SAMA INSIDER

MAY 2013

SAMA CONFERENCE 2013

Changing the Future of Healthcare

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THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

SOUTH AFRICAN
MEDICAL ASSOCIATION

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MAY 2013

"Dawn in the Desert"" – Dr Teresa Nel.

EDITOR'S NOTE MAY 2013

Roy Watson
Editor: *SAMA INSIDER*

Paving the way ...

SAMA has it on very good authority that the Minister is all for having a National Convention of Doctors.

Via the same authority, SAMA also knows that the Minister is not too keen on staging such an event – as he did for the nurses three or so years ago – until many of the current issues surrounding day-to-day medical practice, both public and private, have reached some sort of resolve.

By implication, the Minister would not like an event of the import of a National Convention to be bogged down by debates that should be played out 'regionally' before impinging on the 'national' stage.

Enter SAMA, and a very timely **SAMA Conference 2013** – great opportunity to address many of these concerns, issues etc., and pave the way for the Minister's big event!

As explained in more detail in this issue, the theme for the August conference will be *Changing the Future of Healthcare* in South Africa. Aside from the statutory clinical input, heading the list of topical issues earmarked for debate will be the regulation of medical practice going forward. In focus here, no doubt, will be the role of the Health Professions Council of South Africa (HPCSA) in a changing environment.

Predominant in such an environment, quite obviously, will be National Health Insurance (NHI). To this end, SAMA Conference deliberations on the subject are already being designed to go beyond the norm in terms of what will be expected from both public and private practitioners, as well as a need for clarity on the many NHI-associated funding issues.

There you go! Already a promise of heated debate as SAMA plays its role in preparing the sector, and more specifically its members, the country's practitioners, for what lies ahead ...

... hopefully a National Convention of Doctors, for starters!

Au revoir ...

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Teaching and training

Prof. Zephne van der Spuy, *President, SAMA*

All of us were influenced during our undergraduate years by those clinicians and scientists who taught and trained us. Every one of us will be able to give examples of excellent teachers who influenced our professional development and eventually the choices that we made in terms of ongoing careers.

Teaching and training does not end with the award of the MB ChB. Graduates now have to undergo two years of intern training which is intended to prepare them for independent practice in a less supervised environment when they work as a community service medical officer. These junior doctors, however, require supervision, training and input and their future career choices are, to a large extent, going to be dependent on the input they receive.

We all recognise the challenges in providing adequate supervision, but also the potential consequences if this is not in place. Medical education is now a subspecialty in our profession, which recognises the importance of different techniques of training and assessment and also its role in the continuing medical education (CME) of newly qualified graduates, specialist trainees and established clinicians.

There has been debate about the requirements of the good teacher. Sir William Osler, who was himself recognised as an outstanding teacher, summarised this very clearly in defining the good teacher as one who has enthusiasm, extensive personal knowledge of the subject and living experience, and not second-hand information. His comments are still relevant today and all of us who practise medicine are, almost by default, trainers and teachers. Wherever we practise, we impact junior medical staff, specialist trainees, colleagues and sometimes students in all the different disciplines of medicine, nursing and professions allied to medicine.

In medicine we usually train by using the apprenticeship model and experiential learning. There has to be adequate and appropriate supervision and, wherever junior staff members are working, there must be a structured programme – staffing should be sufficient to allow for study time.

It is important that we recognise that the professional interaction between colleagues impacts on all students and junior staff. They are not an added workload, but rather an integral part of our team and the future of our profession. There are numerous challenges in training and these include adequate available facilities and equipment, suitable trainers and mentors, and the selection of trainees.

The Royal College of Physicians and Surgeons of Canada has recognised that training not only concentrates on providing and producing a medical expert, and has identified six skills which have to be addressed: those of communicator, collaborator, manager, health advocate, scholar and profession. Each of these roles has been clearly defined and receives attention in the Canadian training system. The role of the medical expert is central to training, but these other skills address a holistic approach to healthcare.

"Medical education starts in year one of the MB ChB course and continues throughout our professional life."

Numerous senior colleagues within medicine in South Africa have emphasised the important role of research. For example, Dr Stuart Saunders, former vice chancellor of the University of Cape Town, commented: "Just as it is impossible to practise clinical medicine without asking critical questions, it is impossible to be an inspiring teacher and to set the appropriate role model for future doctors unless one has a critical approach which is fostered by being active in research". This opinion has been echoed worldwide. There have also been comments about the often overwhelming clinical workload, which limits research productivity. It is impossible to walk away from clinical needs, but it is essential that these are addressed together with training, study and research requirements.

"... every ward round and outpatient session is an opportunity for education."

Wherever we work and at whatever level of service we provide input, how we train, teach and mentor our junior staff will impact on their future careers. Each of us is a teacher and trainer, and we all contribute to the future of medicine in South Africa. We need to lobby for appropriate time for skills training and ongoing education for all clinical staff. Besides structured CME, every ward round and outpatient session is an opportunity for education.

Medical education starts in year one of the MB ChB course and continues throughout our professional life. All of us become educators and, in a country such as South Africa where resources are limited and the clinical load is considerable, it is essential that we address this challenge.

HPCSA, SAMA warn against doctor exploitation

Roy Watson

The Health Professions Council of South Africa (HPCSA) has issued a media statement expressing its concern over the potential exploitation of healthcare practitioners entering Designated Service Provider (DSP) and Preferred Provider Network (PPN) contracts with medical aid schemes.

"The HPCSA," it pointed out in the statement, "has already consulted with the South African Medical Association (SAMA), which represents a large portion of medical practitioners, and together we have outlined concerns where these ethical problems may arise. SAMA has been very proactive and positive in addressing these issues with their members and the Council appreciates all these efforts."

While these schemes may not be illegal *per se*, the HPCSA was concerned about the potential ethical transgressions that may arise from practitioners entering into these agreements with schemes.

DSP and PPN agreements take varied forms, the council explained, but are basically when a practitioner enters into an agreement with a medical aid scheme which results in direct payment and being listed as a preferred service provider: "The area of concern is that schemes in certain instances exert pressure on medical practitioners to prescribe certain medication or take certain decisions on behalf of patients that will benefit the scheme and not necessarily the patient and/or make clinical decisions aimed at cost-cutting.

"The HPCSA reminds healthcare practitioners of their obligation to always act within the best interests of their patients and to desist from entering into any arrangements that may result in the quality of clinical care being compromised."

The Council goes on to stress that practitioners who feel unduly pressurised to sign such contracts, or are placed in any position where they feel their ethics could be compromised, are urged to contact the HPCSA for guidance. They may also contact the Council for Medical Schemes (CMS) if there are any transgressions by the schemes.

"We would also like to welcome patients – if they feel their health has been compromised due to such an agreement – to contact the HPCSA in this regard."

The statement concluded with a reminder that the HPCSA has a mandate to protect the rights of patients and to guide the professions across South Africa. "While healthcare costs are a constant concern to all parties, only by working together within the prescribed ethical guidelines can we ensure that all parties' rights and responsibilities are met."

