

SAMA INSIDER

MAY 2014

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CONTENTS

MAY 2014



"Army medic standby" – Dr Riaz Ismail

- 3 EDITOR'S NOTE**
Public sector left behind in technology race
Conrad Strydom
- 5 FROM THE PRESIDENT'S DESK**
Adoption of the new MOI – justice always triumphs
Prof. Ames Dhai
- 7 FEATURES**
7 Cutting edge technology at the Urology Hospital
Conrad Strydom
- 8** Dispensing licence expiry dates removed from BHF website
Conrad Strydom
- 8** Balanced-billing versus split-billing
SAMA Private Practice Department
- 9** Public Service salary adjustments for 2014/2015
SAMA Trade Union Organising and Collective Bargaining Unit
- 10** Postgraduate career options – a different perspective
Dr Dimple Deepa Shastry
- 11** Member profile:
Dr Mbesi Joseph Ngundu
- 12** SEDASA AGM addresses doctors' concerns
Conrad Strydom
- 15** SAMA PhD supplementary scholarships awarded
Karlien Pienaar
SAMA Legal and Governance Department
- 16** **MEDICINE AND THE LAW**
Risk Management in medical practice and hospitals
SAMA Legal and Governance Department
- 18** Modifiers applicable to endoscopic procedures: Modifiers 0074 to 0075
SAMA Private Practice Department
- 19** The twisted knee
Medical Protection Society
- 20** **BRANCH NEWS**



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EDITOR'S NOTE

MAY 2014



Conrad Strydom
Editor: *SAMA INSIDER*

Public sector left behind in technology race

The medical discoveries that we take for granted must have seemed incredible to the masses of ordinary folk who lived during the time of their discovery. The idea that microscopic entities called germs could lie at the root of many diseases, or that an x-ray can use electromagnetism to take a polaroid of your bones, was probably met with looks of universal befuddlement.

It was an idea I never quite grasped until I recently saw how a doctor can remotely operate a surgical robot that looks like a *Star Trek* prop and produce postoperative results that were only dreamed of before. However, while the daVinci surgical robot at the Urology Hospital is truly a first for South African medicine, one must wonder if it also does not signify an ever-greater gap between the public and private sectors in our country.

While private patients receive the attentions of super-high tech equipment like the daVinci, patients in public hospitals are dying because of a lack of rudimentary surgical tools. It is unfortunate that in our healthcare system five patients are lost, due to a lack of resources, for every patient saved using cutting-edge technology. When will the needs of the public sector be taken seriously?

For a closer look at the awesome daVinci system, check out page 7. We also bear further good tidings about dispensing licenses on page 8, while covering the Senior Employed Doctors Association's (SEDASA) recent AGM on page 12. Also, be sure to have a look at SAMA's PhD scholarship programme on page 15. Last but not least, the newly announced details for the 2014 SAMA Conference are worthy of some attention.

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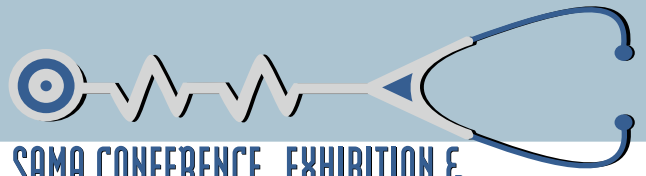
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Adoption of the new MOI – justice always triumphs



Prof. Ames Dhai, President, SAMA

On 7 December 2013, the SAMA Board passed a resolution requesting my guidance regarding issues on the non-resolution of the Memorandum of Incorporation (MOI) and Company Rules that they had been grappling with for some time. This resolution, which was supported and passed unanimously, stated that the final opinion I came up with would be binding on the Board. My final opinion was presented to the Board on 21 February.

The crux of the problem was the interpretation and application of the final paragraph of the Preamble of the MOI which reads as follows: *"In honouring the Agreement of Understanding [the 1997 founding document which established SAMA] it is hereby pledged that members of the Founder Groups [including Historically Disadvantaged Individuals – HDIs] will be represented at a minimum of 50% in all SAMA structures, be it in the Trade Union, National Council, its Committees, Board or Branch Councils, hereinafter referred to as the 'Founding Principle'. The Founding Principle will be reviewed and possibly amended with the consent of the National Council and Board of SAMA when the membership of SAMA reflects the demographics of South Africa."*

Because the 1997 Agreement of Understanding (AoU) was pivotal to the MOI, and in particular the final paragraph of its preamble, it was important that these two documents were read together. When interpreting the AoU it is clear that its main objective was to achieve unity in the medical profession, as this was imperative in the interests of rendering better healthcare to all. One of its key principles, that was important in achieving this unity, was that representation of the different organisations in the *first council* (my emphasis) would be on the basis of 50% MASA

and 50% from all other organisations that were signatories to the AoU, namely the Dispensing Family Practitioners Association (DFPA), Eastern Cape Medical Group (ECMG), Family Practitioner's Association (FPA), Progressive Doctors Group (PDG), South African Medical and Dental Practitioners (SAMDP), and Society for Dispensing Family Practitioners (SDFP). The proportionality had to be attained through a process of negotiation in order to achieve the objectives of broad functional representation and the utilisation of people who would be able to take forward the transformation agenda of the new SAMA.

For Partner Organisations (also called 'founding groups') to be included in the MOI, and in the interests of transparency, proof that each Partner Organisation is still a legally viable and functioning entity with a constituent membership in line with its Constitution was necessary. Despite several requests, this information was not forthcoming and after robust objections from the 'representative' of the organisations as to why this information was not necessary for my job at hand, I was provided with a document by the FORUM of Founder Groups, which listed the purported executive members of the different organisations. I contacted, at random, an 'executive member' from the list, whose response was that the last time they had met was 10 years ago and that the organisation to which he was attached was in actual fact defunct. To add to my difficulties, I was now challenged with the ethics and morality of including shadow entities in the MOI, a founding document of the SAMA processes. Law aside, could this be morally defensible?

It must be stressed that if Partner Organisations do exist and they want to be part of the SAMA processes, they must participate at branch level and have their members democratically elected as branch councillors. SAMA goes to great lengths to ensure that all SAMA members are contacted for electronic election purposes in their specific areas. Partner Organisation members should be fully aware of these elections and if they do not participate it is their choice. It is also to be noted that MASA and the PDG were originally members of the Partner Organisations, but when SAMA was formed they disbanded and lost their right to be part of the 50% representation in terms of the MOI. The same principle should apply to any of the other Partner Organisation members whose organisations are now defunct, even if they have never formally disbanded. Furthermore, it needs

to be acknowledged that SAMA has transitioned towards a pluralistic, multiracial and multicultural membership that is rich in its diversity and is well into the process of transformation as evidenced by the trend in its demographic composition since 1998. Moreover, SAMA has progressed towards maturity since its inception in 1997 and any revision of its MOI and Company Rules must be reflective and supportive of this growth. The re-introduction of the 1997 Founding Document and the stipulation that members of the Founder Organisations will be represented at a minimum of 50% in all SAMA structures ignores this positive shift of the Association since 1997, is regressive, and would serve to reduce the Association back to its pre-conception phase. Moreover, it would be a great injustice to branch councillors who have been elected through the democratic processes and who serve their constituencies conscientiously. Taking this into consideration, together with the fact that the Association has a fiduciary duty towards its membership and an obligation to ensure and maintain the confidence that its members have entrusted to it, I deemed it necessary to replace the last paragraph of the preamble with the following and to amend the content of the MOI and Rules accordingly:

"SAMA's continued commitment to transformation will be reflected in all its structures by ensuring that historically disadvantaged individuals (HDIs) assume and maintain their rightful positions in accordance with the principles of a democratic South Africa and in line with the Bill of Rights of the Constitution. HDIs refer to individuals from those groups that were subjected to racial injustices prior to 1994. HDIs will be represented at a minimum of 50% in all SAMA structures."

