequences. Alternatively ignore them and we can all read about your patients' experiences on Twitter.

This article is adapted from the study material on FPD's Certificate Course in Practice Management. For more information please contact Amor Gerber on 012 816 9084 or amorg@foundation.co.za

Medical funds: Unconscionable, unjust, unreasonable and unfair?

Advocate Willem Smit[1]

What does the term 'scheme tariff', as defined by the medical funds, essentially mean? Also, does this definition provide enough information to scheme members to allow them to make informed decisions about whether medical costs they might incur in future will be covered by their scheme tariff?

When it comes to paying benefits, medical funds have a general rule that states: *"*[The fund] *pays 100%* [or 200% or 400%, as the case may be] *of the scheme tariff for services approved by the Board of Trustees. The member is responsible for the payment of any amount that exceeds these tariffs and this is applicable to all the fund's benefit options. Service providers* [for example, doctors and specialists] *are not required to levy the medical scheme's scheme tariff, but it is the member's responsibility to negotiate the tariff with the service provider if their tariff is higher than the scheme tariff."*

The full implications of this rule are often not fully explained to scheme members.

Members' responsibilities

Since *"… it is the member's responsibility to negotiate the tariff with the service provider if their tariff is higher than the scheme tariff"*, the following questions arise:

- Can a member negotiate with a service provider (doctors or specialists) if he/she has not been fully informed of the implications of the medical scheme's 'scheme tariffs' and terms?
- Can a member negotiate with service providers (doctors or specialists) if he/she does not know exactly what the medical scheme's 'scheme tariffs' and terms are?

Definition of the term 'scheme tariff'

The medical fund Medihelp, for example, provides a concise definition of the term 'scheme tariff' in their rules. This definition does not fully describe the implications of the term. *"Scheme tariff is the prescribed tariff amount for services agreed to by the Board of Trustees. The tariff amount for 2013 is calculated as the tariff amount for 2012 plus 6%."*[2]

Can a member who has read this definition understand what is meant by the term 'tariff amount', or is there an additional risk description which can cause said member to incur further excess costs if he/she incurs medical costs in future?

A medical fund wrote a letter to a member containing information that is not generally known to scheme members. This member received the letter after undergoing an operation. He was given the following definition of 'scheme tariff': *"According to the rules of the scheme, as approved by the Council for Medical Schemes,* [the fund] *pays benefits for certain services covered under the scheme tariff. The scheme tariff is determined according to guidelines set by the National Health Reference Price List (NHRPL) which was released by the Department of Health (DoH) in 2006. The majority of medical schemes use the NHRPL to determine their scheme tariffs. Because the NHRPL was declared invalid by the High Court of South Africa in July 2010, the NHRPL of 2006 is therefore the last tariff schedule that all parties in the industry have agreed on.* [The fund] *uses this schedule as a basis to determine benefits, but consults with the South African Medical Association (SAMA) about the composition and interpretation of accounts.* [The fund's] *scheme tariff is therefore based on the NHRPL of 2006 and is subject to an annual increase,which has to be approved by* [the fund's] *Board of Trustees."*

It is true that the NHRPL of 2009 was invalidated by the High Court. According to an article[3] that reveals the current confusion surrounding the determination of scheme tariffs, the *"NHRPL* [of] *2009* ... [was] *based on* [the] *NHRPL 2006 with an inflator adjustment and NHRPL 2006 could end up with a similar legal challenge."*

The following is another letter by a medical fund to one of its members concerning permission for an operation the member wished to undergo. It contains highly complicated warnings about "tariff details":

"Disclaimer: This authorisation is not a guarantee of payment and is given based on the information available at the time and is subject to the validity of the membership, scheme rules, available benefits and scheme tariff schedules. Medical practitioners and members please take note of the following with regard to the tariff details: The amount confirmed will be influenced/reduced by modifiers linked to the item codes. No modifiers have been taken into account in this confirmation. General rules or modifiers are applicable to certain item codes according to the DBM and where applicable, the tariff will be adjusted accordingly which can influence the value of an item code and the amount payable as confirmed. When conducting a clinical validation on hospital accounts [the medical aid] *follows the industry guidelines as set by the South African Medical Association's Doctors Billing Manual (DBM). If more clarity is required because SAMA and the DBM do not address the issue effectively, we use Current Procedural Terminology (CPT) guidelines."*

It must be noted that this complicated definition of the term 'scheme tariff' was only revealed to the scheme member after he had been a member for a number of years and just before he was to undergo an urgent operation.