Intensive strategy plan in place to enhance SAMA member benefits

SAMA Communications

The South African Medical Association (SAMA) Board of Directors, in collaboration with SAMA management and employees, recently completed an exhaustive strategy-planning programme to streamline the support and services that the association provides to its members.

The underlying objective of the project has been to reinforce an empowered, motivated and involved membership with the assurance that SAMA is the only choice in terms of multifactorial representation.

Once implemented, the strategy elements will augment SAMA's role as a visionary, visible and influential organisation for doctors, i.e. "SAMA works for doctors".

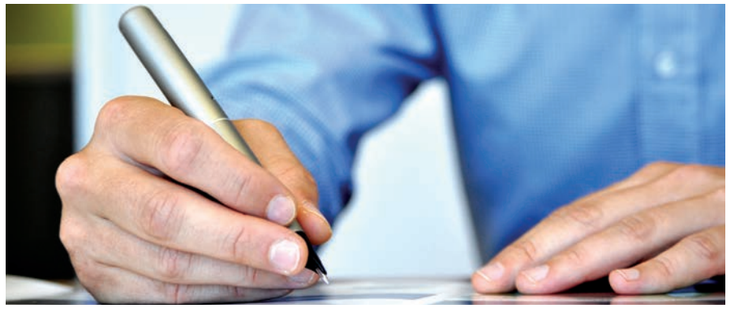
Key performance areas subjected to the intensive strategy revision to meet these objectives were: *Financial, Customers/Members, Internal Processes, and Learning and Growth*.

The primary aim in the financial category is to guarantee the financing of activities that address members' needs and create a better value proposition throughout the association – the primary beneficiary being the SAMA member. Aligned to this aim will be a closer relationship between head office and branches and branch activities, to engender financial expediency throughout the organisation.

Aside from the development and improvement of the various support services offered by SAMA, such as legal, industrial relations and coding, part of the new strategy plan will be to generate more member participation and involvement in the various SAMA-convened conferences and meetings. These include the annual SAMA Conference, the GP and Specialist Indabas, and the fast-expanding Committee for Public Service Doctors (CPSD) AGM and Conference.

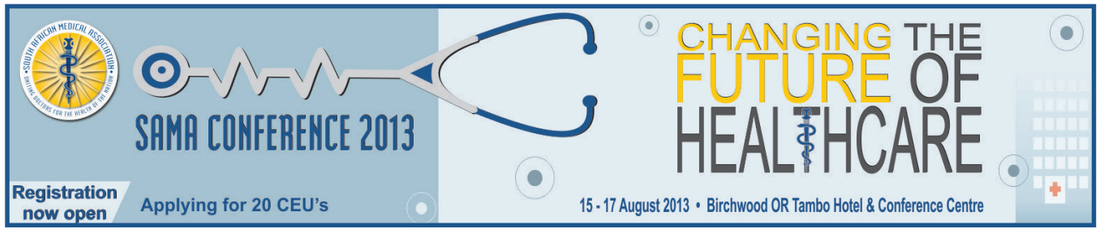
Internal processes critical to the day-to-day functioning of the association will now be monitored via a Balance Scorecard, featuring performance measures, compliance and risk management, vital in maintaining a coherent organisation with a capability and capacity to deliver the desired results.

Core management competencies expected from this will be strategic capability and leadership, financial management, problem solving and analysis, change, programme and project management, and knowledge management.



Healthcare future in focus at premier SAMA event

Corné Engelbrecht, *SAMA Events Co-ordinator*



The South African Medical Association (SAMA) will be hosting the 2013 version of its traditionally successful annual conference at the Birchwood OR Tambo Conference Centre near Johannesburg's OR Tambo Airport from 15 to 17 August.

Running concurrently with the event will be a trade exhibition and an exhibit of the **SAMA 2013 Photography Competition** entries.

The **SAMA 2013 Doctors Awards** will also take place at the conference venue during the event.

The theme for the SAMA Conference and Exhibition 2013, *Changing the Future of Healthcare*, will see focus on:

- Clinical updates for practical guidelines
- National Health Insurance (NHI), with focus on:
  - Roles of public and private sectors now and in the future
  - Funding and funders
  - Human resources for health
- Regulation and regulatory bodies
  - Health Professions Council of South Africa (HPCSA) – current role and role in the future
  - How will health be regulated going forward?

SAMA's key objectives for this conference will be to bring together policy-makers, opinion formers, academics and practitioners to address the obstacles facing healthcare and the optimisation of access to quality healthcare.

The trade exhibition will provide an ideal opportunity for companies and institutions to showcase and/or introduce their products and services to a specific target audience – mainly GPs and specialists – from throughout South Africa.

The **2013 Photography Competition,** facilitated by SAMA and the Medical Protection Society (MPS), is open to all SAMA and MPS members.

Selected entries will be displayed at the 2013 SAMA Conference. The winners will be announced at the cocktail reception on 15 August and winning entries will be published in all SAMA and MPS media. Those who wish to enter the competition simply have to complete an entry form and upload a digital image of their entry on the competition website.

More detailed information regarding the theme and categories as well as the rules will soon be available on the SAMA/Competition website.

Doctors' Awards

The Housecall Doctor Awards, administered by SAMA and Bonitas, represents the Association's annual recognition and acknowledgement of excellence and achievement by the country's doctors. The ceremony will take place on Friday 16 August at the Birchwood Hotel and Conference Centre.

SAMA, in collaboration with Bonitas, will honour those individuals and teams who have significantly advanced our healthcare through quality service and innovative solutions that realise maximum benefit for patients.

Recognising such vital contributors is a core value of the association. There are many colleagues who deserve to receive recognition awards, but their achievements go by unnoticed.

Readers who know of doctors who have made a remarkable contribution to servicing both the profession and patients and are deserved of such recognition, are encouraged to contact SAMA.

For more information on the SAMA Conference, Exhibition, Photography Competition and Awards function, please visit www.samedical.org or contact Corné Engelbrecht (email: cornee@samedical.org).

SAMA to lead SANAC's Health Professionals Sector

Bernard Mutsago, *SAMA Health Policy Researcher*

At the South African National AIDS Council (SANAC) Health Professionals Sector (HPS) summit held on 27 March at the Department of Health offices in Pretoria, SAMA's Dr Sizeka Maweya was elected as the leader of the HPS.

Two other Sector representatives were elected into the leadership team, namely Ms Dorothy Matebeni, president of the Democratic Nursing Organisation of South Africa (DENOSA), and Ms Ria Pretorius, from the Pharmaceutical Society of South Africa (PSSA).

These three organisations were the previous leaders of this Sector. The ballot elections were facilitated by SANAC officials and were declared free and fair. Dr Maweya's participation in the leadership contest was agreed upon by SAMA's Health Policy Committee, of which he is a member.

The HPS is one of the 17 different sectors falling under the SANAC Civil Society Forum (SCF). The HPS summit was held immediately ahead of the CSF set for 3 - 4 April.

During the summit, stress was legitimately laid on the fact that in going to the CSF, the HPS leader represents the Sector, not his/her organisation or him/herself. HPS and CSF summits are held approximately quarterly and all costs are borne by SANAC.