Just as the Constitution of our country stresses that South Africa belongs to all who live in it, and that we are *"united in our diversity"*, SAMA belongs to all that support it, i.e. its membership and any election and nomination process must be fair to the membership. This will go a long way towards building a united and democratic SAMA and will enable it to take its rightful place as the Association for doctors in this country.

The support from most members present at the extraordinary general meeting together with the record numbers of proxies received is witness to an overwhelming endorsement (89% in favour) of the amended MOI. Thank you SAMA members for your commitment to democracy, for reclaiming our Association and for your trust and confidence in your Board.



Prof Bavesh Kana
Conference Chair 2014

Tuberculosis (TB) continues to claim more lives annually than any other bacterial infectious agent. Globally, this disease has been fuelled by various factors among which are slow diagnostic modalities, the lack of active case finding and the emergence of multi- or extensive drug resistance. In southern Africa, the rampant HIV pandemic has been the major underlying contributor to the inability to contain TB in the region.

Today, South Africa represents the highest TB burden country, per capita, in the world; it is also home to the largest number of TB-HIV co-infections. These shocking statistics have mobilised both local and international research and development programs to search for new interventions and novel treatments for this dreaded disease.

Whilst a chemotherapeutic regimen for TB exists, the positive effects of widespread use of directly observed antibiotic treatment are hindered by the amazing ability of tubercle bacteria to evolve drug resistance. Moreover, the current BCG vaccine is able to confer effective protection against the onset of TB meningitis in children but has limited benefit in protecting adults against pulmonary TB. In this context, novel drugs and vaccines are urgently sought after to combat the disease. Moreover, a comprehensive understanding of the biology of the tubercle bacillus, during infection in people, is lacking.

The management of TB disease at district, province and national levels all require immediate attention. Many programs are poorly resourced and not integrated. Another obstacle to the eradication of TB is the fact that this disease occupies little space, if any, in the public consciousness. The advocacy and associated public engagement efforts fall significantly short of what is required to contain the spread of disease.

In considering all these matters, the TB epidemic now represents one of the biggest public health challenges in the world. It is in this backdrop that South Africa will host the 4th SA-TB Conference to be held between the 10th-13th June at the International Conference Centre in Durban. In recognition of the urgency associated with the disease and the massive loss of human life, leading experts in various disciplines will gather to discuss important findings. Key stakeholders in the basic and applied sciences, drug development, clinical disciplines, diagnostic development, operational and health systems research will debate the topical issues associated with TB eradication through an abstract driven program involving oral and poster presenters, plenary talks, round table discussions, mini-symposia and skills building sessions.

The 2014 SA-TB Conference represents an unprecedented gathering of the brightest minds in the field with the ultimate hope of plotting a new course for containment and ultimate elimination of TB from our society.

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Chris Dye was the head of the Vector Biology and Epidemiology Unit at the London School of Hygiene and Tropical Medicine until 1996, carrying out research on leishmaniasis, malaria, rabies and other infectious and zoonotic diseases in Africa, Asia and South America. In 1996, he joined the World Health Organization where he has developed methods for using national surveillance and survey data to study the large-scale dynamics and control of tuberculosis (TB) and other communicable diseases.



Gary Maartens is a clinical pharmacologist and practicing specialist physician with an infectious disease interest. He has a joint appointment as chief specialist physician and professor at Groote Schuur hospital and University of Cape Town, South Africa, where he is head of the Division of Clinical Pharmacology. His main research interests are HIV-associated tuberculosis, and the safety, effectiveness and cost-effectiveness of antiretroviral therapy in resource-limited settings. He has been involved in guideline development for both the WHO and the CDC.



David G. Russell, Ph.D., is the William Kaplan Professor of Infection Biology in the Department of Microbiology and Immunology in the College of Veterinary Medicine, Cornell University. He received his Bachelor of Science from St. Andrews University in Scotland and was awarded a Ph.D. from Imperial College, London University, in 1982.



Dr. Friedland, Professor of Medicine and Epidemiology and Public Health at the Yale University School of Medicine, in New Haven Connecticut, USA and an Adjunct Professor at the Mailman School of Public Health at Columbia University in New York City. Dr. Friedland has focused his career on the prevention, care and treatment of infectious diseases in vulnerable and underserved populations in the US and globally.



Keertan Dheda is Professor of Medicine, and Head of the Division of Pulmonology, Department of Medicine, at the University of Cape Town. He has been the recipient of several prestigious awards including the 2013 MRC Gold Scientific Achievement Award and the 2010 International Union Against Tuberculosis and Lung Disease Scientific Award.



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Cutting edge technology at the Urology Hospital

Conrad Strydom

Now that human head transplants are theoretically possible and people can monitor the state of their health in real time with their smart phones, the cutting edge of medicine is in danger of becoming blasé. But it is hard not to be impressed – and a little freaked out – by the host of high-tech gadgetry available to the medical staff of the Urology Hospital in Hatfield, Pretoria. This is a natural response to a remote-controlled surgical system that seems to spring from a particularly imaginative sci-fi movie. But the technological overdrive on display here is purely functional and focused squarely on patient care.

Of all the hospital's gadgetry, it is the daVinci Robot Surgery System – the only one of its kind in the country – that has generated the most buzz. At a whopping R20 million price tag, the daVinci is widely considered the shape of things to come in the surgical wards of the near future. Consisting of a patient-side cart with four interactive robotic arms, a remote doctor's console and a high-definition 3D imaging system, the daVinci allows a specialist physician to operate remotely by manipulating the cart's robotic arms. These arms can be fitted with the full range of surgical equipment, and can also be mounted with a high-definition camera that relays visual information to the specialist.

According to the Urology Hospital's Sister Janice van Hurten, the daVinci offers the most minimally invasive surgical procedures currently available. "The patients experience much less pain and much less blood loss during operations using the daVinci," she said. "We have seen patients go home two to three days after a prostatectomy, which was impossible before." According to Sister van Hurten, patients also do not have to take as much pain medication postoperatively.

Even though the procedure is controlled remotely, a full complement of surgical staff still accompanies every procedure to ensure that nothing out of the ordinary takes place. Before a physician can use the daVinci system, however, they have to undergo a rigorous training course in Belgium. The daVinci system also includes a training simulator that allows doctors to practise performing an operation before they attempt it in real life.

According to Dr Hugo van der Merwe, one of the first South African physicians trained to use the daVinci, the system's benefits are overwhelming. "It is exciting to be a part of



Some of the amazing technology on display at the Urology Hospital in Hatfield, Pretoria

this," Dr van der Merwe said, "but it all comes down to the benefits our patients experience post-op. Out of 77 procedures, we have not received a single complaint thus far, which is highly unusual with these kinds of operations."