This medical fund provided the following reason for not explaining the full meaning of the term 'scheme tariff' to their member: *"*[The fund] *publishes the scheme tariff on our website, but only for the perusal of doctors, not members. It is provided so that doctors can compare the scheme benefits with their own fees. The NHRPL is a very comprehensive document – the guidelines for medical practitioners alone are 163 pages long – and is not available on our website due to the scope of the information it contains and the complexity associated with interpreting its codes,indicators, rules and clinical information. It is only available from the website of the Council for Medical Schemes."*

[1] *BA (Pol) (Unisa) 1985, LLB (Stell)1991, LLM (International Business Law) (Stell) 2004, National Bar Exam of the General Council of the Bar South Africa 1992, Advocate of the High Court of South Africa*

[2] *See http://www.medihelp.co.za/resources/scheme-rules-and-forms/scheme-rules* (viewed on 04-02-2014)

[3] *See paragraph 4.5 of an article that appeared on the following website: http://www.hpcsa.co.za/downloads/service_fees-tariff/submissions/sappf_c_nhrpl_2006_commentary.pdf* (viewed on 04-02-2014)

Unconscionable, unjust, unreasonable and unfair?

Does the following behaviour by this particular medical fund indicate that this fund, as a service provider, markets their services and/or negotiates agreements to provide services or goods in a way that can be described as unconscionable, unjust, unreasonable or unfair according to the Consumer Protection Act (68 of 2008)?

- The fund does not reveal the full definition of the terms 'scheme tariff' and 'tariff details' to its members when they join;
- The fund only revealed complicated information regarding 'tariff details' and the existence of any form of indemnity once the member's operation had already been approved;
- The fund does not reveal the full details/content of concepts such as *"modifiers linked to the item codes", "DBM", "... industry guidelines", "South African Medical Association (SAMA)"* and *"Current Procedural Terminology (CPT) guidelines"* to its members;
- The fund did not use ordinary language to explain the extent of the information contained in its members' indemnity conditions[4];
- The fund did not make sure that the member fully understood the terms of their indemnity, by which a badly outlined cost risk was passed onto the member[5]; and
- The fund neglected to provide the member with enough information regarding the meaning of the term 'scheme tariff' to place him/her in a position to negotiate a fair tariff with his/her service provider in terms of the scheme tariff.

Available remedies

What can a member of a medical fund do if he/she is faced with one or more of the following scenarios after an operation/medical claim?:

- The member is informed that the fund might not pay in full;
- They are told this is because the service provider's tariff was higher than the scheme tariff;
- The member was not fully informed (in ordinary, comprehensible language) about the scope and meaning of the term 'scheme tariff' and was therefore not in a position to negotiate his/her tariff with his/her service provider;
- If the fund does not pay in full, the member should question the service provider in person.

If any of these scenarios happen to a member, he/she can (depending, of course, on the facts of his/her individual case), seek recourse to the law to enforce his/her rights as outlined in the Consumer Protection Act.

He/she can, in terms of articles 69 and 71 of the Consumer Protection Act, hand in a complaint to the National Consumer Commission. He/she can complain about infringements of one or more of these articles of the Consumer Protection Act:

- **Article 22** (the right to receive information in plain, comprehensible language);
- **Article 29** (general standard for the marketing of goods or services);
- **Article 40 (2)** (unscrupulous behaviour);
- **Article 41 (1)** (false, misleading or deceptive representations);
- **Article 48** (unfair, unreasonable or unjust contract terms);
- **Article 49** (notice required for certain terms and conditions); and
- **Article 51** (prohibited transactions, agreements, terms or conditions).

The National Consumer Commission's guidelines for the handling of investigations are contained in article 72. After the conclusion of a Commission investigation the Commission can take further action in terms of article 73. The National Consumer Commission has quite wide-ranging powers to ensure the enforcement of its decisions.

Infringements of articles 40 (unscrupulous behaviour), 41 (false, misleading or deceptive representations) or 48 (unfair, unreasonable or unjust contract terms) allow a member to take the infringing person(s)/institution to court in terms of article 52 (powers of court to ensure fair and just conduct). Article 52 (3) is of particular importance to those who wish to take this step.[6]

The definition of unscrupulous behaviour[7] contained in the Consumer Protection Act may prove particularly helpful in the event that legal action is taken.

Information on the internet

An article available on the internet entitled *Medical aid schemes 'breaking the law'*[8] is a good introduction to and overview of many of the problems we have already discussed. Medical fund members (and consumers in general) should also try to download and read the Consumer Protection Act.[9] You will also find many websites with contact information and addresses of government bodies that are tasked with enforcing the stipulations of the Consumer Protection Act.[10]

In conclusion

The events outlined in this article are experienced on a daily basis by members of medical funds. Medical fund members are protected by the Consumer Protection Act (68 of 2008) and should avail themselves of its contents. It is up to consumers to enforce their rights through legal means in order to ensure that they are not exploited or cheated out of their benefits by medical aid schemes.