The current leader of the CSF, and also the deputy chairperson of SANAC (replacing Mark Heywood), is Mmapaseka Steve Letsike.

Armed with passion and experience in the area of HIV/AIDS, Dr Maweya's job description is to successfully lead the HPS in supporting the implementation of the *National Strategic Plan on HIV, STIs and TB, 2012 - 2016*, and to represent the Sector on SANAC structures and Sector Leaders Forum.

Dr Maweya is the Limpopo provincial co-ordinator for the Southern African HIV Clinicians Society (SAHIVSOC), as well as the HIV/AIDS/TB provincial clinical advisor. He is a specialist family physician in Polokwane at Mankweng hospital complex, a lecturer at the University of Limpopo, the SAMA provincial secretary in Limpopo, as well as national secretary of the Academic Doctors Association of South Africa (ADASA).

In a nation with an antenatal HIV prevalence of ~30%, the HPS is one of the most important sectors of SANAC. Although HIV/AIDS is a multisectoral epidemic, the heart of AIDS fighting is in the health sector. In the recent past, when SAMA was the Secretariat and Leader for the Sector, the HPS was labelled as malfunctioning, mainly due to leadership challenges and disunity, among others.

The first summit in 2013 has been a consequence of Dr Phophi Ramathuba, SAMA board director, agitating for the resuscitation of this Sector and the convening of the meeting. It appears, therefore, that the re-election of SAMA as Sector leader following a dark period of dormancy for the HPS is a graceful second chance to correct past mistakes, and is testament to the Sector's trust in SAMA's leadership potential.

The election of a member of the association into a top leadership position simultaneously charges SAMA with the responsibility of supporting Dr Maweya in whatever way necessary. It is also an opportunity for SAMA to improve its commitment to SANAC-related HIV and TB programmes/tasks. For example, in the past few years SAMA, among other stakeholders, participated in the revision of the previous National Strategic Plan (NSP). SAMA already has a five-member task team on HIV and TB issues, under the auspices of the Health Policy Committee. The current NSP 2012 - 2016 needs scrutiny, active participation and engagement by doctors, and the development of the new Fixed-Dose Combination (FDC) guidelines – rolled out nationally on 1 April 2013 – is an area where doctors' input was needed.

Participating organisations

Many different health organisations constitute the HPS, including the Rural Doctors Association of South Africa (RuDASA), South African Dental Association (SADA), Hospice Palliative Care Association (HPCA), Professional Association of Clinical Associates in South Africa (PACASA), South African Stoma Therapy Association (SASA), Society of Midwives of South Africa (SOMSA), Renal Care Society of South Africa (RCSSA), Forum of University Nursing Deans in South Africa (FUNDISA), the Soul City Institute (SCI) for Health & Development Communication, and the Centre for the AIDS Programme of Research in South Africa (CAPRISA), among others.

Message from incoming JUDASA president

Dr Kgopotso Pege, *JUDASA President*

I humbly greet all of my colleagues in the medical fraternity, senior and junior. As the first female president of the Junior Doctor's Association of South Africa (JUDASA), I feel truly honoured to have been entrusted with the responsibility of leading this organisation as a young female.

This is a great compliment to the country's efforts of moving towards gender equality and transforming the male-dominated leadership.

I have served in JUDASA since I was in my first year of internship, and the learning platforms that I was afforded have been truly beneficial in terms of grooming.

Looking at the challenges that we face as junior medical doctors, we appear to be going around in circles. These are longstanding challenges that I believe will only change if the doctors start taking charge of their working environment, demanding the respect that this profession deserves, and protecting the image of our fraternity.

JUDASA is the only organisation in the country, as a wing of the South African Medical Association (SAMA), available to champion the issues of junior doctors. I encourage *you*, my fellow colleagues, to utilise this organisation to the full. Not only can we do more with our members' support, but also indicate solidarity in us paving a better health system for the future, *our* future.

This year has already begun on a rather horrible note for my fellow women in the country, having been exposed to the surge of gruesome criminal acts that women and children are experiencing. As medical doctors, we have to be firm against this inhumane action in the country, because we are the ones who deal with the anatomical trauma and psychological impact that this has on our patients. It ruins their lives. We need to support all the actions against this rape surge because it can happen to anyone, be it yourself or your partner.

Let us not be oblivious to the social impact that this has.

JUDASA AGM resolves on key revitalisation issues

Revitalising the South African healthcare system through a progressive and revolutionary trade union was the theme of this year's JUDASA annual general meeting (AGM) and convention, the core feature of which comprised intensive discussions on key issues identified to achieve this revitalisation.

Held at SAMA's head office in Pretoria on 9 - 10 March, the meeting addressed four main challenges and, after specific sub-group deliberations (illustrated), arrived at the respective resolutions.

Issues and resolutions were:

1. Financial model of the JUDASA PEC

Noting that:

a. JUDASA PEC struggle to perform their functions and have difficulties implementing projects due to lack of funds.
b. SAMA trade union has just been adopted and funding models are not well defined.

We therefore resolve that:

a. The SAMA head office should issue a directive to the branches reminding them to fund JUDASA provincial activities.
b. In addition to the above, JUDASA NEC should continue to provide financial support to their PEC when necessary.
c. After the SAMA trade union has implemented the leadership model, funding of the JUDASA PEC should be provided for by the trade union PEC.

2. Integrating JUDASA into the SAMA trade union

Noting that:

a. The SAMA trade union have just adopted a constitution that entails major restructuring of the public sector department.
b. No clear document has been presented on the integration of the special interest groups into the SAMA union at operational level.
c. The newly adopted constitution needs to be reviewed thoroughly by the constitutional matters committee.

We therefore resolve that:

1. Recommendations should be forwarded to the trade union as follows:

Leading the JUDASA electoral proceedings were Daniel Madiba (left), SAMA PubSec Department acting head, and Ntokozo Sibeko, senior legal advisor in the department.

Two of the sub-groups in session.

a. Definitions of terms to be included in the constitution.
b. The term "registered medical practitioner" should be well defined to include all medical interns.
c. To address the JUDASA membership, students should be included in the membership profile of the trade union. However, the NEC will still need to resolve whether the students become associate members of the trade union and have no voting powers, but continue to participate in the organisational activities.
d. JUDASA members should participate in the shop-stewardship of the trade union (as outlined in the constitution) and continue to represent members at this level. They should also take part in the branch leadership of the trade union.
e. Provinces should be demarcated by the existing geographical demarcations, and provinces with one branch should be expanded to have more branches. The NEC should not have powers to demarcate the provincial offices.
f. The term *interest group* should be continued to be used, as opposed to *sub-committee* of the trade union. The role of these groups should be clearly outlined, not least their powers.

2. The NEC is to form a task team to finalise all outstanding matters of the JUDASA constitution, and all other documents pertaining to the trade union.
3. JUDASA should strengthen and align its strategies with the marketing divisions of SAMA, to maintain the corporate identity of the organisation.