According to Dr van der Merwe, interest in the machine has grown exponentially since the initial word got out, resulting in an increased number of referrals. But there have been some unexpected challenges along the way. "Probably the biggest challenge to using this system effectively is the significant amount of training it takes for you to get proficient. You also can't get trained academically to perform

these remote surgeries, so the technology is currently out of reach for many doctors."

Another issue that has frustrated doctors at the Urology Hospital is the lack of recognition the daVinci system is receiving from medical aids. "Despite the absolutely incredible risk profile of this machine, we are having a lot of trouble getting the medical aids to cover procedures where the daVinci is used," Dr van der Merwe said. However, he is hopeful that this attitude will soon change thanks to post-op inputs from patients and the fact that Netcare has recently placed an order for two of the machines.

Dispensing licence expiry dates removed from BHF website

Conrad Strydom



Dr Norman Mabasa, chairman of the National Convention of Dispensing

South African doctors are in for some good news – from the beginning of April, all the expiry dates on dispensing licences have been removed from the website of the Board of Healthcare Funders (BHF). While this may seem to be an innocuous occurrence at first, it is in fact big news for the country's medical profession, which has been in a state of disarray since the Medicines and Related Substances Act (2003) imposed a controversial set of regulations on doctors' dispensing licences. The move has received lots of support from medical professionals, including the management and board of the South African Medical Association (SAMA).

According to National Convention of Dispensing (NCD) chair Dr Norman Mabasa, the removal of the expiry dates signals that the industry is finally taking seriously the amendments to the original act which appeared in the October 2013 Government Gazette after extensive negotiations with

the Department of Health (DoH). With these changes, dispensing licences remain valid indefinitely but require an annual payment of R200 to maintain. Even though these changes were instituted by the DoH, they have received little or no recognition until the recent changes to the BHF website. "This is a great victory for the profession," Dr Mabasa said. "It is encouraging that this unfortunate chapter in our profession's history is now well and truly over."

Among other things, the old dispensing licences forbade doctors from dispensing if they were within five kilometres of a pharmacy. Doctors were also restricted to a 16% dispensing fee. "We at the NCD have been fighting for a long time to effect these changes," Dr Mabasa said. "We urge all doctors with dispensing licences to visit the BHF's website (www.bhfglobal.com) to confirm that the expiry dates have indeed been removed from their licences."

Balanced-billing versus split-billing

SAMA Private Practice Department

There is a great difference between balanced-billing and split-billing. Balanced-billing is when a service provider sends two identical accounts to both the patient and the scheme, indicating the full amount for the service delivered, but specifying the portion owed by the patient and the portion of benefits the medical scheme is prepared to pay for the service rendered.

Split-billing occurs when a medical practitioner sends two separate accounts, one to the patient and one to the medical scheme, that present different amounts for the same service.

In other words the account to the patient only reflects the amount that the patient is responsible for, while the claim to the medical scheme only reflects the amount equal to the benefits the medical scheme is prepared to pay for the service rendered. Therefore balanced-billing on one account, as opposed to split-billing on separate accounts, is perfectly admissible.

Balanced-billing

It is permissible to make use of columns on the account to indicate which portion of the total amount constitutes the medical schemes benefit portion (first column) and the balance portion (second column). The final column should reflect the total charge for a particular service.

Thus one account reflects the medical scheme benefit portion, the amount payable by the patient and the total amount for the service rendered.

Split-billing

In terms of decisions and rulings adopted by the HPCSA, it is not permissible to issue two accounts for the same service, such as one account for the medical scheme benefit portion and one account for the balance of the amount of the account not covered by the scheme's benefit for the particular service(s) provided.

One account must reflect the medical scheme benefit, the patient payable portion, and the total amount for services rendered.

Split-billing is illegal in terms of the following laws:

- According to the National Health Act (Act 61 of 2003) and section 53 (1)(b) of the Health Professions Act 56 of 1974, providers are required to disclose and obtain agreement on the cost implications of treatment from their patient and their patient's scheme before the consultation and/or treatment is to begin.
- Also in terms of the Medical Schemes Act 131 of 1998, a healthcare practitioner is required to reflect the full cost and nature of the service rendered on all accounts and is not permitted to charge a patient an amount upfront without that amount being included on the statement sent to the medical scheme and/or the patient.

Public Service salary adjustments for 2014/2015

SAMA Trade Union Organising and Collective Bargaining Unit

In 2012 the Public Service Co-ordinating Bargaining Council (PSCBC) signed a three-year collective agreement regulating wages and other allowances and benefits for public service employees. Regarding wages, the provisions of the PSCBC Resolution 1 of 2012 stipulate that:

- For the 2012/2013 financial year, employees would receive a 7% salary adjustment. This was in effect from 1 May 2012 to 31 March 2013;
- For the 2013/2014 financial year, employees would receive an adjustment based on the average projected CPI plus 1%. The agreement further states that, should the average projected CPI prove to be less than the actual CPI, the state shall make good the difference between the projected and the actual CPI. As a result the actual average CPI for 2013/2014 was 6.8% while the projected CPI was determined at 6.6% by the State. Consequently, the result is that the State owes its employees a 0.2% salary adjustment for the 2013/2014 financial year.

The PSCBC signed a three-year collective agreement regulating wages and other allowances and benefits for public service employees

- The shortfall of 0.2% mentioned above will be paid to employees retrospectively dating back to 1 April 2013. The shortfall will be paid during May 2014 as a once off payment. Please note specifically that this is not a salary adjustment but a once-

off payment resulting from the previous year's shortfall.

2014/2015 financial year salary adjustments (7.2%)

- The salary adjustment for the 2014/2015 financial year will be based on the average projected CPI plus 1%, and the average projected CPI as per the National Treasury's forecast is at 6.2%. It therefore means that for the financial year 2014/2015 the salary adjustment for public servants who fall within the scope of the PSCBC will receive a 7.2% adjustment effective from 1 April 2014.
- All other matters relating to other Conditions of Service and benefits will be dealt with as soon as possible due to the fact that PSCBC Resolution 1 of 2012 comes to the end of its lifespan as a multi-term agreement.

For more information, please contact Polelo Ndala at (012) 481 2042 or Advocate Mpotlana Daniel Madiba at (012) 481 2075.

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Postgraduate career options – a different perspective

Dr Dimple Deepa Shastry, *Medical Officer, Kalafong Hospital*

After a long journey, your community service year has come to an end. For the first time in many years, you are faced with innumerable options for how to shape the rest of your career.

There are those among our college friends for whom the answer has always been clear as to what direction they would like to pursue. For them, the community service year was spent obtaining the necessary experience and passing exams to get into their chosen field sooner. For others, community service was an adventure – one that may or may not have been spent trying to make the 'big' decision. Ultimately, many doctors who have completed their community service are undecided. Never fear!! It is a common situation and you are not alone. It might feel as if there is undue pressure from others (but mostly from ourselves) to have it all figured out as soon as possible. However, it can be said that many an amazing life has been made up of a string of unexpected coincidences. If you are one of those people with multiple interests and whose personality type fits in easily anywhere, it could mean that you would be equally good at and happy doing any number of things.