[4] *See article 22 of the Consumer Protection Act.*

[5] *See article 49 (5) of the Consumer Protection Act.*

[6] *Article 52 (3) reads as follows: (3) If the court determines that a transaction or agreement was, in whole or in part, unconscionable, unjust, unreasonable or unfair, the court may –*
(a) make a declaration to that effect; and
(b) make any further order the court considers just and reasonable in the circumstances, including, but not limited to, an order –
(i) to restore money or property to the consumer;
(ii) to compensate the consumer for losses or expenses relating to –
(aa) the transaction or agreement; or
(bb) the proceedings of the court; and
(iii) requiring the supplier to cease any practice, or alter any practice, form or document, as required to avoid a repetition of the supplier's conduct.

[7] *See article 40 (2), entitled "Unconscionable conduct": 40. (2) In addition to any conduct contemplated in subsection (1), it is unconscionable for a supplier knowingly to take advantage of the fact that a consumer was substantially unable to protect the consumer's own interests because of physical or mental disability, illiteracy, ignorance, inability to understand the language of an agreement, or any other similar factor.*

[8] *See: http://www.timeslive.co.za/local/2011/08/05/medical-aid-schemes-breaking-the-law>* (viewed on 04-02-2014)

[9] *See: http://www.vra.co.za/index.php?option=com_content&view=category&layout=blog&id=3&Itemid=3>* (viewed on 04-02-2014)

[10] *See among others http://www.southafrica.info/services/consumer/consumer.htm#.Uu9YaodBupo* (viewed on 04-02-2014) *and http://www.ecodev.gpg.gov.za/ConsumerAffairs/Pages/ConsumerAffairs.aspx* (viewed on 04-02-2014)

Risk Management in medical practice and hospitals

This article on clinical management is the second part of the article published in the February edition of *SAMA Insider*.

Checking procedures

When ordering drugs or other treatment over the telephone, you should always ask the recipient to repeat your instructions back to you so you can be sure they were received correctly.

- Be particularly careful when choosing the dose for a drug you are not familiar with.
- If a pharmacist or nurse questions a drug order or prescription, check it carefully – many problems are prevented by helpful interaction between colleagues.
- Always read the label on the bottle or vial before administering a drug or other substance, such as water for an injection.
- Establish the identity of the patient and double-check the prescription before administering medication.

Communication

It is often necessary to order medications over the telephone, but this is a notoriously risky practice because your instructions may easily be misheard or misunderstood:

Case report: misheard verbal prescription leads to patient's death

A patient, in the course of treatment in an acute hospital, was given parenteral morphine. The patient was sensitive to the drug and developed respiratory depression. The patient's doctor called in an order for an ampoule of naloxone to be administered. A dose was prepared from ward stock and given but there was no response. A repeat order for a second ampoule of naloxone was also given and again the patient showed no improvement. The nurse then questioned the doctor: "How much of this Lanoxin do you want me to give?" Instead of NaLoxone, the nurse heard LaNoxin. The patient subsequently died. Contributing to the error, the nurse had not repeated back the verbal order to the doctor, and the doctor had prescribed an ampoule of the drug rather than a metric weight dose. The nurse had accepted the incomplete order and administered an ampoule of LANOXIN® (digoxin) both times. (Irish Medication Safety Network, Briefing Document on Sound Alike Look Alike Drugs (SALAD) 2010.)

General advice regarding communication

If you are prescribing medication to be administered by other members of the healthcare team, issue clear and unambiguous instructions – answer fully any queries they may have.

"It is often necessary to order medications over the telephone, but this is a notoriously risky practice because your instructions may easily be misheard or misunderstood"

Prescribing for children

We see many examples of errors occurring because a doctor failed to check the appropriateness of a drug and its route of administration for children or infants, or to prescribe the correct dose. While all the foregoing advice on avoiding medication errors applies to both children and adults, special care is needed when prescribing, preparing and administering drugs to children. Drugs that are relatively innocuous in adults may have adverse effects in children. Variations in height, weight and body mass can make them more susceptible; or they may quickly accumulate toxic levels as a result of slower metabolism and excretion. MPS sees many examples of errors occurring because a doctor failed to check the appropriateness of a drug and its route of administration for children or infants, or to prescribe the correct dose. MPS has also seen tragic cases (such as the one recounted in the case report below) in which infants have died or been seriously and permanently impaired because doses of drugs were miscalculated or a decimal point misplaced.