3. JUDASA on the Cuban programme

Noting that:

a. There are several challenges faced by the medical students while studying in Cuba and when they complete their training in our domestic medical schools.
b. JUDASA was silent and could not intervene when the Cuban medical students embarked on a strike.
c. There is no established relationship between JUDASA and the Cuban medical students.
d. There is a widespread negative attitude towards the Cuban graduates by doctors qualified within domestic medical schools.
e. The six Cuban students who returned to South Africa after the stipend protests have shown remorse for what they have done.

We therefore resolve that:

a. A portfolio for an international relations officer should be formulated within JUDASA to deal with all matters relating to international programmes.
b. The NEC should outline properly the powers and functions of this portfolio.
c. JUDASA is to support the six medical students and engage with the Minister of Health on absorbing them into the domestic medical schools.
d. It should be recommended to the minister that the number of years spent by the students in Cuba be reduced.

4. Framework of electoral process within JUDASA

Noting that:

a. There is no clear policy that informs the invitation of the delegates to the national AGM of JUDASA.
b. Members are elected into leadership positions without a clear track record of previous involvement in leadership roles.
c. Provinces have unequal numbers of active members in the organisation.

We therefore resolve that:

a. Provinces should nominate candidates for the NEC, and nominations can still be open during the AGM.
b. Short *curricula vitae* and motivations for the candidates be submitted during or prior to the AGM.
c. The presidential candidate should have been in the NEC or PEC.
d. For provinces without a PEC, invitations should be open to all members.
e. It is recommended that equal numbers of delegates attending the AGM across all the provinces be maintained.

Risk management in medical practice and hospitals

The South African Medical Association (SAMA), through its Human Rights, Law and Ethics committee, has taken the initiative to partner with the Medical Protection Society (MPS), in an attempt to bring information to members relating to risk management in medical practice and hospitals. To this end, the MPS has given SAMA permission to publish its risk management booklets in a series of articles in the *SAMA Insider.*

Article No. 3
Ethical considerations

The medical profession subscribes to a strict code of ethical conduct; breaching it in any way may attract disciplinary penalties from the Council, but we focus here on three main areas:

- Respect for patient autonomy (informed consent, shared decision-making)
- Respect for patient confidentiality
- Probity.

Respect for patient autonomy

This section contains only a brief overview of consent issues, which can be complex. You will find more detailed advice in the MPS booklet: *Consent to Medical Treatment in South Africa – An MPS Guide*. This is available in hard copy (free for MPS members) or electronically via the MPS website.

Managing expectations

Many claims and complaints are brought, not because a doctor has been negligent, but because the patient's expectations have been disappointed. Quite apart from the legal and ethical requirement to do so, there is a very good practical reason for seeking informed consent – it may prevent claims and complaints about you if the outcome of treatment is less than optimal. Many claims and complaints are brought, not because a doctor has been negligent, but because the patient's expectations have been disappointed. If you discuss openly with your patients what is and is not possible, they will have more realistic expectations and are therefore less likely to feel disappointed when an otherwise successful treatment leaves them with residual problems, or when it doesn't work at all.

Those who have researched the subject seem to agree that you should aim for shared decision-making when one or more of the following apply: the patient prefers to be involved in decision-making; there is a degree of uncertainty about the outcome of treatment options; two or more options with similar potential outcomes are available; the risks and benefits of the proposed treatments are high; or the patient has a chronic illness.

If you discuss treatment options with a patient and duly note the substance of the discussion in the patient's notes, it will be much easier to defend your position if an allegation of negligence is later made against you.

Consent to treatment

Consent is not something that only applies to invasive surgical procedures, as stated earlier; a patient's right to autonomy is enshrined in the Constitution and is therefore an ideal that carries the force of law. In particular, the Health Act of 2003 (Chapter 2, sections 1 and 2) explicitly obliges healthcare providers to inform a health service user of:

"(a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user; (b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user's right to refuse health services and explain the implications, risks and obligations of such refusal."

"The healthcare provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy"

Technically, any bodily contact with a patient is an assault if the patient did not consent to it. Clearly, it would be ludicrous to obtain formal consent before performing every little act, such as measuring blood pressure or feeling a pulse, so the law allows healthcare practitioners to carry out much of their work on the basis of implied consent. If patients co-operate with your actions (for example, rolling a sleeve up for the sphygmomanometer cuff), you may assume that they have given consent. Even so, a short explanation of what you intend to do, and why, is still advisable – especially if it entails examining genitals or breasts. Even an examination of the fundus of the eye with an ophthalmoscope or palpating the glands in the neck can feel threatening to patients if they don't know what to expect.

Consent is also needed for non-interventional treatments such as drug therapy, and for investigations and tests. Although it might seem that you have implied consent if the patient co-operates by taking the medication prescribed or by allowing you to take a blood sample, if the patient is unaware of the possible side-effects of the drug, or doesn't know what blood tests you're going to request, the consent is invalid because the patient did not make an informed decision.

To be considered valid, consent to a medical intervention must meet three criteria:

1. Information – The patient must be informed about the material risks and benefits of the proposed intervention.
2. Capacity – He/she must be capable of taking in the information, weighing it in the balance and arriving at a decision.
3. Non-coercion – The patient must be free of undue pressure or coercion in making his/her decision.

Information

Just presenting patients with information sheets or briskly rattling off a list of possible side-effects of a drug is not sufficient; the information that should be given to patients so that they may make an informed decision is listed in below. The information must be tailored to the needs of the individual – it must therefore be presented in a form the patient can understand and in the context of his/her particular preferences and circumstances.

The Council offers this guidance regarding the context in which the information should be presented: "When providing information, healthcare practitioners must do their best to find out about patients' individual needs and priorities. For example, patients' beliefs, culture, occupation or other factors may have a bearing on the information they need in order to reach a decision. Healthcare practitioners should not make assumptions about patients' views, but discuss these matters with them and ask them whether they have any concerns about the treatment or the risks it may involve."

These are important considerations as each patient will take a different view on the implications of the risks and benefits, depending on his/her personal priorities. A patient who earns his living as a professional driver, for example, is likely to be reluctant to take medication that causes drowsiness.

Information the patient should be given in the consent process

- "[Provide] details of what the patient might experience during or after the procedure, including common and serious side-effects.
- Details of the diagnosis, and prognosis, and the likely prognosis if the condition is left untreated.
- Uncertainties about the diagnosis, including options for further investigation prior to treatment.
- Options for treatment or management of the condition, including the option not to treat.
- The purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure, including common and serious side effects. For each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes which may be caused or necessitated by the treatment. Advice about whether a proposed treatment is experimental.
- How and when the patient's condition and any side-effects will be monitored or re-assessed.
- The name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team.
- Whether students will be involved, and the extent to which students may be involved in an investigation or treatment.
- A reminder that patients can change their minds about a decision at any time.
- A reminder that patients have a right to seek a second opinion.
- Where applicable, details of costs or charges which the patient may have to meet."

Source: *HPCSA, Seeking Patients' Informed Consent: The Ethical Considerations (2007), para 3.1.3.*

Capacity

Even if you do explain your intentions to the patient, you will also need to check that he/she understands what you've been saying, otherwise you will fall at the second fence (the patient's capacity to understand and weigh choices in the balance).