You'll be surprised by how much you learn about yourself during internship and community service

By creating a list of things you like to do and do not like you can obtain a good idea of what direction to think about. Simple things like performing interventions, overtime duty, ward rounds, clinics, theatre, working with many new people and in stressful situations constantly, administration, family time, academia, specific population groups, need for travel and work flexibility – you'll

be surprised by how much you learn about yourself during internship and community service. In South Africa, we are limited in terms of support and advice for postgraduate career guidance. This is an area that requires further development and with that in mind, I compiled a small summary of some of the options available:

Go back to school

This does not necessarily mean specialising in medicine. Various personality and psychometric testing tools are available to help you get a better idea of your strengths and weaknesses. These are by no means 100% accurate, but some tests can give you an idea of what type of environment, knowledge and activities might suit you.

Medical Clinical

If you have decided to specialise, then whether you start immediately after community service or after taking some time off, be prepared to accept that it will be an uphill struggle especially during the first two years. What matters most is that you remain unaffected by the office politics and focus solely on your goal. It is also a long-term (at least four years) commitment and will require many compromises on your part.

Many factors play a role in deciding the chosen field: work life balance and quality of life, type of clinical contact, personal enjoyment, compensation, total time to study, average time to wait for a post, job prospects after completing, desire to remain in academia and opportunity for professional growth in the future, among others. There are as many different options as there are personality types, and it pays to think out of the box.

Do research beforehand, especially if it is a field you had limited experience in during undergraduate study. There are many websites with ample information about each field, but there is no better experience than talking to people or working in the discipline yourself. A simple classification of the various fields is diagnostic (microbiology, chemical pathology, radiology), surgical or medical disciplines but within each there are numerous further areas. Alternatively there

are many diplomas which may be studied for including occupational health, HIV (immunology), sports medicine, emergency medicine or anaesthesia. Studying towards a diploma may be a more easily attainable short-term goal but can still add considerably to your educational achievements, allowing you to work in a varied albeit limited role.

There are as many different options as there are personality types, and it pays to think out of the box

Non-clinical

If public health or administration is important to you, then healthcare management is an area worth investigating. There are various programmes offered both nationally and globally such as a master's in public health, masters in health economics, masters in global health and executive leadership programmes (offered by FPD or ASELPH) which can open any number of doors for doctors. There are also a host of awards, bursaries, scholarships and organisations willing to fund your studies in order to improve health outcomes in developing countries.

Non-medical

Although the MBA is a popular choice among most professionals looking to further their careers in a business-orientated direction, there are many other options for part-time or full-time study through a number of institutions.

Work in the private sector

- GP locums or open your own practice if this is financially feasible.
- Emergency units as a locum casualty officer.
- Emergency pre-hospital medicine – flying emergency rescue helicopters, working with ER vehicles.
- Aerospace medicine or military services.

- Research units.
- Pharmaceutical companies and /or medical equipment companies.
- Medical journalism.
- International SOS.

Work abroad

This can be a lengthy process to organise so start as early as possible. This is because doctors cannot work in any country without being registered with the relevant medical council (unless they obtained their degree from an institution recognised by that country). As each country has their own rules and requirements, it will become difficult to apply to another country once you commit to going through the process.

There are many categories in this section including foreign-trained doctors who want to work in South Africa, non-South African citizens who qualified in South Africa, and those South African-trained citizens

wanting to go abroad either temporarily or permanently. Comprehensive research is required and it helps to speak to someone who is going through the procedure.

The general format consists of an initial English language proficiency test, followed by the medical tests which are divided into a written and practical part. Thereafter a certificate of good standing, official transcripts verified from your university and other documents will need to be provided.

Once you register with any council, it is very important to understand what the extent of registration means. Is it registration for independent practice or limited practice, and do they require you to work under supervision before being able to practise independently? Only once these are completed can you apply to various places to work. Popular destinations include:

- UK
- Canada

- Australia
- Maritime medicine – cruise doctor

Take time off

Working in the overburdened public health sector can be emotionally and physically taxing. While we frequently advise our patients about healthy diets, lifestyles and adequate exercise, we seldom follow our own advice. Taking time off to relax, travel and pursue other activities helps put a fresh perspective on any situation and is necessary every so often to prevent burnout.

We seldom appreciate the abundant opportunities available to us as doctors, but with a little research the multiple platforms upon which to build a fruitful career are revealed.

Whatever the choice, it is never too early or too late to make a fresh start. Community service is not the end; it is merely the beginning of an incredible journey!

Member profile: Dr Mbesi Joseph Ngundu



Dr Mbesi Joseph Ngundu is a member of the Northern Cape Department of Health's clinical specialist team tasked with improving healthcare within the Frances Baard district. He is also the Northern Cape provincial representative for

the Senior Employed Doctors Association (SEDASA).

What is the state of healthcare in the Northern Cape?

At the moment it is generally fine, the biggest problem being a tremendous shortage of medical officers. We are different from other provinces in that, despite our size, we only have one tertiary hospital – in Kimberley – and one regional hospital. The rest of our hospitals are all district hospitals, some with only two or three doctors apiece. It is very difficult to co-ordinate medical services over such a large area, most of which is rural. Unfortunately, the local SAMA branch has been inactive for quite some time. If the branch becomes active again, we will be in a much better position to improve healthcare.

What are South Africa's biggest healthcare challenges?

At the moment, our failure to meet the Millennium Development Goals is the most glaring challenge. HIV/AIDS is still a

big problem, too, although it has gotten much better. In the Northern Cape, we have done well in fighting mother-to-child transmission especially. We must also keep our eye on the growing epidemic of chronic diseases such as diabetes. If nothing is done, we will be overwhelmed by a huge burden of care ten years from now.

Another big problem is attracting doctors to rural areas. There have to be more incentives for rural doctors.

What gives you hope for the future?

The fact that doctors are realising they cannot work in isolation. Also, I believe some challenges are being taken seriously. There are signs that the government is working to increase the number of doctors, and this is encouraging. NHI, if well implemented, will solve many, many problems. As long as our political leadership can implement policies that benefit patients, there is hope. But we as doctors cannot only play the victim. SAMA especially should take the lead and effect changes in healthcare.

SEDASA AGM addresses doctors' concerns

Conrad Strydom

The Senior Employed Doctors Association of South Africa (SEDASA), the largest public-sector organisation in the SAMA Trade Union, held its annual general meeting at the Birchwood Hotel and Conference Centre in Boksburg on 11 April. Comprising senior medical practitioners such as clinical managers and specialists, SEDASA is a widely-respected voice in the South African public practice environment and represents members of the South African Medical Association (SAMA) who are permanently employed in primary, secondary and tertiary public hospitals throughout South Africa.

“We believe capacitated doctors will make the best managers. We can no longer abide a situation where qualified postoffice workers run our hospitals.”

According to SEDASA chairperson Dr Zameer Brey, the last few years has seen the association move towards the adoption of a progressive medical agenda. “From 2010 to today we have been engaged in a process of building SEDASA and re-establishing it,” Dr Brey said. He noted that SEDASA had been involved in many turn-key issues for doctors’ rights. “We are also actively lobbying the Health Ministry and exerting a direct influence at a policy level,” Dr Brey said, citing the association’s success in influencing the Department of Health’s (DoH) official Remunerated Work Outside the Public Service (RWOPS) policy as an example. SEDASA has also been active in a number of other areas, notably the struggle to ensure

that the Occupation Specific Dispensation (OSD) system is implemented fairly and the defence of registrars working for the National Health Laboratory Service (NHLS).