Case report

An overworked doctor, who had been on duty for 11 hours overnight while deputising for a colleague on leave, was asked to see a premature infant with biventricular heart failure. He was not normally responsible for the care of premature infants, but he prescribed digoxin to be given intramuscularly and calculated (by mental arithmetic) that the dose should be 0.6 mg. Just as he was settling down for a well-earned rest, the ward nurse phoned to ask whether the dose should not be 0.06 mg as she had to open two ampoules. Without thinking, he told her to "Give it as I ordered". An hour later he was called to the ward because the baby had suffered a cardiac arrest.

Advice for safer paediatric prescribing

Remind [parents] of the importance of storing drugs in their labelled containers, and well out of children's sight and reach.

- Refer to a paediatric formula when appropriate and always seek advice from colleagues if you are not sure.
- When writing a prescription, include the child's age and write the exact dose in weight and (if liquid) volume required for administration.
- Always calculate doses on paper and get a competent colleague to check your arithmetic.
- When writing dosage, take special care in placing the decimal point and putting a zero in front of it.
- If you are prescribing in very small amounts of less than one milligram, prescribe in micrograms (written out – not abbreviated) to avoid confusion over the placing of decimal points.
- When prescribing for a child, it is particularly important to give the parents all relevant information such as:
  - the name of the drug
  - the reason for the prescription
  - how to store and administer the drug safely (if appropriate)
  - common side-effects
  - how to recognise adverse reactions.

Parents must always be warned about side-effects, particularly those that will be distressing to the child (e.g. alopecia with cytotoxic drugs). It is also helpful to remind them of the importance of storing drugs in their labelled containers, and well out of children's sight and reach.

Systems and resources

Errors have a tendency to compound themselves, so it is worth taking the time to ensure that essential tasks are carried out carefully. Many complaints arise from simple mistakes that could have been easily avoided.

The most common system failures are:

- failure to pass on important information
- failure to arrange appointments, investigations or referrals with the appropriate degree of urgency
- failure to review the results of investigations
- failure to arrange follow-up and monitoring
- mislabelling, misfiling and failure to check labels.

Minimising administrative risks

Transfers of care. In all scenarios it is crucial that those taking over the patient's care be equipped with up-to-date key information. This includes shift handovers, transfers to other wards and departments, transfers between hospitals and discharge home. In all these scenarios it is crucial that those taking over the patient's care be equipped with up-to-date key information. At a minimum, this should include diagnosis, treatment plans, medications, outstanding tests and test results.

Tests and investigations. When arranging urgent tests and investigations, let the lab know who they should contact with the results, especially if you are likely to be off-duty by the time they are available (and be sure to let the incoming shift know). Make a note in the patient's record whenever tests and investigations are arranged, and record the results once they are available. Any abnormal results should be acted upon, not just filed in the notes.

Patient identification. Record any crucial information as soon after the event as possible. Make a habit of checking a patient's identity – either by asking the patient or by checking the wristband – before administering any treatment. Do not rely on names on bedheads or on the charts at the foot of the bed as the patient may have got – or been put – into the wrong bed. For handover, use a combination of identifying information (e.g. name, age, DOB, diagnosis, bed number) to avoid confusion over patients with the same or similar-sounding names. Do not rely solely on bed or bay numbers to refer to patients as these may change.

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

Rash decisions

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

Mr M, a 56-year-old clerical worker, developed severe pain in his left foot and made an appointment to see his usual GP, Dr P. Dr P knew him well, having diagnosed Mr M with chronic kidney disease several years earlier, and supported him when he suffered a stroke. Dr P suspected he was suffering from gout on this occasion and prescribed diclofenac, with omeprazole cover, since he was also taking aspirin.

Less than a month later, Mr M's symptoms deteriorated and he requested a telephone consultation with his doctor. Dr P arranged for him to have a further prescription issued for diclofenac and omeprazole, and organised blood testing with the nurse to monitor his renal function.

A further month after attending for bloods, Mr M attended his follow-up appointment with Dr P, where he was advised that the blood tests had confirmed gout, alongside the ongoing chronic kidney disease. He was commenced on allopurinol, and advised to double the dose after ten days of treatment.

A fortnight after commencing the new medication, with Mr M now on 200 mg of allopurinol, Mr M started to feel unwell. He initially reported nausea and a small itchy area on his torso. Over the next few weeks, a similar rash began to appear on his face. He used calamine lotion without success, and eventually returned to see Dr P for advice. Dr P concluded that the rash was likely to be secondary to a viral illness, and antihistamines were prescribed. That night, the rash seemed to be getting worse, so Mr M consulted with Dr P again the very next day, and a course of prednisolone was commenced. The allopurinol was briefly discussed, and the patient was advised to continue taking it at a dose of 200 mg daily.