Non-coercion

Lastly, you should not put patients under pressure to agree to a particular intervention (and you must be particularly scrupulous in this regard if you have a financial interest in a facility to which you wish to refer the patient).

As a doctor, you have a duty to give your patients the benefit of your expert opinion, so there is nothing wrong with advising them and letting them know what your preferred course of action would be if you were in their shoes, but be careful not to let your advice cross over into pressure or coercion.

Case report: A rushed decision

Mr H is a plasterer in his late 40s. He has been experiencing pain in his left knee, on and off, for several years, but this has been adequately managed with a combination of physiotherapy and non-steroidal anti-inflammatory drugs (NSAIDs). One day, he comes to see his general practitioner (GP), Dr J, complaining of intense pain and limited movement in his knee. Dr J, noting Mr H's history and finding, on examination, that the knee is slightly swollen, recommends an intra-articular injection of Kenalog. As he is aware that Mr H is self-employed and needs to be able to return to work as soon as possible, he suggests that he administers the injection there and then. Mr H is doubtful about having an injection straight into the joint, but Dr J brushes aside his doubts, saying that it will get him "up and running in no time". He points out that it is unlikely he will get another appointment at the practice until the following week, which will only delay his recovery. Mr H reluctantly acquiesces, and allows Dr J to administer the injection. Unfortunately, he subsequently develops septic arthritis in the joint, although this is successfully treated with antibiotics, he loses several more weeks of work and decides to sue Dr J for compensation. His claim alleges invalid consent, not only because he had not been warned about the small risk of infection, but because he had felt coerced into making a hasty decision.

LEAVE

Sick, maternity and family responsibility leave

Julian Botha, *Senior Legal Advisor, SAMA*

All employees, as a condition of their employment are entitled to leave. There are a number of different types of leave, such as annual, maternity and sick leave, each of which is regulated differently. The Basic Conditions of Employment Act (BCEA) deals extensively with leave in Chapter 3.

In our previous article (March 2013), we dealt comprehensively with the legislative provisions pertaining to annual leave. In this article, we will deal with the legislative provisions governing sick leave, maternity leave, as well as family responsibility leave.

Sick leave

Section 22 of the Act governs sick leave. Reference is made to a "sick leave cycle". This means a three-year (36-month) period of employment from the date of commencement of employment, or the conclusion of a previous sick leave cycle. In each sick leave cycle, an employee is entitled to an amount of paid sick leave equivalent to the number of days that they would ordinarily work during a period of six weeks.

It is important to note that an employer may not divide the sick leave into annual periods, i.e. 10 days per year for three years.

There is a limitation on the amount of sick leave that an employee is entitled to at the commencement of employment (section 22(3)). During the first six months of this first sick leave cycle, the employee is entitled to one day of paid sick leave for every 26 days worked. This restriction does not affect the total amount of sick leave available to the employee for the full 36-month cycle; it merely limits the amount of sick leave that can be taken during the initial six months of employment. In subsequent sick leave cycles, there is no such limitation.

It must also be remembered that unused sick leave cannot be carried over into the next sick leave cycle. Unused sick leave merely falls away.

Further, employees who leave employment are not entitled to claim payment for unused sick leave, nor are employers entitled to claim any amount back from employees who leave employment in the middle of a sick leave cycle, but have already used up all their sick leave for that particular cycle.

In terms of section 23 of the Act, an employer is not required to pay an employee for sick leave where that employee has been absent from work for more than two consecutive days or on more than two occasions during an eight-week period and that employee has not, despite a request by the employer, furnished a medical certificate which states that the employee was unable to work for the duration of the absence due to sickness or injury.

The section provides further that the certificate must be issued by a medical practitioner or any other person who is certified to diagnose and treat patients, and who is registered with a professional council established by an Act of Parliament.

Should the employee fail to produce such a certificate, the period of absence must be treated as unpaid leave and cannot be deducted from paid annual leave.

Many employers have a policy that requires employees to produce a medical certificate if they are absent from work on a Friday, a Monday or both a Friday and a Monday, or where the employee is absent on the day before or after a public holiday. This is not permissible as the Act clearly provides that a certificate can only be requested where an employee is absent from work for more than two consecutive days (in other words, three days or more). Employers may rely on the provisions of section 23 (1) referred to above - where an employee is absent on more than two occasions in an eight-week period, but specific reference to Fridays, Mondays and Public holidays is not allowed.

Application to occupational accidents or diseases

In terms of section 24 of the Act, in the case of an employee who is unable to work due to an accident or occupational disease, as defined in the Compensation for Occupational Injuries and Diseases (COID) Act (No. 130 of 1993), any period of absence is not deducted from ordinary sick leave, unless there is no compensation payable in terms of the COID Act.

Maternity leave

Section 24 of the Act provides that employees are entitled to at least four months' maternity leave. The maternity leave may be taken at any time from four weeks to one month before the expected date of birth of the child, unless there is an agreement to the contrary or on a date which a medical practitioner or a midwife certifies is necessary for the employee's health or that of her unborn child.

No employee may return to work for six weeks after the birth of the child, unless a medical practitioner or midwife certifies that she is fit to do so (section 25(3)).

In the event that the employee suffers a miscarriage in the third trimester of the pregnancy or bears a stillborn child, the employee is still entitled to maternity leave for six weeks after the date of the miscarriage or still birth, irrespective of whether the employee had already commenced maternity leave at the time of the miscarriage or stillbirth.

Section 25(5) places an obligation on the employee to notify her employer in writing, unless she is unable to do so, of the date on which she intends to commence maternity leave and return to work after this maternity leave. Such notification must be given at least four weeks prior to the commencement of the leave or, where it is not "reasonably practicable" to do so, as soon as is reasonably practicable.

An employer is obliged to keep the employee's job open, and no employee may be dismissed on grounds of pregnancy, or for any reason in relation to pregnancy or intended pregnancy. In terms of section 187(1) of the Labour Relations Act, such a dismissal would be automatically unfair. This has the effect that the maximum amount of compensation that can be claimed by the employee so dismissed is doubled.

Maternity leave is unpaid leave, but the employer is free to make arrangements or policies that employee will receive some, or all, of their salary and benefits during this period. Such arrangements do not enjoy statutory protection, but can be enforced in contractual law.

Family responsibility leave

Employees who have been in employment with the same employer for longer than four months, and who work more than four days per week for the employer, are entitled to family responsibility leave.

The employee is entitled to three days of family responsibility leave per annual leave cycle. As is the case with sick leave, unused family responsibility leave is not carried over into the next annual leave cycle and thus falls away.

Section 27(1) of the Act obliges the employer to grant the employee paid family responsibility leave, at the request of the employee only under the following circumstances:

- when the employee's child is born
- when the employee's child is sick
- upon the death of the employee's spouse or life partner, or the employee's parent, adoptive parent, grandparent, adopted child, grandchild or sibling.

An employee is entitled to take family responsibility leave in respect of the whole or part of the day (section 27(4)).

The employer is entitled to ask for proof of the event for which the family responsibility leave is sought, such as a medical or death certificate.