Dr Brey also noted with pride that the first group of graduates from the FPD’s School of Advanced Management had recently graduated following a joint scholarship programme organised by SEDASA and the FPD. It was also announced that another 20 scholarships will soon be made available. According to Dr Brey, public sector health organisations should prioritise the building of management capacity in the health sector. “With all due respect,” he said, “we believe capacitated doctors will make the best managers. We can no longer abide a situation where qualified postoffice workers run our hospitals.”

SAMA Trade Union president Dr Phophi Ramathuba addressed the doctors on various pertinent issues. She reiterated SAMA’s policy that public doctors may engage in RWOPS, but emphasised that it must not interfere with patient care: “When you perform RWOPS you must prioritise your public patient’s needs. Don’t compromise your responsibilities.” She also spoke at length about the experiences of military doctors, noting that many are leaving the military and joining the state.

“Out of all our Trade Union affiliates, only SEDASA is truly in a position to develop tools to deal with issues of national health strategy,” Dr Ramathuba said. She warned doctors, however, that changes would only be effected if they could get rid of the culture of apathy the profession currently wallows in. “Yes, South African doctors are being exploited,” she said, “but no one is going to come and save us – we must do it ourselves. We have a pathetic track record when it comes to fighting for our rights.”

Dr Ramathuba counselled the AGM attendees to demonstrate that they have enough fight in them to effect change. “We must take matters into our own hands,” she said, “But we must do so in an organised fashion.” She pointed out that the recent Department of Defense enquiry into the state of healthcare in the military would never have come about if the SAMA Trade Union had not lobbied the relevant departments or contacted the press corps with information regarding the situation.

One often-discussed topic was the establishment of a foreign doctors desk at SEDASA, due to the increasing numbers of foreign-trained doctors in the South African healthcare system. South African doctors who complete their training in places such as Cuba or China have experienced difficulty integrating into the South African health sector. RWOPS, however, dominated the discussion. According to SEDASA’s Project and Campaigns Manager, Dr D Menge, SEDASA’s RWOPS task team has continued to experience resistance from administrators who do not understand the RWOPS issue, while some doctors are continuing to misuse the policy. However, the initial controversy around the issue has died down and doctors are now in a much better position to negotiate with hospital managers.

OSD progression proved to be a thorny topic, with many of the doctors present complaining about the lack of proper implementation in all state hospitals. In response, a special OSD task team was appointed at the AGM. There was also good news from KZN, where the provincial SEDASA delegates had managed to appoint 150 Trade Union representatives in local hospitals in less than three weeks, thanks to an aggressive recruitment campaign.

“Out of all our Trade Union affiliates, only SEDASA is truly in a position to develop tools to deal with issues of national health strategy”

In his closing remarks, Dr Brey addressed the problem of apathy in South African healthcare. “When we communicate with our members, there is often little or no response,” he said. “Don’t wait until the pressure is too much before you start doing things.”

PROJECTED RETIREMENT INCOME



CURRENT RETIREMENT SAVINGS

YEARS UNTIL RETIREMENT

EXPECTED INFLATION RATE

INITIAL TAX RATE

MONTHLY CONTRIBUTIONS

ANNUAL RETIREMENT EXPENSES

RATE OF RETURN BEFORE RETIREMENT

TAX RATE ON PAYOUT

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Thinking ahead

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Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

For further information please contact the SAMAREC/CPD Secretariat on 012 481 2000 OR email us on samarec@samedical.org or cpd@samedical.org

SAMA PhD supplementary scholarships awarded

Karlien Pienaar, SAMA Legal and Governance Department

The Bursary Committee of the SA Medical Association is proud to announce that the PhD Scholarship applications process was successfully completed at the end of 2013 and scholarships have been awarded. The successful candidates receiving PhD scholarships in 2014 are Dr A Bekker and Dr K Donald.

Dr Adrie Bekker



Dr Bekker completed her medical degree in 1997 at the University of the Free State, her MMed (Paeds) at the Stellenbosch University in 2005 and was awarded her Certificate in Neonatology from the College of Medicine in 2008. She was also awarded a fellowship in Neonatology in Belgium in 2005 and a mini-fellowship in paediatric infectious diseases in Colorado, USA in 2010.

The main purpose of her PhD is to comprehensively address strategies to prevent and treat perinatal and infant TB in the context of maternal HIV infection.

She has published three first author research articles towards her doctorate:

- High tuberculosis exposure among neonates in a high tuberculosis and human immunodeficiency virus burden setting, published in the *International Journal of Tuberculosis and Lung Disease* on 1 August 2012;
- Determinants of tuberculosis treatment completion among newborns in a high-burden setting, published in the *International Journal of Tuberculosis and Lung Disease* in March 2014 and;
- The pharmacokinetics of isoniazid in low birth weight and premature infants, published in *Antimicrobial Agents and Chemotherapy* in April 2014 (e-print February 2014).

She has also been co-author in several peer-reviewed journals and has recently been awarded three PhD scholarships: the Discovery Academic Award, the MRC Clinician Researcher PhD Programme and the SAMA PhD Scholarship.

Dr Kirsty Donald



The second PhD candidate for 2014 is Dr Kirsty Donald and she received her MBChB from the University of Cape Town, also in 1997. She obtained higher specialist training in paediatrics by completing her MRCPCH in the UK in 2003 and did her FCPAED in South Africa in 2006. She completed her Certificate in Paediatric Neurology in 2009 and her MPhil on intellectual and behavioural functioning in a South African cohort of boys with Duchenne Muscular Dystrophy.

Her PhD project is focused on multi-modal neuro-imaging techniques in infants who have been exposed to methamphetamines and/ or alcohol antenatally and their neuro-cognitive correlates.

She is the first-author of papers on Cerebral Palsy in Africa and on the Neurological complications of HIV in Seminars on Paediatric Neurology, 2014 and co-author of many publications, including a chapter in the *Handbook of Paediatrics for developing countries* (Oxford University Press Southern Africa, Cape Town, 2010).

Progress reports from the 2013 recipients of SAMA PhD supplementary scholarships

The required progress reports were received from the recipients of the 2013 PhD Supplementary Scholarships, Dr AE Theron and Dr K Outhoff. Both the candidates' projects entailed studies on various elements of breast cancer.

Dr Theron wrote: "I thank the SAMA for the support and funding over 2013, and am grateful for the research progress that the funds have enabled me to achieve."

Dr Outhoff stated that "without the scholarship, it would not be possible to carry out these repeats, and I remain eternally grateful ..."

We wish them both only success for the remaining parts of their projects and their future careers.

SAMA PhD Supplementary Scholarship

The SA Medical Association wishes to encourage postgraduate research, specifically with a view to promoting research and development in the medical field in South Africa.

SAMA is therefore proud to offer the SAMA PhD Supplementary Scholarship. The scholarship is awarded on merit to the successful applicant who must be a South African citizen and a graduate of any university in South Africa who has started their PhD study within one year of application for this scholarship.