The situation continued to deteriorate and Mr M had two further appointments with Dr P over the course of the next week. His steroids were initially increased, and when this failed to improve symptoms, Dr P suggested the allopurinol should be discontinued. To complicate matters further, Dr P forgot to document the second consultation since he had a busy surgery. Three days later, Mr M developed generalised swelling, throat discomfort and difficulty breathing. Dr P spoke to the patient over the telephone and advised he was likely to be suffering from thrush.

Dr P realised at this stage he had failed to document his previous consultations so made some brief notes, without indicating he was doing this retrospectively.

The next day Mr M was admitted to hospital by ambulance and diagnosed with Stevens-Johnson syndrome. He spent a week being treated in the ICU for septicaemia and renal failure, but unfortunately died as a result of these conditions. Causation reports concluded that on the balance of probabilities, the patient developed Stevens-Johnson syndrome due to allopurinol, and experts were critical of Dr P's decision to initiate the treatment after just one attack of gout, and at an increasing dose.

Experts agreed in this case that Dr P had ample opportunity to make the connection between the rash and the allopurinol, and furthermore, the steroid treatment, which is likely to have contributed towards the ulceration, could have been avoided. The case was indefensible and was settled for a moderate sum.

Learning points:

- The basics can sometimes be overlooked – an apparently trivial rash, as in this case, can herald a more serious condition, which reflects the need for 'joined-up' thinking.
- Clear and contemporaneous note-keeping is essential, and this case highlights the importance of adequate documentation. Clinical notes are legal documents and any alterations or retrospective entries should be clearly marked and dated. GMC guidance states that doctors should "keep clear, accurate and legible records". Alteration of medical records is a probity issue.

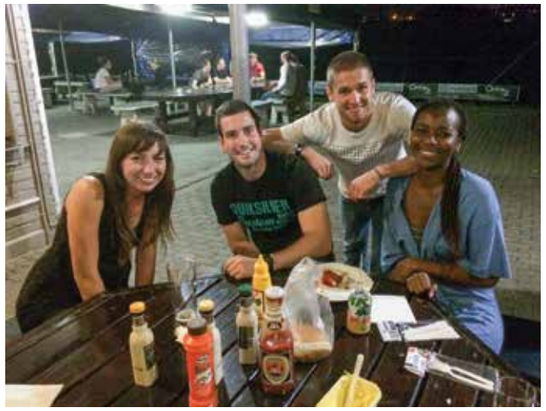
Border Coastal hosts braai for young doctors

Dr Ralph de Kramer

SAMA's Border branch realises the importance of making young doctors working in the region aware of SAMA and the services we can provide for them. To be more efficient and truly represent them, it is essential that they join SAMA or, if they are already members, update their physical addresses with SAMA head office, so that we can have a more accurate picture of how many young doctors the border branch needs to serve. Our ingenious solution to this problem was to help co-host an intern welcoming braai.

The doctors' committee of Frere Hospital and Cecilia Makiwane Hospital in East London, with financial backing from the Border Coastal branch, hold an awesome welcoming braai on New Year's Day every year, which is designed to be a meet and greet of sorts. This year's braai was a major success – every single intern who had started work at the complex signed up with SAMA. The new interns were not the only doctors to show up; doctors from the complex also attended and ate their fill. All in all we had a wonderful evening of socialising, meeting new colleagues and making new friends – a great success by all accounts!

As the chairman of the doctors' committee I would like to thank SAMA, and especially the Border Coastal branch, for helping to make it such a successful evening!



Young intern doctors at Frere and Cecilia Makiwane Hospitals were treated to a New Year's Day braai sponsored by SAMA's Border Coastal branch

Eastern Highveld branch to hold annual AGM

The Eastern Highveld branch will be holding their annual AGM on 5 March. All branch members are invited to attend. Besides offering branch members an opportunity to engage with the branch leadership about matters of importance, the event will also double as a lecture function where branch members can acquire valuable CPD points.

Among the speakers at the session will be Dr L Marcus of Marcus and Associates, Dr HM Smalburger and Dr N Mqhayi, the official-in-charge of TB control for the Department of Health's Gauteng office. The talks will cover a wide range of topics of relevance to doctors in South Africa. Doctors who are not SAMA members but are interested in joining the association may also attend. Dinner will be served after the meeting has concluded.

Where: The Venue, 14th Avenue, Northmead, Benoni
When: 5 March 2014
Time: 15:30 – 19:30
Dress code: Smart-casual

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