Other types of leave

The BCEA makes no reference to any entitlement to unpaid leave, study leave or paternity leave. Should an employer wish to grant these types of leave, provision must be made in their policies and employment contracts.

Conclusion

This concludes our survey of the legislative provisions pertaining to leave. It must be remembered that the employer is always free to provide higher amounts of annual, sick, family responsibility and maternity leave to their employees. Although these higher amounts, if granted, do not enjoy legislative protection, they do enjoy contractual protection. An employer may not grant additional leave in their policies and employment contracts and then unilaterally withdraw the same relying on the fact that the Act only provides for a certain amount of leave.

Our members in private practice are encouraged to contact the SAMA Governance and Legal Department if they have any questions regarding the leave granted to their employees. SAMA members in the public service are encouraged to contact the Industrial Relations department for assistance.

Malpractice indemnity in an NHI system*

Dr Graham Howarth, *Head, Medical Services Africa, MPS*

The existing arrangements for malpractice indemnity differ depending on whether care is delivered in the private or state sector.

At present, healthcare professionals in the private sector are responsible for ensuring that they have their own professional indemnity arrangements in place. In the event that a healthcare professional provides negligent care, the patient would pursue that practitioner under the law of delict for financial compensation. The practitioner is personally liable.

The patient's access to compensation may be put at risk if the practitioner fails to put adequate and appropriate indemnity arrangements in place. Patients treated in the state sector would bring any claim for compensation for negligent treatment against the state.

Treasury regulations accept that the state is vicariously liable for the acts or omissions of state employees, thus the state would be responsible for the payment of compensation due to the patient.

Patients treated privately are compensated by the private practitioner who has their own indemnity arrangements in place.

Patients treated in state (i.e. provincial) hospitals and clinics are compensated by the province.

If, after the introduction of National Health Insurance (NHI), state patients receive care in the private sector, it will be important that there is clarity as to where liability for negligent treatment, and with it the requirement for indemnity, lies.

There would appear to be two options. Either the state takes responsibility for indemnifying the patient regardless of the sector in which the state patient receives treatment. Or, the state requires the private provider to have their own indemnity arrangements in place.

No-fault compensation

No-fault compensation schemes – where the patient does not have to sue the provider to secure compensation – operate in several countries and are frequently discussed in many others.

With no-fault compensation schemes, patients do not need to prove fault although other qualifying criteria, such as the "avoidability" test, may be applied.

There is still a requirement to prove that the harm was caused by the act or omission of the provider. Undoubtedly, a system of accountability and learning would need to be carefully considered if the introduction of no-fault compensation were to be seriously contemplated.

There are clear benefits to no-fault schemes, but there are also significant drawbacks. More people would obtain compensation because of the removal of the requirement to prove fault. However, this may mean a higher overall cost even with the potential reduction in legal fees, and despite the fact that financial compensation or entitlements in the existing schemes are usually set lower than those in successful clinical negligence claims brought under delict-based systems.

To be effective, decisions about no-fault compensation need to be made through a robust and independent process and in a timely way. It must be simple to access and people who use the scheme must feel that they have been treated equitably. Compensation could be awarded much more quickly, because the award could be made by administrative means or a tribunal rather than following an adversarial process. A no-fault scheme also has the potential to integrate issues such as rehabilitation with financial compensation.

Critics of no-fault compensation will often cite the lack of accountability and lack of a patient safety incentive. There are concerns that by removing the element of fault-finding, doctors are no longer held to account for the mistakes that they make and the opportunity to learn and improve is diminished. Undoubtedly, a system of accountability and learning would need to be carefully considered if the introduction of no-fault compensation was to be seriously contemplated. So, too, would the cost.

**This article was first published in* CMS News, *the official newsletter of the Council for Medical Schemes (CMS) (www.medicalschemes.com).*

Implications of employer refusing to sign end-of-contract HPCSA Form 27 (Part One)

Ntokozo B Sibeko, *Legal Advisor, SAMA Industrial Relations Unit*

The Law

Community service is governed by provisions of section 24(a) of the Health Professions Act (No. 56 of 1974) and a doctor is required to do community service for a period of one year.

In terms of Regulation No. R688 published on 15 May 1998 in *Government Gazette* No. 18890, the relevant provincial department, as the relevant health authority in terms of the provisions of paragraph 7 of the Regulation 688, must issue a report in the form of a signed Health Professions Council of South Africa (HPCSA) Form 27 to certify that a doctor has satisfactorily completed community service. Obtaining this form will enable him/her to register as an independent medical practitioner with the HPCSA.

What happens if the employer refuses to issue a report?

It happens from time to time that the employer refuses to issue a report, despite the member completing the 12-month community service period as envisaged by section 24(a) of the Act.

The failure by the employer to issue the report would automatically prevent a member from registering with the HPCSA as an independent medical practitioner, thereby preventing a member from pursuing his/her career as a medical practitioner.

A member is entitled to be issued with a signed HPCSA Form 27, which would serve as a report confirming that he/she performed the one-year community service.

In a recent case dealt with by the South African Medical Association (SAMA), one of our members completed the 12-month community service period upon which she completed Part A of Form 27 and handed it to the employer to complete Part B. Signing of Part B would serve as confirmation that she completed one year of community service. The employer representative further completed the form but deleted the word "satisfactory" and inserted the following: "unsatisfactory, further 2 months of paediatrics needed".

This led to the member being unable to register as an independent medical practitioner. The implications of refusal to complete the form properly further meant that the member was prohibited from practising as a medical practitioner. She could not take up employment in the public service or in private practice to exercise her profession. The refusal by the employer to present her with an unqualified Form 27 further meant that she was unable to commence with employment, which she secured and to which she had committed herself some months before completing the 12 months of community service.

What next?

In January 2013, SAMA took the matter up with the employer, but all attempts were unsuccessful. Although the actions of the employer seem grossly unfair, we were unable to refer the matter to the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) since the employer's actions did not fall within the definition of an unfair labour practice as per section 186(2) of the Labour Relations Act (No. 66 of 1995).

We were further prevented from bringing an application to the Labour Court since the fixed-term contract, in terms of which the member was employed, came to an end and rendered the Labour Court without jurisdiction to hear this matter.

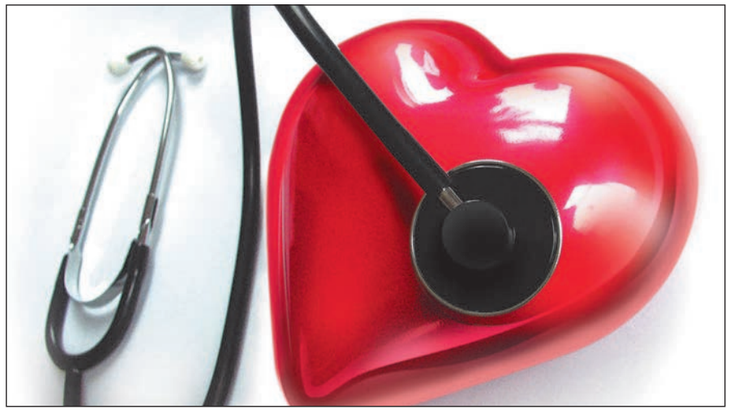
We had to revert to the relevant High Court and SAMA instructed its legal representatives to pursue the matter further through the available legal avenues. This meant bringing an urgent application through the High Court to compel the employer to issue a report in the form of a signed and unqualified HPCSA Form 27.