The successful applicant will receive a stip-end of R100 000 as well as one year's tuition fees.

The application must contain the following:

- Completed application form together with a passport size photograph;
- Abbreviated Curriculum vitae (max of two pages);
- Letter of intent (explaining motives for applying);
- Proof of registration with academic institution;
- Title of project and short abstract of your research project (approx 500 words);
- Brief outline of the methodology you will use (including a budget if possible); and
- Letter of recommendation by two supervisors.

Applications will only be received between 1 August and 30 September each year and must be addressed to :

The SAMA Bursary Committee
P O Box 74789
Lynnwood Ridge
0040
or email: karlienp@samedical.org

Risk Management in medical practice and hospitals

This article on keeping comprehensive and contemporaneous clinical records is the fourth part of the article first published in the February edition of *SAMA Insider*.

Keeping comprehensive and contemporaneous clinical records

Thorough documentation is crucial, not only in the interests of good continuity of care, but also to show (in the event of a claim) the facts on which you based a decision. There are many cases where the doctor did examine the patient, but either did not document it at all, or did not document the important findings – especially significant negative findings.

Many serious illnesses do not start out as typical presentations but can develop quickly, so a note in the records that a diagnosis was excluded because specific signs or symptoms were absent can provide crucial evidence in defence of a claim of negligence. Examples might be the absence of neck stiffness in a young person with a severe headache and fever, or the absence of muscle guarding in a case of abdominal pain.

Inadequate medical records are the underlying cause of many failures of communication – the records are the essential tool of communication between members of the multidisciplinary team. Subtle but significant changes may be missed when several different doctors see a patient over many days, unless adequate information is available from previous examinations.

What you include or leave out of the record is a matter of professional judgment, but you should take care to include all information that other members of the team will need to continue care of the patient safely. Months or years may elapse between treatments or illnesses and staff may have changed in the meantime. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should therefore be comprehensive enough to allow a colleague to carry on where you left off.

Poor-quality medical records are not only a major cause of iatrogenic injuries, they also make it difficult to defend a clinical negligence claim or a Council disciplinary inquiry; it is axiomatic that poor note-keeping is evidence of poor clinical practice. All of the following can compromise patient safety or lead to medico-legal problems:

- Not recording negative findings.
- Not recording the substance of discussions

about the risks and benefits of proposed treatments.

- Not recording drug allergies or adverse reactions.
- Not recording the results of investigations and tests.
- Illegible entries.
- Not reading the notes when seeing a patient.
- Making derogatory comments.
- Altering notes after the event.
- Wrong patient/wrong notes.

To be useful, the medical records should contain all the significant information that members of the healthcare team, or future carers, will need in order to be sufficiently informed about the patient's past and current clinical assessments and treatment, relevant family and social history, lifestyle and beliefs.

The Health Professions Council considers the following as the absolute minimum necessary for each patient's records:

- Personal (identifying) particulars of the patient.
- The bio-psychosocial history of the patient, including allergies and idiosyncrasies.
- The time, date and place of every consultation.
- The assessment of the patient's condition.
- The proposed clinical management of the patient.
- The medication and dosage prescribed.
- Details of referrals to specialists, if any.
- The patient's reaction to treatment or medication, including adverse effects.
- Test results.
- Imaging investigation results.
- Information on the times that the patient was booked off from work and the relevant reasons.
- Written proof of informed consent, where applicable.

To this we would add, from a medico-legal and risk-management perspective:

- All important positive and negative findings from the consultation with the patient. Information about the presence or absence of certain signs or symptoms at different stages in the course of a patient's illness is not only important for forming a picture of the development of the patient's condition, but can be crucial in defending any future medico-legal challenges.
- Differential diagnosis, including reasons for ruling out (or preferring) a potential diagnosis.

- Details of discussions with the patient about the risks and benefits of proposed treatments, including the risks of no treatment, costs and any information given to them in this regard (e.g. patient information leaflets).
- Any advice or warnings given to the patient – not to drive while taking certain medication, for example.
- Arrangements for follow-up tests, future appointments and referrals made.
- Any instructions or advice given to the patient. It is particularly important to make a note of any instructions you give to patients about what to do if their symptoms change, persist or worsen, such as returning for another consultation.

For the sake of good continuity of care, patients' records should be kept as up-to-date as possible, which means that information should be added to the patient's notes as soon as it becomes available. It is good practice to make a habit of noting information as it arises so that it is not lost if something happens to distract your attention – e.g. an emergency, a phone call, or an interruption by a colleague.

Abbreviations

Abbreviations are commonly used in medical records but can be misinterpreted and lead to mistakes in diagnosis or management. So the rule is, when in doubt, write it out – in full. Sarcastic and derogatory abbreviations have no place in medical records – acronyms like FAS (fat and stupid) are gratuitously offensive and sure to destroy any therapeutic relationship if the patient discovers their meaning.

Alterations

Once an entry has been made in a medical record, it should not be deleted or obliterated, even if it is later found to be erroneous or misleading. If you need to make a correction, use a single black line to cross out the error and then add the amendment and your signature, name (in block capitals) and the date and time.

Follow-up arrangements

British GP, Roger Neighbour, introduced the notion of 'safety-netting' in his 1987 book, *The Inner Consultation*, and a great many GPs have since incorporated this simple technique into their daily practice. In essence, safety-netting is the art of managing uncertainty by developing the habit of asking yourself three

questions and making contingency plans based on the answers. The three questions are:

- If I'm right, what do I expect to happen?
- How will I know if I'm wrong?
- What would I do then?

One of the more obvious – and effective – strategies for dealing with this sort of uncertainty is to tell the patient what sort of changes to look out for (e.g., side-effects, no improvement, condition worsening, etc.) and what to do about them if they occur. It might even be as simple as saying: "If it's no better in ten days, come back and see me".

On the subject of informing patients about side-effects, sometimes you may need to issue a warning to the patient. For example, a patient taking warfarin should be warned not to take St John's Wort, which is known to interact with warfarin. Patients should also be warned not to drive or use machinery when taking drugs that cause drowsiness.

You should make a note in the patient's records about any warnings or instructions you give the patient.

Handover

Responsibility for the average patient's care passes between numerous healthcare teams during the course of one episode of hospitalisation. And to shift changes and transfers between departments and specialty units must be added the transfer of the patient from primary to secondary care and back again. Each transition from one setting to another, or from one team to another, represents a heightened risk for the patient. One of the most common root causes of medical mishaps is communication failure during the transfer of care.

Given the potential for communication breakdown at each transfer, it is little wonder that poor handover has been identified as a root cause of so many medical mishaps. The World Health Organization recommends that handovers between shifts and between units should:

- "Use a standardised approach to minimise confusion;
- Allocate sufficient time for staff to ask and respond to questions;
- Incorporate repeat-back and read-back steps as part of the hand-over process;
- Limit the exchange to information that is necessary to providing safe care to the patient."

NOTE: An international concern: "Breakdown in communication was the leading root cause of sentinel events reported to the

Joint Commission in the United States of America between 1995 and 2006 and one USA malpractice insurance agency's single most common root cause factor leading to claims resulting from patient transfer. Of the 25 000 to 30 000 preventable adverse events that led to permanent disability in Australia, 11% were due to communication issues, in contrast to 6% due to inadequate skill levels of practitioners." (WHO Collaborating Centre for Patient Safety Solutions, Communication During Patient Hand-Overs, Patient Safety Solutions, vol. 1: solution 3 (May 2007)).