It must be made clear that in the case of this member, the court agreed that our member fulfilled her obligation to the employer by completing the 12 months of community service as prescribed in section 24(a) of Act; further, that the employer should furnish our member with an unqualified Form 27.

A lesson learnt from the case is that if the employer refuses unreasonably to sign HPCSA Form 27, legal action can be taken depending on the merits of the case.

Where the heart is...

The Medical Protection Society shares a case report from its case files.



Fifty-five-year-old Mr R had a history of hypertension for which he was taking an angiotensin-converting enzyme (ACE) inhibitor.

He attended his general practitioner (GP), Dr S, with intermittent tightening of the chest and a sense of breathlessness. He did not have any symptoms of nausea or pins and needles. Mr R felt that he was suffering panic attacks, especially as he had recently been made redundant and was experiencing financial difficulties.

On examination, Mr R's blood pressure was found to be high and Dr S attributed these symptoms to anxiety. However, he arranged an electrocardiogram (ECG) and routine blood tests and asked Mr R to return to discuss the results.

When the results were available, Dr S considered the ECG for any abnormalities of rate, rhythm or appearance, and looked for changes suggestive of myocardial ischaemia or infarction. He felt that the ECG was essentially normal, aside from mild tachycardia, and did not see any gross abnormality requiring emergency admission.

Two days later, Mr R attended the surgery as an emergency, complaining of chest pain, shortness of breath and nausea over the weekend. Dr S saw him before surgery began in the morning and arranged for emergency admission to hospital. The ECG and blood test results were sent along with a handwritten referral letter.

Mr R's blood pressure was found to be high and Dr S attributed these symptoms to anxiety.

Upon admission to hospital, Mr R clinically deteriorated and cardiopulmonary resuscitation (CPR) was performed; however, Mr R died within an hour of admission. The postmortem found that Mr R had a large saddle embolus in the pulmonary artery, causing complete obstruction of the lumen.

The left popliteal vein showed residual deep venous thrombosis, which was the likely source of the fatal embolism.

Mr R's widow made a claim against Dr S. Expert opinion criticised Dr S for his initial diagnosis of anxiety, his failure to consider that Mr R's symptoms were potentially life-threatening and for failing to note that the ECG showed right-bundle branch block and right-axis deviation compatible with pulmonary embolism. Mr R should have been referred to hospital when he initially presented with chest discomfort, where a cardiologist would have diagnosed him and Mr R would have survived. The claim was settled for a moderate sum.

Learning points

- In any patient with chest discomfort, you need to rule out serious cardiopulmonary causes with a careful history, examination and ongoing referral, if warranted.
- Mr R had a number of risk factors for cardiovascular disease, including his age, high blood pressure and other symptoms that could possibly relate to circulatory problems. In any patient with chest discomfort you need to rule out serious cardiopulmonary causes with a careful history, examination and ongoing referral, if warranted.
- You should refer a patient for further assessment if an ECG is abnormal and if they have risk factors for cardiovascular disease. Mr R should have been admitted to hospital to exclude a myocardial infarction (MI), even if Dr S was unsure of the diagnosis, because of his risk factors for cardiovascular disease.
- Be aware of non-cardiac causes of chest pain. In this case, the history, in combination with tachycardia, pointed towards pulmonary embolism. However, the doctor only excluded a cardiac cause without considering embolism.
- Anxiety symptoms can be very similar to symptoms of more sinister pathologies. When assessing someone with a history of, or new presentation with anxiety symptoms, consider risk factors for cardiopulmonary disease when taking the history, examining and arranging follow-up tests.

The original case report can be found in MPS's edition of Casebook Vol. 21 No. 1, January 2013: www.medicalprotection.org/southafrica/casebook-january-2013/where-the-heart-is.

Working towards a medical management specialty

The South African Society of Medical Managers (SASMM), previously the Medical Administrators Group within the South African Medical Association (SAMA), is now working in close collaboration with the Division of Medical Management (DMM) of the College of Public Health Medicine of South Africa (CPHMSA) towards the re-establishment of medical management as a specialty.

According to Dr Ntombi Mutshekwane of SASMM, in correspondence with the *SAMA Insider*, such specialties are already recognised in many countries such as Australia, India, New Zealand, Pakistan and Sri Lanka.

SASMM and DMM, it was noted, would like to position themselves to respond to the National Department of Health's need and commitment to strengthen health systems. Policies that will exercise SASMM include the policy on management of hospitals, occupation-specific dispensation (OSD) policy for medical managers, and the human resource for health policy, which require managers to be trained in medical management.

The Human Resources Strategy for Health also proposed the establishment of an Institute for Leadership and Management in Health Care, which was recently launched by the Hon. Minister of Health.

The implementation of National Health Insurance (NHI), Dr Mutshekwane added, also calls for improvement in the management of health facilities and health districts. SASMM therefore proposes that smaller hospitals come under the management of doctors, whereas larger hospitals should have clinical directorates.

"This would require services of a specialist medical manager who is competent in evidence-based medicine, clinical medicine, clinical economics, and administrative medicine acquired through theoretical as well as experiential learning under constant supervision."

SASMM will soon be contributing to a regular management column in SAMA Insider.

WORLD DIGESTIVE HEALTH DAY, 29 MAY 2013

Liver cancer: Act today – save your life tomorrow

Dr Mark Sonderup, *Vice Chairman (SAMA), SAGES Councillor and Division of Hepatology, UCT*
Prof. Michael Kew, *Departments of Medicine, Universities of Cape Town and the Witwatersrand*

World Digestive Health Day, an annual event of the World Gastroenterology Organisation, serves to highlight important digestive health issues. The South African Gastroenterology Society, an affiliate and special interest group of the South African Medical Association (SAMA), fully supports this initiative, particularly as this year the focus is on liver cancer, a significant yet potentially preventable disease in sub-Saharan Africa (SSA).

The challenge for 2013 of 'acting today and saving a life tomorrow' with respect to hepatocellular carcinoma (HCC), is a formidable one. Globally, HCC is the 5th most common human cancer with approximately 800 000 new cases annually. It ranks 3rd in global cancer mortality and has the shortest survival time of any cancer. The burden is most significant in developing countries with 80% of HCC occurring here. SSA, and notably South Africa (SA), is one such area where the prognosis is decidedly poorer with patients often presenting with advanced stage disease aggravated by limited access to any available therapeutic interventions.

The dominant aetiological factor in SSA, accounting for 80% of HCC, is chronic hepatitis B virus (CHB) infection. Important cofactors are dietary exposure to fungal toxin, aflatoxin B1, as well as dietary iron overload. Exposure to hepatitis B occurs before the age of 5 in the majority of those with CHB infection. HCC can occur in the absence of cirrhosis in those with CHB and occurs more commonly in men and a decade or two earlier than those with HCC in the developed world. HIV co-infection potentiates the risk of HCC. Other factors associated with a significant risk of HCC include cirrhosis due to alcoholic liver disease and chronic hepatitis C virus infection. An emerging cause of cirrhosis, and hence HCC, is non-alcoholic steatohepatitis as a consequence of the metabolic syndrome and the burgeoning obesity epidemic.