One communication technique that seems to be finding wide favour globally is SBAR (Situation – Background – Assessment – Recommendation). SBAR is in many respects an ideal communication model in healthcare because it is not only simple and easy to remember, but is also flexible, and therefore as applicable for a nurse phoning the on-call doctor with concerns about a patient in the middle of the night as it is for a formal handover between shifts.

Organisations that have adopted SBAR report that it has played a vital role in overcoming the traditional communication barriers between professionals of different status. This is absolutely crucial. There have been too many instances where nurses and junior doctors have known perfectly well that something is amiss, but haven't felt able to voice their concerns in unambiguous terms to senior clinicians. Classically, in these situations, they adopt a 'hinting and hoping' mode of communication – i.e. hinting at what they think needs attention and hoping that the hint will be taken.

To be truly effective, SBAR should be adopted by a whole team (and preferably throughout the hospital) and everyone should be given training in its use. However, there's nothing to stop individuals using it independently as an efficient means of structuring information. Its advocates have also found it useful for structuring reports, letters and medical notes. The description below sets out the essential structure of the model, but further information can easily be found on the internet.

SBAR explained

S – Situation:

What is happening at the present time – i.e., who you are, who the patient is, the patient's location and current condition. Briefly state the problem and/or your concern clearly at this point.

B – Background:

The circumstances leading up to this situation, i.e., a brief summary of relevant past medical history, the admitting diagnosis, date of admission, prior procedures, current medications, allergies, pertinent laboratory results and other relevant diagnostic results. Include most recent vital signs, important observations outside normal parameters and your clinical impression.

A – Assessment:

What you think the problem/diagnosis/appropriate management is – e.g., patient is deteriorating/stable, requires monitoring, is at risk of haemorrhage/shock.

R – Recommendation:

What should be done to correct the problem/manage the patient/monitor the situation/maintain continuity of care – e.g., awaiting lab results which must be acted upon as soon as they are available, keep an eye on fluid balance, set up an IV if necessary, watch for signs of internal haemorrhage. (The SBAR tool originated in the US Navy SEALs and was adapted and developed for a healthcare setting by Kaiser Permanente.)

Referrals

Referrals are another form of transfer of care, so you should ensure that all the essential information about the patient is conveyed to the receiving consultant. A tool like SBAR can be used for structuring the referral letter. Include an indication of the level of urgency of the referral.

Remember to tell the patient (or the patient's carer) why you are making the referral and let them know what they can expect.

Case report: Poor communication with blinding results

A diabetic clinic in a teaching hospital diagnosed TB in a diabetic patient with a history of weight loss. He was admitted to hospital and, on discharge, was prescribed three months' supply of ethambutol, rifampicin, pyrazinamide, isoniazid and pyridoxine. A month later, he was seen in the diabetic clinic but there was no discussion of his TB treatment. He failed to attend his next appointment. Three months after starting TB treatment, the patient began to complain of deteriorating vision and his GP made an urgent referral to the eye clinic. The GP had not yet received a discharge letter about the patient's last hospital admission for the treatment of TB, nor had the diabetic clinic informed him of the diagnosis, so his referral letter to the eye clinic made no mention of the

fact that the patient was taking ethambutol. The patient attended the eye clinic several times over a month, but no history of TB or treatment for TB was obtained – his visual loss being attributed to diabetes. However, his vision continued to deteriorate and by the end of this period he was only capable of counting fingers. A week later, the patient attended the diabetic clinic. Only then was the diagnosis of ethambutol eye toxicity raised. The patient was seen immediately in the eye clinic where the diagnosis was confirmed and the ethambutol stopped, but by then he had sustained a permanent loss of 90% of his vision.

Communication with colleagues in primary care

Patients' GPs should be notified whenever their patients are seen in secondary care, and especially if they have referred the patient themselves. The divide between primary and secondary care is an area where communication can easily break down, particularly when patients are receiving long-term treatment. If the patient is being given ongoing care as an outpatient it is particularly important to keep the GP informed about his or her progress and treatment, as they may have a bearing on the GP's own treatment of the patient.

Delays in mailing discharge summaries to GPs are another common cause of adverse incidents. Patients' GPs should be notified whenever their patients are seen in secondary care, and especially if they have referred the patient themselves. As the GP is often familiar both with the patient's past medical history and with relevant family history, their concerns and suggestions should be taken seriously.

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

Modifiers applicable to endoscopic procedures: Modifiers 0074 to 0075

SAMA Private Practice Department, Coding Unit

The following are explanations of the coding modifiers 0074 and 0075. These are crucial modifiers that govern the use of a doctor's own equipment or procedure rooms for selected procedures. It is crucial that private practitioners and administrators understand these modifiers, their ramifications and the differences between them.

Modifier 0074		
AM	0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33,33% (1/3) of that fee (plus '+' codes excluded) will apply where endoscopic procedures are performed with own equipment.
	Extra information on Modifier 0074	• Modifier 0074 may be used when endoscopic procedures are performed with own equipment. • Modifier 0074 may be used for every endoscopic procedure done at the same setting, e.g. gastroscopy and colonoscopy = modifier 0074 x 2. • This fee is chargeable by the doctor who owns or rents the equipment. • Modifier 0074 may not be used in conjunction with modifier 0004 as endoscopic examination can safely be done in the doctor's consulting rooms. • Modifier 0074 may not be used in conjunction with modifier 0007 when the doctor uses his/her own endoscopy equipment in theatre.

Modifier 0075		
AM	0075	Endoscopic procedures performed in own procedure room: - The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in own rooms. - This fee is chargeable by medical doctors who own or rent the facility. - Modifier 0075 may not be used in conjunction with modifier 0004. - Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the structure.
	Extra information on Modifier 0075	• This fee is chargeable by doctor who owns or rents the facility. • Modifier 0075 may only be charged once, regardless of the number of endoscopic procedures done at the same sitting, e.g. gastroscopy and colonoscopy = modifier 0075 x 1. • Modifier 0075 may not be used in conjunction with modifier 0004 for making the infrastructure available. • Not appropriate with any of the diagnostic procedures in the otorhinolaryngology section e.g. naso-endoscopy (item 1019).

Difference between Modifier 0074 and 0075

- Modifier 0074 – enables doctors to charge for the use of their own equipment.
- Modifier 0075 – enables doctors to charge for the use of their own procedure rooms.

The twisted knee

The Medical Protection Society shares a case report from their archives

Ms C, a 42-year-old risk manager, fell from her horse while out riding. At the time of the fall she felt her left knee twist, as her left foot had been caught in the stirrup.

Two days later she presented to her GP, who noted that she had not lost consciousness at any stage, had landed on her outstretched hands and knees and had sustained some bruising on her neck. He documented that the medial aspect of the left knee had sustained a bruise, that the cruciate and collateral ligaments were fine and that McMurray's test was negative. Analgesia, gradual mobilisation and exercise were advised.

Ten days later Ms C re-attended her local clinic. It was noted that an effusion had developed in the left knee and the range of flexion had decreased. Physiotherapy was advised. A week later, Ms C presented to the local emergency department (ED) with persistent pain, at which point an x-ray excluded any gross bone injury. A splint was provided and she was re-referred to her GP. Her GP duly sought advice from the local orthopaedic surgeon.

A month after the fall, consultant orthopaedic surgeon Dr T reviewed Ms C in his orthopaedic clinic. He noted the above history and found the knee held in approximately 10° of flexion. Attempts to flex or extend the knee were limited by reticence, rather than pain. A significant effusion was also observed. Exquisite tenderness was elicited on palpation over the medial joint line but upon testing the medial collateral ligament, no abnormality was evident.

On balance Dr T felt that Ms C "may simply have sustained bruising along the medial joint line, but any chance of a tibial plateau fracture or a meniscal injury should be excluded". An MRI scan was requested and Ms C was encouraged to mobilise as and whenever possible, while wearing a brace.

A fortnight later, Ms C attended a follow-up consultation with Dr A, a consultant orthopaedic surgeon. The MRI had yet to be performed. Dr A noted that Ms C had sustained a significant injury to the left knee and that she was limping heavily. Moreover, she was unable to fully extend the knee and could not flex beyond 20° without severe medial joint line pain.

Concerned about a significant disruption of the medial meniscus with or without an

associated injury to the anterior cruciate, Dr A advised Ms C that an MRI scan was likely to be academic and that urgent arthroscopy was more appropriate. Admission was arranged a week later and the patient consented to an arthroscopic meniscectomy. At arthroscopy a large injury to the medial femoral condyle was observed but the menisci were not torn – Ms C was advised that healing would occur with time. After a brief overnight admission due to pain, Ms C was discharged.

However, 48 hours post-arthroscopy, Ms C developed erythema, pain and swelling of her left calf. On the same day she also developed chest pain, following which she attended the ED. Subsequent venography of the left leg did not demonstrate a DVT, but a CT pulmonary angiogram demonstrated a number of sub-segmental pulmonary emboli (PE). She was duly anticoagulated and discharged.

A year after the accident Ms C was assessed at the local chronic fatigue syndrome (CFS) service. At that time, she described fatigue, memory impairment, diminished concentration, word-finding difficulties, myalgia, sensitivity to light and noise, and disturbed sleep. Although not formally diagnosing Ms C as having CFS, the reviewing physician noted that her symptoms were synonymous with those of CFS.

Two years later, Ms C brought a claim against Mr A, alleging that he had negligently performed an arthroscopy in the absence of an MRI scan, unreasonably diagnosed a meniscal tear, failed to obtain informed consent for the procedure, failed to adequately assess the thromboembolic risk postoperatively and failed to administer thromboprophylaxis. As a result of the alleged negligence, she felt that she had undergone an unnecessary arthroscopy, which caused the PE and led to chronic fatigue syndrome.

In defending the claim, expert opinion was sought. Professor D, a consultant orthopaedic surgeon, noted that Dr A's pre-operative working diagnosis was eminently reasonable in light of the claimant's symptoms and signs, that it is not routine practice to carry out an MRI pre-operatively if the clinician is happy with the working diagnosis, and that appropriate written consent was sought, clearly warning of the risks of DVT.

With regard to the assessment of thromboembolic risk, Professor D noted that



when Ms C completed a pre-operative health questionnaire, there was nothing to suggest any personal or family history of thromboembolic disease. Moreover, Professor D noted that routine anti-DVT prophylaxis is not standard practice prior to or following arthroscopy.

Had a normal MRI result been obtained, Professor D felt that the claimant would still have undergone an arthroscopy due to the persistent nature of her symptoms. Furthermore, he felt it unlikely that the arthroscopy had caused Ms C's chronic fatigue syndrome.

If the claim had proceeded, the Medical Protection Society's (MPS) legal team would have considered commissioning expert evidence from a vascular surgeon to confirm the cause of the PE. However, in light of the supportive expert evidence, liability was denied and the claim was subsequently discontinued; no damages or claimant costs were paid.

Learning points:

- This case underlines the importance of instructing robust experts – highlighted by Professor D's key role in securing the discontinuance of the claim.
- A swift conclusion to this case ensured that any anxiety suffered by Dr A was limited and MPS did not pay any claimant costs.
- It is also important to recognise that a complication does not necessarily amount to negligence. Therefore, it is important to cover complications in the consent process and document such conversations diligently.

North Gauteng hosts gynaecology update seminar

On Wednesday 19 March the lush grounds of the University of Pretoria's medical campus at Steve Biko Hospital served as a backdrop for a gynaecology seminar hosted by SAMA's North Gauteng branch. The CPD-accredited seminar, which was jointly sponsored by MSD and Bayer Pharmaceuticals, was well attended by medical doctors and students and covered a broad range of gynaecology-related topics.

Dr Ronald Makwela opened proceedings with a discussion surrounding the use of long-acting reversible contraception methods. He considered the pros and cons of the various contraceptive methods available to women today, noting that most women in the developed world use some form of contraception over roughly thirty years of fertility. He recommended the use of Implanon, a reversible, intravenous contraceptive that is

99% effective at preventing pregnancy over a period of three years.

“The bat failed to collide with any of the attendees and spent the last half hour hanging upside down near an air vent”

Dr Priya Soma-Pillay, head of the fetomaternal unit at Steve Biko Hospital, spoke about the preterm delivery of very small infants. She

examined ways to prevent preterm birth and how to reduce the risk involved in the procedure. Dr Soma-Pillay also examined ways to correctly manage a case of twin gestation. Dr Alta Maphalala, meanwhile, examined the correlation between HIV and infertility. Currently, 15–20% of HIV/AIDS patients are infertile. Dr Soma-Pillay also focused on menstrual disorders in adolescents.

Prof. Gerhard Lindeque delivered a lecture on offering hormone treatments during menopause, despite being interrupted by the dive-bombing antics of one of the faculty building's resident bats. Thanks to its remarkable sonar ability, the bat failed to collide with any of the attendees and spent the last half hour of the meeting hanging upside down near an air vent. Prof. Lindeque concluded the evening with a series of tips about being patient with one's patients.

Free State branch holds AGM at Emoya

SAMA's Free State branch held its annual general meeting on 15 March 2014 at the Emoya Hotel and Spa Estate just outside of Bloemfontein. The branch council and branch members were joined by final-year medical students from the University of the Free State's Medical School to discuss pertinent matters.

Despite the cold weather, delegates to the AGM managed to reach a number of important conclusions regarding the future policies of the branch.

After the AGM concluded, the delegates were treated to a gala dinner on the estate grounds. The food was excellent and a good

time was had by all. The guest speaker was Dr FCJ Bester, who regaled his audience with a collection of interesting and little-known medical facts.

The newly-elected branch president, Dr N Mofolo, also officially took up his duties at the event.

Looking at the numbers

6.7

The number of dizygotic twin births per 1 000 births in Japan.

40

The number of dizygotic twin births per 1 000 births in Nigeria.

100 000

The minimum number of annual US patient deaths due to medication errors, according to the US Department of Health and Human Services.

17%

The percentage of South Africans who have joined a medical scheme.

80%

The percentage of South Africans who consult traditional healers alongside general practitioners.

R9 916

Amount the South African government spends on health per capita.

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