Prevention of the aetiological factors associated with HCC is key to dealing with this aggressive malignancy, given that treatment options remain relatively limited and unavailable to most in SSA. The development of a vaccine against hepatitis B virus marked the first available true anti-cancer vaccine. Globally 177 countries have introduced hepatitis B vaccine.

In SA the vaccine was incorporated into the World Health Organization (WHO) Expanded Programme of Immunisation in 1995. Babies currently receive 3 doses at 6, 10 and 14 weeks and the carriage rates of hepatitis B surface antigen in children has already been reduced <20 years after its introduction. Catch-up vaccination for adolescents was not introduced and there is no schools-based vaccination programme.

The time is right for us to consider these factors, synergise with WHO recommendations and initiate the vaccine schedule at birth. Another pressing matter is that a vast number of children in SSA do not receive the full course of vaccination. The standout example of what can be achieved is in Taiwan: Vaccination was initiated in 1984 with universal coverage by 1986. HCC has dropped by 70% in the vaccinated groups while rates of CHB have plummeted.

Other preventive strategies for HCC include addressing the excessive use of alcohol. The medical profession in SA should support any programmes or strategies to curb the promotion and consumption of alcohol. Aggressive educational strategies to address lifestyle issues causing obesity are not only required to address the risks of HCC but also health benefits in general. Those at risk of hepatitis C, e.g. exposure to blood/blood products prior to 1990 and current or previous injecting drug users, should be offered screening.

The timely recognition of HCC may influence prognosis and patients with cirrhosis are advised to undergo bi-annual ultrasound and alpha-fetoprotein evaluation as a screening tool. This recommendation may however pose a challenge in resource-constrained areas.

Therapeutic interventions for HCC include surgical re-section, loco-regional therapies, e.g. radio frequency ablation, liver transplantation or newer molecular targeted anti-tumour agents. Unfortunately, most of these interventions have limited applicability in SSA; hence, prevention remains critical.

HCC remains a significant burden and challenge in SSA and SA, with a generally poor prognosis. Political will remains critical for the effective preventive strategies that we have listed to be introduced, sustained and expanded.

Protection advised at well-attended Border CPD meeting

Stella Kaschula, SAMA Border Coastal branch secretarial stalwart, registers doctor delegates on arrival.

A thought-proving talk on 'The 10 Cs to keep out of trouble' by Dr Graham Howarth, head of Medical Services Africa for the Medical Protection Society (MPS), contributed to the success of a well-attended continuing professional development (CPD) meeting convened by the Border Coastal branch in East London in mid-March.

The meeting attracted 74 delegates, mainly doctors, but also a few laboratory technologists. The main message from Dr Howarth's talk was that good medical protection is a necessity, particularly for private practitioners.

Concerns expressed from government service doctors in this regard were in terms of how they are to protect themselves when they know they are working in poor conditions and putting themselves at risk, e.g. too many patients, poor equipment and inadequate drugs available.

Survey again points to human resource deficiencies

Local experts leader, Prof. Bongani Mayosi (left), with Dr Sabine Kleinert (centre), The Lancet *representative, and Dr Aaron Motsoaledi (right), Minister of Health.*

Despite the impressive progress that South Africa has made in many aspects of healthcare over the last three years, it is clear that much more needs to be done.

Focusing on effective human resource systems for the country's "burgeoning national health insurance system", for example, will be crucial if health targets are to be met, according to the authors of the most recent *The Lancet* survey into the country's healthcare.

Led by noted University of Cape Town (UCT) academic, Prof. Bongani Mayosi, the group of experts outlined four key challenges that need to be met to accelerate progress towards health targets:

- Racial disparities in the social determinants of health remain striking – for example, just 10.3% of black South Africans have medical insurance, compared with 70.9% of white people in the country.
- Successfully strengthening public healthcare systems will be a fundamental first step if universal healthcare is to be successfully established, with the authors pointing out that, currently, "the struggling public healthcare system is a deterrent to many who try to obtain medical health".
- Improving health surveillance and information-gathering will be absolutely critical if South Africa is to strengthen its health systems and effectively monitor progress, with the authors stating that, "South Africa can be judged to be data rich but information poor, because existing data systems might not provide nationally representative, good quality information in a timely manner, [especially] in view of the rapid changes in health outcomes that have probably occurred in the past few years."
- Successful innovations in service delivery that have been achieved locally in the last 10 years have generally failed to reach a wider national scale. Administrative and managerial deficiencies in the state will need to be addressed if these innovations are to be successfully applied on a national scale.
- The authors concluded that implementation of these recommendations depends on the effectiveness of the government and the demand by citizens to access their basic rights and entitlements and discharge their responsibilities.

For the full review, see: http://press.thelancet.com/southafricareview.pdf.

SAMA at ASSA

A welcome visitor to the SAMA exhibit at the recent Association of Surgeons of South Africa (ASSA) conference in East London was Dr Anthea Klopper (right), SAMA Border Coastal branch chairperson, seen with Jeanette Snyman, SAMA marketing officer.

Registrars elect 2013 committee

SAMA affiliate group, the South African Registrars Association (SARA), elected its 2013 executive committee at a well-attended annual general meeting held at The Farm Inn in Silverlakes, Pretoria, in mid-March. Committee members are (back, from left) Dr S Jiyana (WSU, East London), Dr Puzi (FS), Dr J Jeme (WSU, Mthatha), Dr O Mosiane (MEDUNSA), Dr N Masinga (UP, Vice-Chairperson), Dr L Majake (UP, Treasurer), Dr B Matha (UKZN); (front, from left) Dr M Adam (Wits), Dr L Mbodi (Wits, Chairperson), and Dr L Mbuli (UCT). Not in photograph: Dr S Malefatlho (UP) and Dr J Nkoana (Limpopo).

Gauteng branch supports Glorious Children's Home

SAMA Gauteng Branch members rallied to the call after Branch Council received a request towards the end of last year to assist the Glorious Children's Home in Braamfisherville, Soweto.

Many pledged varying amounts to this worthy cause, resulting in the donation of much-needed soccer shirts and soccer and basketball equipment.

Every picture tells a story …

Glorious Children's Home soccer team, proudly wearing their new shirts.

Dr Kalli Spencer presenting one of the boys with his shirt.

Dr Gary Reubenson handing over a soccer shirt.

OBITUARY

Dr Pieter le Roux

It was with regret and sadness that SAMA learnt of the sudden and untimely passing of Tygerberg Boland branch stalwart, Dr Pieter le Roux.

Dr le Roux was a National Councillor of SAMA, representing Anaesthetics. He worked at Tygerberg Hospital in the Department of Anaesthesia and was the incumbent Vice-President of the South African Society of Anaesthesiologists.

He also served on the College of Anaesthetists of the College of Medicine of South Africa (CMSA).

The Association extends its profound sympathy to his family, friends and colleagues.

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